MEMORANDUM

TO: Joint Budget Committee

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

SUBJECT: Affordable Care Act Implementation Update

DATE: December 18, 2013

Since the date the JBC staff briefing document for the Department of Health Care Policy and Financing was written, the Department and Connect for Health Colorado have released new metrics for the implementation of the Affordable Care Act covering activity through December 14, 2013. This memo provides an update to the briefing issue "Affordable Care Act Implementation" that begins on page 41 of the JBC staff briefing document, because the new information changes some of the findings.

Enrollment through December 15

The table below summarizes the enrollment statistics for Connect for Health and Medicaid through December 14. For Medicaid the "enrollment" is approved applications by people who will be newly eligible as of January 1, i.e. parents with income from 101 percent through 133 percent FPL and adults without dependent children from 11 percent through 133 percent FPL. For Connect for Health "enrollment" is people who have committed to a coverage plan.

Affordable Care Act Metrics

	Total Enrollment	Medicaid Newly Eligible	Connect for Health
Prior to October*	9,233	9,233	NA
October	28,343	24,935	3,408
November	36,694	30,122	6,572
December 1-14	62,931	49,902	13,029
Cumulative	137,201	114,192	23,009

* Wait list adults without dependent children.

Medicaid

One of the conclusions in the JBC staff briefing document was that Medicaid approved applications were consistent with assumptions about average monthly enrollment used in the fiscal note for S.B. 13-200. Based on the new information released by the Department, approved applications through December 14 are actually ahead of the average monthly enrollment assumption for January used for S.B. 13-200 by 15,134. Note that approved applications and average monthly enrollments are not the same thing, but they should correlate closely with one another.

Medicaid Expansion		
Month	Approved Applications	Projected Average Monthly Enrollment S.B. 13-200
Prior to Oct	9,233	
Oct-13	34,168	
Nov-13	64,290	
Dec 1-14	114,192	
Dec 15-31		
Jan-14		99,058
Feb-14		111,935
Mar-14		116,503
Apr-14		131,419
May-14		136,181
Jun-14		141,317

Connect for Health Colorado

Another conclusion in the JBC staff briefing document was that Connect for Health Colorado enrollments were below "worst-case" projections from Connect for Health's internal planning documents of 11,108 enrollments by November 13 and 22,215 by December 13. The new information indicates a surge in enrollments for the first part of December brought cumulative enrollments to 23,009, which is slightly above the "worst-case" projection.

Of those enrolled through December 14 Connect for Health reports 54 percent, or 12,385, will qualify for financial assistance with their health insurance premiums. This was not part of the press release, but provided separately to the JBC staff. Connect for Health is still validating data on the dollar value of that financial assistance, and so was not yet ready to release the information.

National comparisons

Since the JBC staff briefing document was prepared the federal government has released new data on enrollments through November 30. The New York Times did a comparison of each state's enrollment to an administration projection contained in a September memo from Marilyn B. Tavenner, the administrator of the Centers for Medicare and Medicaid Services, to Kathleen Sebelius, the health and human services secretary. This is an attempt to normalize the enrollment data to account for differences in factors such as population and the number of uninsured. Some of the differences in the actual experiences of the states may be due to flaws in the projection, but hopefully the margin of error in each state is similar, making the data comparable across states. Using the new data through November and the New York Times metric, Colorado's enrollment looks slightly higher compared to other states than the older analysis presented in the JBC staff briefing document by the Foundation for Governmental Accountability.

New York Times Comparison of Exchange Enrollment to Administration Projections for the First Two Months				
State	**Who runs the exchange**	**Individuals who have selected a private plan**	**Private plan enrollment target for first two months**	**Pct. Of second-month target reached as of Nov. 30**
Connecticut	STATE	11,631	5,610	207%
Rhode Island	STATE	2,669	2,040	131%
New York	STATE	45,513	37,060	123%
Colorado	**STATE**	**9,980**	**15,640**	**64%**
Vermont	STATE	4,987	9,690	51%
New Hampshire	FEDERAL	1,569	3,230	49%
California	STATE	107,087	221,000	48%
Maine	FEDERAL	1,747	3,910	45%
Wisconsin	FEDERAL	5,303	13,430	39%
Minnesota	STATE	4,478	11,390	39%
Kentucky	STATE	13,145	37,400	35%
Pennsylvania	FEDERAL	11,788	35,020	34%
Delaware	FEDERAL	431	1,360	32%
Washington	STATE	17,770	57,800	31%
Hawaii	STATE	444	1,530	29%
Illinois	FEDERAL	7,043	24,310	29%
Nebraska	FEDERAL	1,965	6,800	29%
North Carolina	FEDERAL	8,970	32,470	28%
Montana	FEDERAL	1,382	5,270	26%
Idaho	FEDERAL	1,730	6,800	25%
Michigan	FEDERAL	6,847	27,370	25%
Alabama	FEDERAL	3,448	13,940	25%
Nevada	STATE	4,834	19,550	25%
Wyoming	FEDERAL	521	2,210	24%
Virginia	FEDERAL	4,946	21,590	23%
Florida	FEDERAL	17,908	81,090	22%
Tennessee	FEDERAL	4,507	20,910	22%
Kansas	FEDERAL	1,855	9,010	21%
Missouri	FEDERAL	4,124	20,060	21%
New Jersey	FEDERAL	3,259	16,320	20%
Georgia	FEDERAL	6,859	34,680	20%
Utah	FEDERAL	1,865	9,690	19%
Arizona	FEDERAL	3,601	18,870	19%
West Virginia	FEDERAL	775	4,080	19%
South Carolina	FEDERAL	2,761	15,640	18%
Ohio	FEDERAL	5,672	32,300	18%
Indiana	FEDERAL	3,492	21,250	16%
Arkansas	FEDERAL	1,404	8,670	16%
Maryland	STATE	3,758	25,500	15%
North Dakota	FEDERAL	265	1,870	14%
Louisiana	FEDERAL	2,193	15,980	14%
Texas	FEDERAL	14,038	106,930	13%
Oklahoma	FEDERAL	1,673	14,280	12%
Alaska	FEDERAL	398	3,400	12%
South Dakota	FEDERAL	372	3,230	12%
Iowa	FEDERAL	757	6,970	11%

New York Times Comparison of Exchange Enrollment to Administration Projections for the First Two Months				
State	Who runs the exchange	Individuals who have selected a private plan	Private plan enrollment target for first two months	Pct. Of second-month target reached as of Nov. 30
Mississippi	FEDERAL	802	9,860	8%
New Mexico	FEDERAL	934	14,110	7%
Massachusetts	STATE	1,138	42,500	3%
Oregon	STATE	44	40,290	0%
District of Columbia	STATE		7,310	
Total		**364,682**	**1,201,220**	**30%**

Young Invincibles

The JBC staff briefing document included some comparisons of Colorado's enrollment of people ages 18-34 with the experience of other states. Those comparisons are dated, but it is worth noting that the new information about enrollments through December 14 included demographic information for Medicaid that shows much higher enrollment among "young invincibles" in Colorado's Medicaid program than through Connect for Health. The young invincibles tend to have lower health care costs, and so including more of them in the risk pool reduces per capita costs.

"Young Invincibles" ages 18-34 as a percent of new enrollments October 1 - December 14	
Medicaid	49%
Connect for Health	18%

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

Prepared By:
Eric Kurtz, JBC Staff
December 19, 2013

For Further Information Contact:

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

TABLE OF CONTENTS

Department Overview 1

Department Budget: Recent Appropriations 1

Department Budget: Graphic Overview 2

General Factors Driving the Budget 4

Summary: FY 2013-14 Appropriation & FY 2014-15 Request 14

Issues:

- Forecast trends 20
- Health Information Technology (R5 & R9) 25
- Eligibility Process (R6) 29
- Provider Rates (R11) 35
- Affordable Care Act Implementation 41
- Long-term Services and Supports (R9) 49
- Breast and Cervical Cancer Prevention 52
- Transfer and Overexpenditure Authority 55

Appendices:

- A - Numbers Pages 62
- B - Recent Legislation Affecting Department Budget 92
- C - Update on Long Bill Footnotes & Requests for Information 96
- D - Indirect Cost Assessment Methodology 104

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

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

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

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

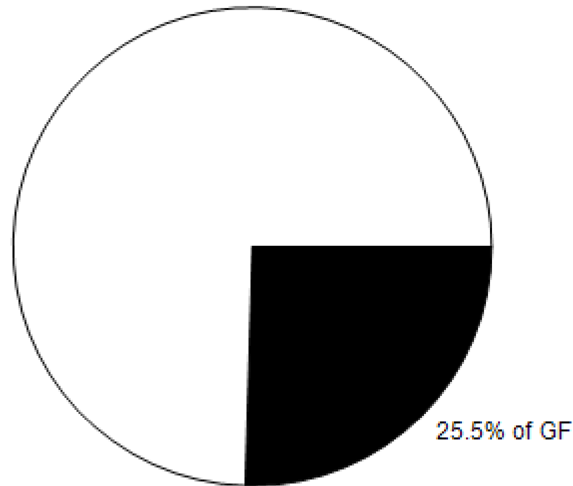
Department Budget: Recent Appropriations

Funding Source	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15 *
General Fund	$1,698,937,482	$1,847,607,793	$2,063,159,596	$2,208,767,959
Cash Funds	886,393,498	936,373,544	888,516,606	946,274,662
Reappropriated Funds	8,576,440	7,174,145	10,483,522	9,685,529
Federal Funds	2,589,886,684	2,804,373,050	3,575,483,329	4,383,420,616
Total Funds	**$5,183,794,104**	**$5,595,528,532**	**$6,537,643,053**	**$7,548,148,766**
Full Time Equiv. Staff	312.5	327.1	358.1	395.1

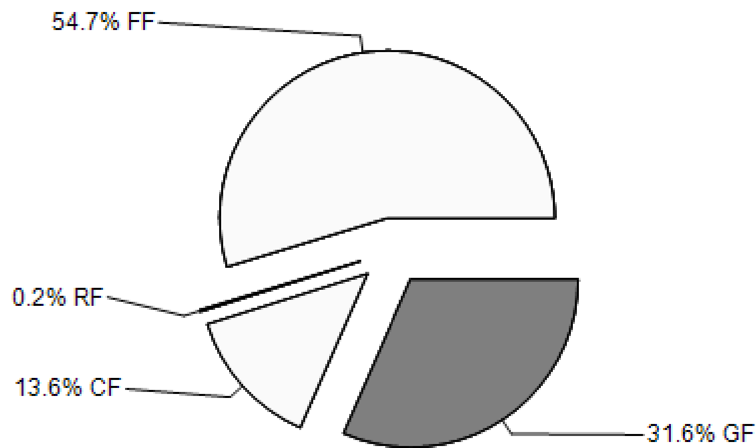
*Requested appropriation.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

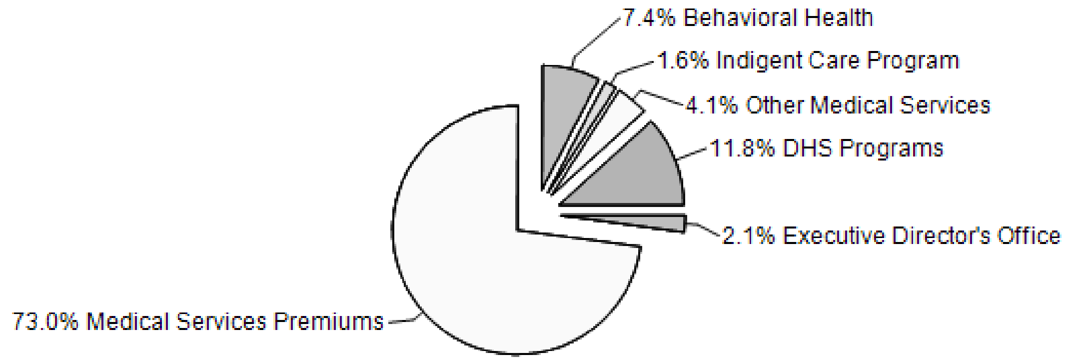


Department Funding Sources

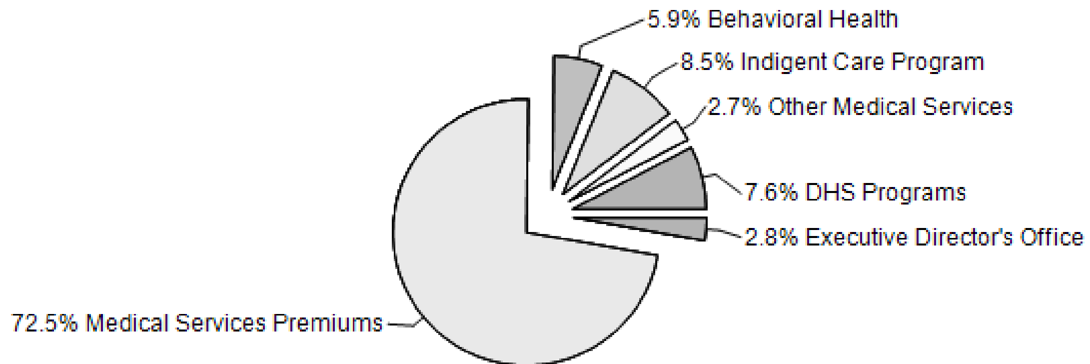


All charts are based on the FY 2013-14 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2013-14 appropriation.

General Factors Driving the Budget

Funding for this department in FY 2013-14 consists of 54.7 percent federal funds, 31.6 percent General Fund, 13.6 percent cash funds, and 0.2 percent reappropriated funds. The major 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; and (5) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

MEDICAID

Medicaid provides health insurance to people with low income and to 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. Administration and policy making responsibilities for the program are shared between the federal and state governments. For most claims and administrative costs the federal government pays Colorado 50.0 percent of the covered rate and state funds must provide the remaining 50.0 percent as a match, but there are exceptions where a specific type of service or a service to a specific eligibility category may receive an enhanced federal contribution.

Medi**caid** should not be confused with the similarly named Medi**care** that provides insurance for people who are elderly (or have a specific eligible diagnosis) regardless of income. Medicare is federally administered and financed with 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. Also, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term care and Medicare does not.

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, in Section 24-75-109 (1) (a), C.R.S., to overexpend the Medicaid appropriation.

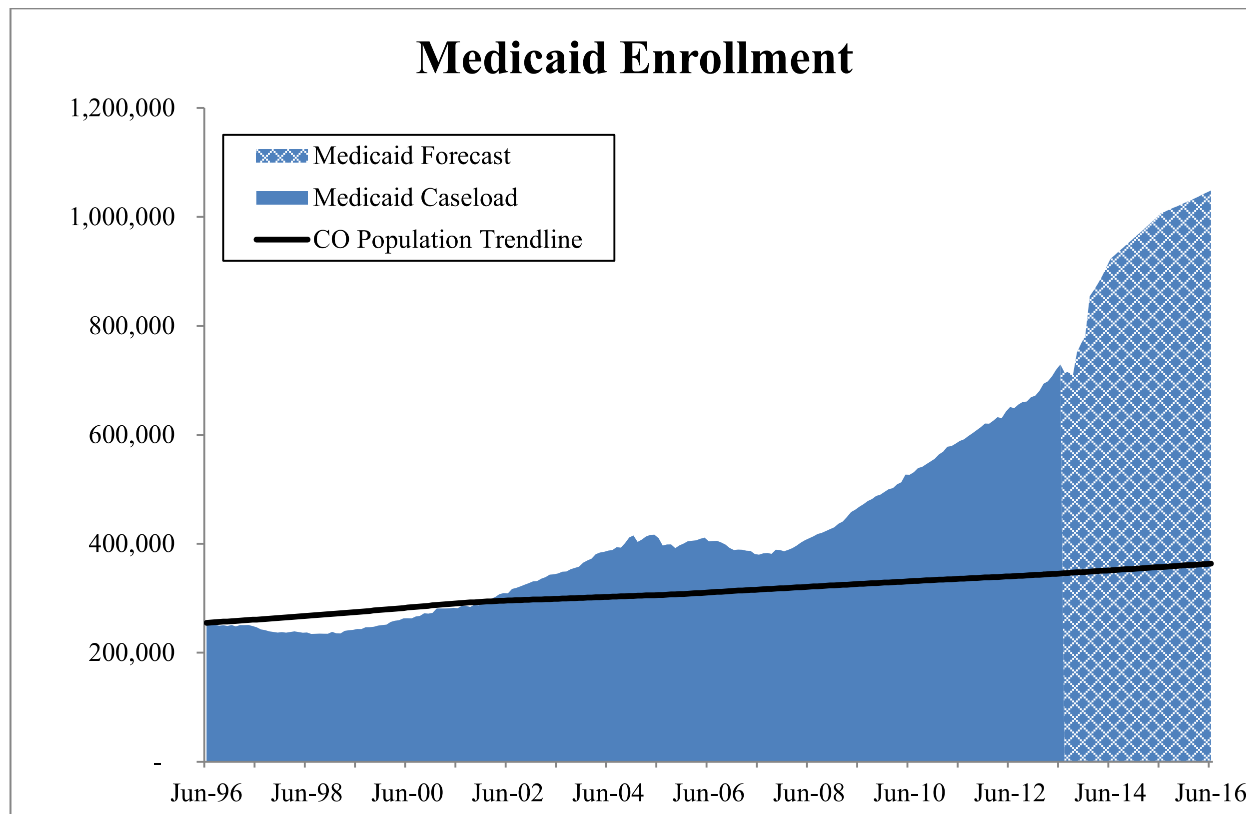
[1] The exception where participants would pay a premium is the voluntary "buy-in" program for people with disabilities whose income is below 400 percent of the federal poverty guidelines but above the standard Medicaid eligibility criteria.

Appropriations for Medicaid are divided into five main components, not including administration: (1) Medical Service Premiums; (2) Mental Health Community Programs; (3) the Office for Individuals with Intellectual and Developmental Disabilities; (4) the Indigent Care Program; and (5) programs administered by other departments. Each of these is discussed in more detail below.

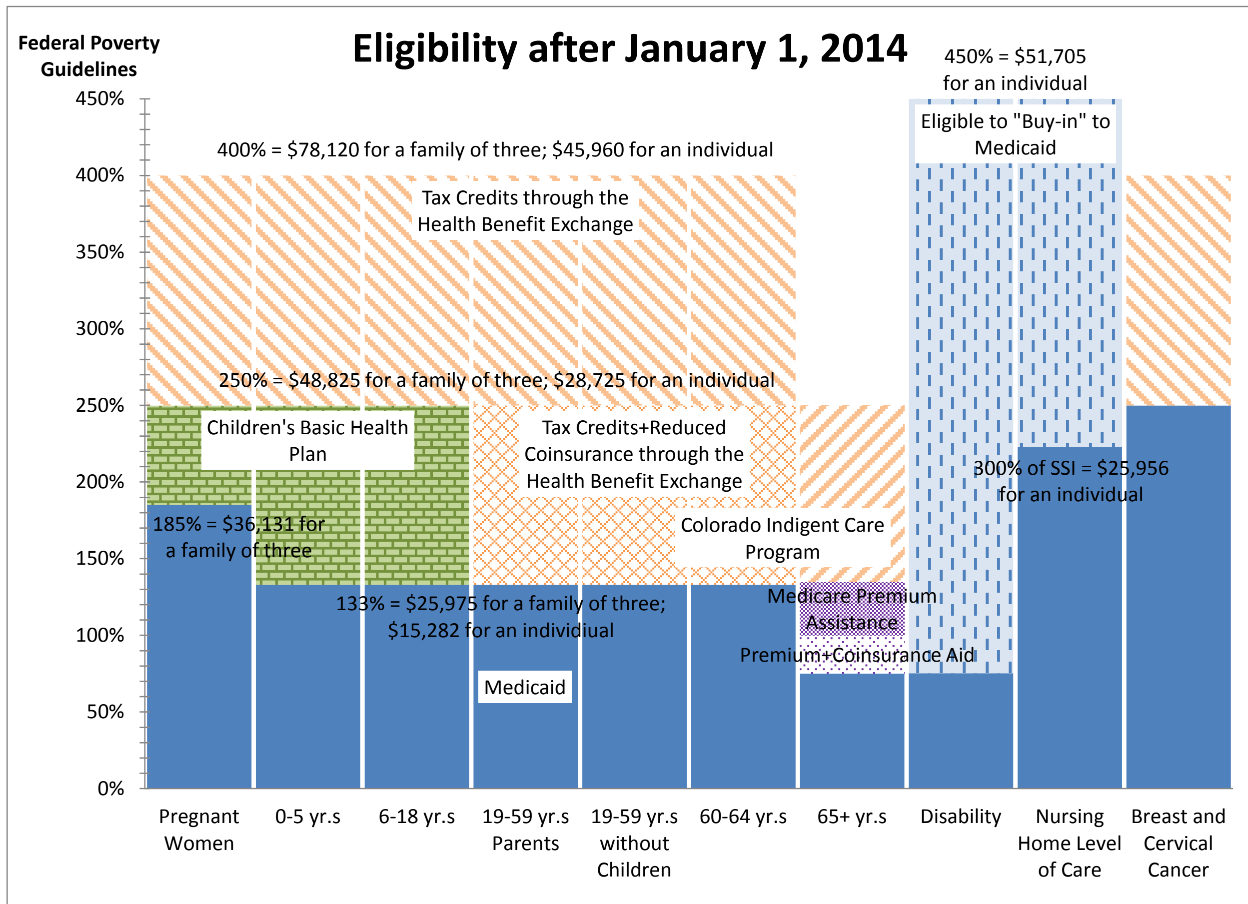
(1) Medical Service Premiums

Medical Service Premiums pay for physical health and long-term care services. Expenditures for Medical Service Premiums are driven by the number of clients, the amount of services each client uses, and the cost per unit of service.

Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. The chart below shows the actual and forecasted Colorado Medicaid population. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 1996.



The next table summarizes eligibility criteria for Medicaid and other state-financed health care programs as of January 1, 2014 when the expansion authorized by S.B. 13-200 takes effect[2].



[2] Note that eligibility for some of the programs is based on standards other than the federal poverty guidelines, such as eligibility for federal Supplemental Security Income (SSI), and these alternate standards have been converted to a percentage of the federal poverty guidelines for these charts. Also, note that the treatment of assets, the income of relatives, and other elements of the eligibility calculation can vary significantly between eligibility categories.

The 2013 Poverty Guidelines for the
48 Contiguous States and the District of Columbia

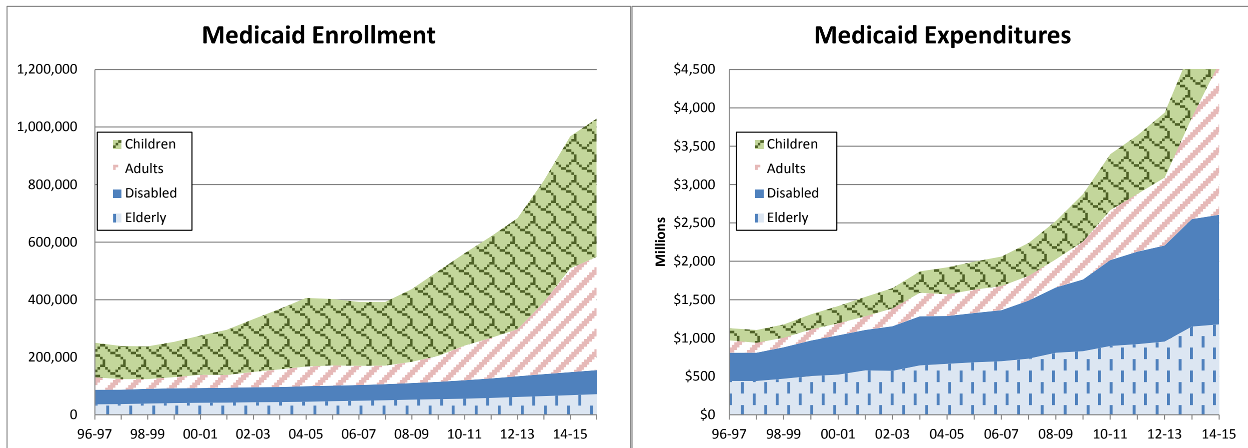
Family Size	Percent of poverty guideline									
	10%	**73%**	**75%**	**100%**	**133%**	**185%**	**226%**	**250%**	**400%**	**450%**
	AWDC	OAP	SSI		ACA	Pregnant	300% SSI	CHP+	Tax Credits	Buy-in
1	$1,149	$8,388	$8,652	$11,490	$15,282	$21,257	$25,956	$28,725	$45,960	$51,705
2	$1,551	$11,323	$11,679	15,510	$20,628	$28,694	$35,037	$38,775	$62,040	$69,795
3	$1,953	$14,257	$14,706	19,530	$25,975	$36,131	$44,118	$48,825	$78,120	$87,885
4	$2,355	$17,192	$17,733	23,550	$31,322	$43,568	$53,200	$58,875	$94,200	$105,975
5	$2,757	$20,127	$20,760	27,570	$36,668	$51,005	$62,281	$68,925	$110,280	$124,065
6	$3,159	$23,062	$23,787	31,590	$42,015	$58,442	$71,362	$78,975	$126,360	$142,155
7	$3,561	$25,996	$26,814	35,610	$47,361	$65,879	$80,443	$89,025	$142,440	$160,245
8	$3,963	$28,931	$29,841	39,630	$52,708	$73,316	$89,524	$99,075	$158,520	$178,335

Senate Bill 13-200 expanded Medicaid eligibility for adults as of January 2014 to 133.0 percent of the federal poverty limit (FPL). The newly eligible populations as a result of this change include adults without dependent children with income from 11 percent through 133 percent of the FPL and parents with income from 101 percent through 133 percent of the FPL. Pursuant to the provisions of the federal Affordable Care Act, Colorado is eligible for an enhanced federal match rate for certain populations as a result of the eligibility expansion authorized in S.B. 13-200. For Colorado the enhanced federal match rate applies to adults without dependent children with income from 0 percent through 133 percent of the FPL and to parents with income from 61 percent through 133 percent of the FPL. The enhanced federal match rate is 100 percent from 2014 through 2016 and then it reduces in increments until it reaches 90 percent in 2020. Senate Bill 13-200 authorizes the Hospital Provider Fee to pay the state share of costs for the newly eligible populations when the enhanced federal match rate is reduced. The table below summarizes the projected increases in enrollment associated with the bill.

Projected Enrollment Impact of S.B. 13-200 Medicaid Eligibility Expansions

	FY 13-14	**FY 14-15**	**FY 15-16**
Newly eligible as a direct result of the expansion			
Adults without dependent children 11% through 133% FPL	54,834	144,244	166,748
Parents 101% through 133% FPL	6,534	17,189	19,870
Emergency services	26	92	159
Subtotal	61,394	161,525	186,777
Newly eligible due to enhanced federal match freeing up Hospital Provider Fee money			
Continuous eligibility for children	4,286	17,460	17,722
Expected increase in participation from among eligible but not enrolled (EBNE)			
Medicaid	1,137	7,083	6,053
SUBTOTAL Medicaid enrollment	**66,817**	**186,068**	**220,552**
Enrollment in Other Medical Programs			
EBNE Children's Basic Health Plan	1,124	7,002	15,871
Old Age Pension State Medical Program (Medicaid eligible)	(495)	(1,464)	(1,406)
TOTAL enrollment impact	**67,446**	**191,606**	**235,017**

In addition to costs due to caseload growth, the Medicaid budget also fluctuates as a result of changes in medical costs and utilization of medical services. Per capita costs for the elderly and people with disabilities are much higher than for children and adults, and these costs have risen faster relative to the enrolled population than expenditures for children and adults.

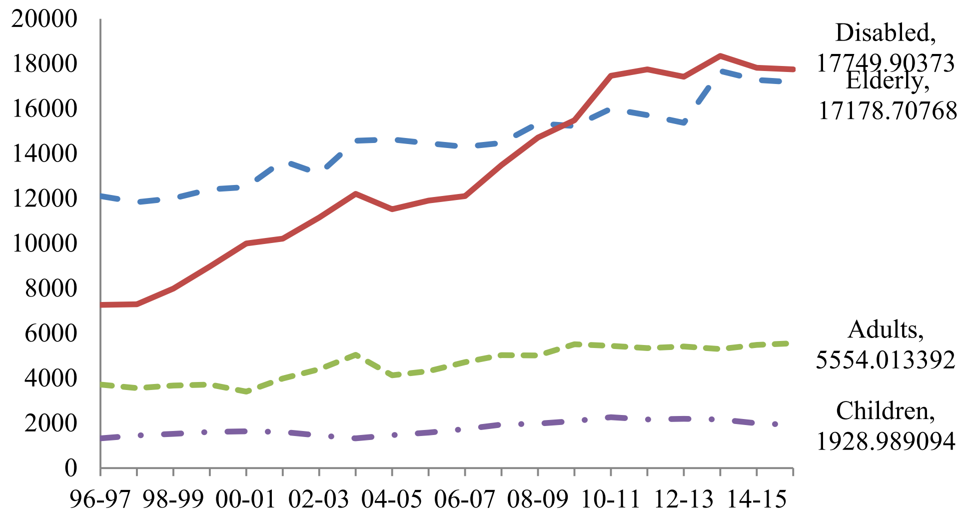


Per capita expenditures are influenced by case mix, utilization of services, and the price of those services. Most of the volatility in Medicaid enrollment is among adults and children impacted by economic conditions, but these populations are much less expensive to serve per capita than the disabled and elderly. The table below shows changes in the overall Medicaid per capita.

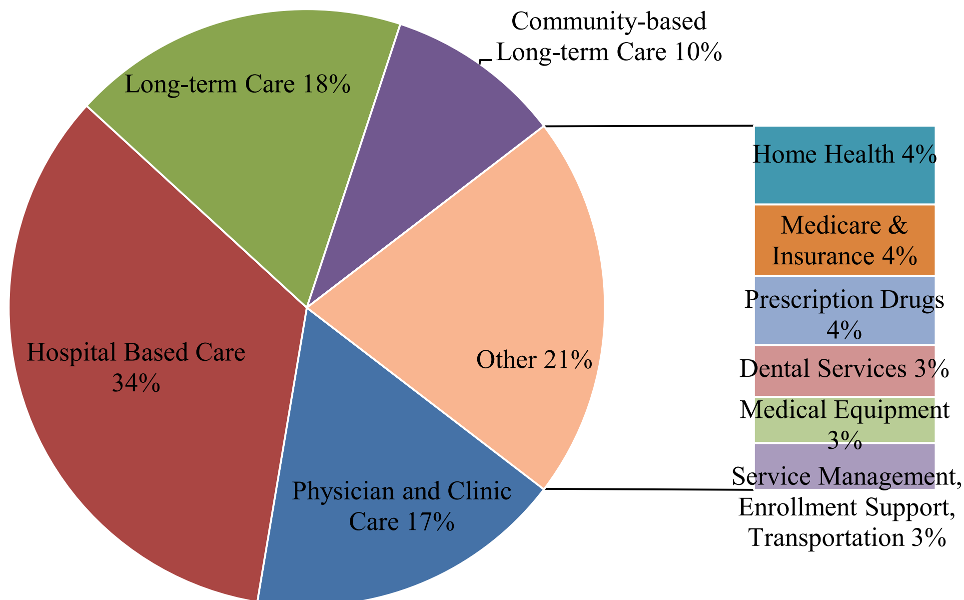
Medical Services Premiums Expenditures, Enrollment, and Per Capita Costs

	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Appropriation
Medical services	$2,508,537,655	$2,552,180,141	$2,769,295,897	$2,924,894,763	$3,178,088,304	$3,864,299,082
Supplemental payments/financing	18,453,787	395,864,563	556,099,288	717,137,999	767,891,188	872,525,795
Medical Services Premiums	2,526,991,443	2,948,044,704	3,325,395,185	3,642,032,762	3,945,979,492	4,736,824,877
Enrollment	391,962	436,812	498,797	560,722	677,509	809,452
Medical services cost per capita[/1]	$6,399.95	$5,842.74	$5,551.95	$5,216.30	$4,690.85	$4,773.97

The next chart shows trends in the per capita cost for subsets of the population. The per capita figures in this chart include both medical services and an estimated allocation of supplemental financing payments.



The chart below shows typical expenditures by service category for Medical Service Premiums. Approximately a third of expenditures are for the three categories of long term care, community-based long-term care, and home health services.



(2) Behavioral Health Community Programs

Medicaid behavioral health community services throughout Colorado are delivered through a managed care or "capitated" program. Under capitation, the State pays a regional entity -- a Behavioral Health Organization (BHO) -- a contracted amount (per member per month) for each Medicaid client eligible for behavioral health services in the entity's geographic area. The BHO is then required to provide appropriate behavioral health services to all Medicaid-eligible persons needing such services.

The rate paid to each BHO is based on each class of Medicaid client eligible for behavioral health services (e.g., children in foster care, low-income children, elderly, disabled) in each BHO's geographic region. Under the capitated mental health system, changes in rates, changes in overall Medicaid eligibility, and case-mix (mix of types of clients within the population) are important drivers in overall state appropriations for mental health services. Capitation represents the bulk of the funding for Medicaid mental health community programs. The following table provides information on the recent expenditures and caseload for Medicaid mental health capitation.

Medicaid Mental Health Capitation Funding						
	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Appropriation
Capitation Funding	$215,860,937	$226,620,818	$249,352,665	$273,376,614	$305,399,042	$380,837,424
Annual Dollar Change	$19,849,904	$10,759,881	$22,731,847	$24,023,949	$32,022,428	$75,438,382
Annual Dollar % Change	10.1%	5.0%	10.0%	9.6%	11.7%	24.7%
Caseload	417,750	479,185	540,456	598,322	653,663	783,425
Annual Caseload Change	43,631	61,435	61,271	57,866	55,341	129,762
Annual Caseload % Change	11.8%	14.7%	12.8%	10.7%	9.3%	19.9%

(3) Office of Community Living

Pursuant to H.B. 13-1314, in March of 2014 community programs for people with intellectual and developmental disabilities will be transferred from the Department of Human Services to this newly created division in the Department of Health Care Policy and Financing. The specific dollar amount transferred is dependent on the remaining funds when the transfer occurs.

(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. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from the Hospital Provider Fee, certifying public expenditures at hospitals, and a small General Fund appropriation.

(5) Programs administered by other departments

The Department transfers Medicaid money to other departments for long-term care services to people with disabilities, for mental health services provided to people in youth corrections, child welfare, and the mental health institutes, for Medicaid's share of the Colorado Benefits Management System, and for the regulation of long-term care settings. The money is first appropriated to the Department and then transferred to the administering departments to comply with federal regulations that one state agency receive 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, but the table below provides the magnitude of the transfers.

Major Programs Administered by Other Departments					
Program	**Department**	**FY 2010-11 Actual**	**FY 2011-12 Actual**	**FY 2012-13 Approp.**	**FY 2013-14 Approp.**
Services for People with Disabilities[/1]	Human Services	$390,563,801	$377,031,150	$394,797,049	$426,160,074
Information Technology, Maintenance, and Administration	Human Services	27,115,136	27,092,121	48,833,821	45,172,314
Child Welfare	Human Services	12,308,914	11,066,417	14,426,342	14,712,207
Office of Early Childhood	Human Services	0	0	0	4,582,485
Mental Health Institutes	Human Services	6,298,534	6,370,737	7,280,521	6,712,261
Youth Corrections	Human Services	2,597,008	1,501,271	1,399,146	1,365,389
Regulation of long-term care facilities	Public Health and Environment[/2]	4,707,033	4,671,998	5,205,465	5,297,765
	TOTAL	**$443,590,426**	**$427,733,694**	**$471,942,344**	**$504,002,495**

[/1] Portions of this program transfer to the Office of Community Living in the Department of Health Care Policy and Financing in March of 2014 pursuant to H.B. 13-1314.
[/2] A portion of this is then sent to the Department of Public Safety.

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated throughout this document 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 allows. Annual membership premiums are variable based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines, and coinsurance costs are similarly nominal. Federal funds pay 65.0 percent of the program costs not covered by member contributions and state funds pay the remaining 35.0 percent as a match. CHP+ typically receives approximately $28 million in revenue from the tobacco master settlement agreement and the 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 that have impacted enrollment.

Children's Basic Health Plan						
	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Appropriation
Expenditures						
Children Medical	$100,411,914	$152,027,675	$142,367,277	$147,398,355	$165,979,136	$163,939,568
Children Dental	9,876,521	10,889,516	10,807,933	12,586,244	14,831,602	13,452,232
Prenatal	19,437,576	17,543,561	25,580,142	24,488,529	20,124,869	18,890,477
TOTAL	$129,726,011	$180,460,751	$178,755,352	$184,473,128	$200,935,608	$196,282,277
Enrollment/1						
Children	61,582	68,725	67,267	74,266	83,316	73,773
Prenatal	1,665	1,560	1,741	2,064	1,812	1,398
TOTAL	63,247	70,285	69,008	76,330	85,128	75,171
Per Capita						
Children Medical	$1,630.54	$2,212.12	$2,116.45	$1,984.74	$1,992.16	$2,222.22
Children Dental	$160.38	$158.45	$160.67	$169.48	$178.02	$182.35
Prenatal	$11,674.22	$11,245.87	$14,692.79	$11,864.60	$11,109.51	$13,517.34

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION

The federal Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This payment is sometimes referred to as the "clawback." To offset the General Fund costs in recent years Colorado has applied bonus payments received from the federal government for meeting performance goals in CHP+ toward this obligation. The table below summarizes Colorado's payments.

Medicare Modernization Act	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY 12-13 Appropriation	FY 13-14 Appropriation
State Contribution	$57,624,126	$72,377,768	$93,582,494	$101,888,629	$107,173,869
General Fund	57,624,126	58,711,725	62,939,212	52,207,622	82,492,862
Federal Funds	0	13,666,043	30,643,282	49,681,007	24,681,007
State Contribution change		$14,753,642	$21,204,726	$8,306,135	$5,285,240
Percent		25.6%	29.3%	8.9%	5.2%
General Fund change		$1,087,599	$4,227,487	($10,731,590)	$30,285,240
Percent		1.9%	7.2%	(17.1%)	58.0%

Summary: FY 2013-14 Appropriation & FY 2014-15 Request

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$6,195,287,695	$2,071,307,480	$1,029,835,723	$8,483,522	$3,085,660,970	$338
SB 13-200 Expand Medicaid eligibility	315,141,256	(123,209)	(154,578,421)	0	469,842,886	19.0
SB 13-242 Adult dental benefit	33,858,405	(738,262)	11,244,171	0	23,352,496	1.3
Other legislation	(6,644,303)	(7,286,413)	2,015,133	2,000,000	(3,373,023)	(0.1)
TOTAL	**$6,537,643,053**	**$2,063,159,596**	**$888,516,606**	**$10,483,522**	**$3,575,483,329**	**358.1**
FY 2014-15 Requested Appropriation						
FY 2013-14 Appropriation	$6,537,643,053	2,063,159,596	$888,516,606	$10,483,522	$3,575,483,329	358.1
R1 Medical service premiums	180,948,596	64,326,142	(60,431,827)	0	177,054,281	0.0
R2 Behavioral health programs	26,923,840	9,087,725	(9,039,333)	0	26,875,448	0.0
R3 Children's Basic Health Plan	(38,043,495)	(9,406,469)	(3,709,744)	0	(24,927,282)	0.0
R4 Medicare drug repayment	(6,366,816)	13,951,390	0	0	(20,318,206)	0.0
R5 Medicaid health info exchange	5,748,926	1,054,893	0	0	4,694,033	0.0
R6 Eligibility determination enhanced match	15,677,849	0	0	0	15,677,849	0.0
R7 IDD Supported living services	15,472,452	7,736,227	0	0	7,736,225	0.0
R8 IDD Increase funded FPE	2,845,976	1,422,989	0	0	1,422,987	0.0
R9 Medicaid community living initiative	1,243,201	846,787	0	0	396,414	0.0
R10 Primary care specialty collaboration	537,497	224,061	3,479	0	309,957	0.0
R11 1.5% Provider rate increase	56,841,628	20,079,070	968,533	0	35,794,025	0.0
R12 Admin contract reprocurements	4,296,941	1,148,457	976,968	0	2,171,516	0.0
R13 Utilization-review services	1,691,977	838,378	0	0	853,599	0.0
R14 Family Support restoration	3,406,321	3,406,321	0	0	0	0.0
R15 Long-term services and supports - complex medical conditions	125,000	62,500	0	0	62,500	0.0
R16 IDD Operating/membership funds	172,002	86,001	0	0	86,001	0.0
R17 Computer and software renewal	322,982	161,491	0	0	161,491	0.0
Annualize SB 13-200 Expand Medicaid eligibility	618,864,754	4,576,671	87,203,584	0	527,084,499	0.0
Annualize SB 13-242 Adult dental benefit	52,814,354	(824,906)	11,591,991	0	42,047,269	0.7
Annualize HB 13-1314 IDD transfer	47,086,941	16,527,153	30,802,356	0	(242,568)	34.5
Annualize substance use disorder benefit	4,124,430	898,349	54,808	0	3,171,273	0.0
Annualize prior year budget decisions	7,871,894	1,312,207	(648,683)	(936,892)	8,145,262	1.8
Human Services programs	5,884,178	7,356,361	(48,774)	0	(1,423,409)	0.0
Centrally appropriated line items	1,863,057	777,566	33,413	146,548	905,530	0.0

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Statewide IT common policy adjustments	145,389	72,685	0	6	72,698	0.0
Technical adjustments	5,839	2,920	(1)	0	2,920	0.0
Indirect cost assessment	0	(116,606)	1,286	(7,655)	122,975	0.0
TOTAL	**$7,548,148,766**	**$2,208,767,959**	**$946,274,662**	**$9,685,529**	**$4,383,420,616**	**395.1**
Increase/(Decrease)	$1,010,505,713	$145,608,363	$57,758,056	($797,993)	$807,937,287	37.0
Percentage Change	15.5%	7.1%	6.5%	(7.6%)	22.6%	10.3%

DESCRIPTION OF REQUESTED CHANGES

R1 Medical service premiums: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing.

R2 Behavioral health programs: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing. *See the briefing on Behavioral Health Community Programs for more information.*

R3 Children's Basic Health Plan: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing.

R4 Medicare drug repayment: The Department requests an increase for the projected state obligation pursuant to the Medicare Modernization Act to pay the federal government in lieu of covering prescription drugs for people dually eligible for Medicaid and Medicare.

R5 Medicaid health info exchange: The Department requests funding to increase connections to Colorado's Health Information Exchange network that allows the sharing of health data between providers using different electronic health record systems. A portion of the funding would be used to help providers adopt electronic health record systems and get them connected to the exchange. The majority of the funds would pay for infrastructure upgrades to increase the data capacity of the health information exchange and to design interfaces for the health information exchange to connect with additional electronic health record systems.

R6 Eligibility determination enhanced match: The Department proposes reinvesting the General Fund saved as a result of lower state matching requirements for eligibility determination services in the following: (1) competitive grants for counties to improve their eligibility determination infrastructure; (2) incentive payments for county eligibility determination offices that meet timely processing and other performance goals; (3) payments for Medical Assistance sites that provide eligibility determination services on location; (4) consulting services to review statewide eligibility determination payment methods; and (5) temporary backup eligibility services to assist with the potential overflow from the implementation of the Medicaid expansion

and the Affordable Care Act. The net result would be no change in General Fund expenditures and an increase in federal matching funds.

R7 IDD Supported living services: The Department requests an additional $15.5 million total funds, of which $7.7 million is General Fund to increase community capacity to serve individuals with intellectual and developmental disabilities by:

- Adding funding to enable approximately 1,526 individuals waiting for services through the supported living services waiver;
- Increasing the maximum annual expenditure for individuals receiving services through the supported living services waiver by 20.0 percent for levels one through six;
- Increasing the maximum services funding limit for support living services from $35,000 to $45,000; and
- Providing additional funding for Medicaid State Plan services that will be accessed by individuals served through the new SLS funding; and to the Medicaid State Plan and Behavioral Health Community Programs for additional Medicaid behavioral health services.

See the briefing on the Office of Community Living for more information.

R8 IDD Increase funded FPE: The Department requests an additional $15,472,452 total funds, of which $7,736,227 is General Fund to increase the number of funded FPE for 61 adult supported living and 125 comprehensive services. *See the briefing on the Office of Community Living for more information.*

R9 Medicaid community living initiative: The Department's request would fund: (1) counseling regarding community-based living options; (2) housing assistance payments; and (3) improved oversight of the home modifications benefit. The Department anticipates making 75 housing assistance payments available the first year and increasing that amount by 75 each year until a total of 225 are available each year. The housing assistance payments are not eligible for Medicaid and would be funded with 100 percent General Fund. The improved oversight of the home modifications benefit would be performed by 2.0 FTE added in the Department of Local Affairs.

R10 Primary care specialty collaboration: The Department proposes funding assistance for primary care providers and specialists to acquire and utilize technology that allows remote specialty care consultation. The Department argues that such technology would improve access to specialty care, particularly in rural areas, and thereby improve patient outcomes. It would also reduce travel time and costs. The request is modeled on Doc2Doc technology used in Oklahoma, but the actual technology solution would be based on the bid process.

R11 1.5% Provider rate increase: The Department requests an increase for provider rates equal to 1.5 percent of eligible base rates. All eligible providers would receive a 1.0 percent increase and the remaining funds would be targeted for select services to, "promote utilization of high quality, cost effective procedures." The Department would award the targeted rate

increases with feedback from an internal working group and, "actively seek stakeholder feedback throughout the process."

R12 Admin contract reprocurements: The Department is scheduled to reprocure three administrative service contracts in FY 2014-15 and proposes funding to allow for overlap between the expiring contracts and the new contracts to ensure smooth transitions. In addition, the Department requests short-term contract services to oversee the transitions. The contracts are for determining eligibility and enrollment for medical assistance programs, for enrollment broker services, and for consumer-directed attendant support services.

R13 Utilization-review services: The Department requests additional funding for utilization reviews that determine whether services are covered by Medicaid. The process involves evaluating the appropriateness, medical need, and efficiency of health care services. The Department specifically needs additional funding for utilization reviews of long-term services and supports and of prescription drugs.

R14 Family Support restoration: The Department requests $3,406,321 General Fund for the Family Support Services Program to increase the Program's so that it is equal to the FY 2009-10 funding level. The request reflects an increase of 104.6 percent over the FY 2013-14 appropriation of $3,255,842 General Fund. *See the briefing on the Office of Community Living for more information.*

R15 Long-term services and supports - complex medical conditions: The Department requests funding for consulting services to study the Hospital Backup Program (HBU). The HBU serves ventilator-dependent and medically complex clients who need to be discharged from a hospital but require more intensive skilled nursing care than typically available in other settings. The Department believes that updating and redesigning the program could result in better health outcomes and lower costs. The Department would like to develop payment incentives to move patients to lower acuity settings, improve communication and care coordination between hospitals and HBU providers, and possibly expand services to fill gaps where medically complex clients currently have no lower-cost alternatives than hospitalization. Because the medical needs of the clients are so complex, the Department argues that it needs to hire consultants with clinical expertise beyond the in-house capacity of the Department to properly evaluate the program and propose improvements.

R16 IDD Operating/membership funds: The Department requests additional operating funds for the Division of Developmental Disabilities transferred from the Department of Human Services. *See the briefing on the Office of Community Living for more information.*

R17 Computer and software renewal: The Department requests on-going funding to replace the Department's desktops on a 5-year rotating schedule and renew core software licenses annually.

Annualize SB 13-200 Expand Medicaid eligibility: These are the annualization costs assumed in the fiscal note for S.B. 13-200. The General Fund and cash fund costs include some

administrative expenses, but are primarily for projected increases in enrollment from people who prior to S.B. 13-200 were eligible but not enrolled (EBNE).

Annualize SB 13-242 Adult dental benefit: These are the annualization costs assumed in the fiscal note for S.B. 13-242.

Annualize HB 13-1314 IDD transfer: These are the annualization costs assumed in the fiscal note for H.B. 13-1314. The General Fund is money being transferred from the Department of Human Services and not a net increase statewide.

Annualize substance use disorder benefit: These are the annualization costs assumed in the Long Bill when the new substance use disorder benefit was approved last year.

Anualize prior year budget decisions: In addition to the annualizations broken out above, the Department's request includes annualizations of the following prior year budget decisions:

Annualize Other Prior Year Budget Decisions

	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 13-14 R5 MMIS Reprocurement	$17,553,173	$1,570,898	$319,424	$0	$15,662,851	0.0
Annualize IDD FPE in Office of Community Living	13,127,753	6,563,877	0	0	6,563,876	0.0
FY 13-14 R13 Provider rate increase	6,998,328	3,362,508	63,038	0	3,572,782	0.0
SB 13-079 Rule review	307,832	61,909	45,832	0	200,091	0.0
FY 13-14 BA14 Colorado Choice Transitions	256,413	128,207	0	0	128,206	0.0
FY 13-14 R6 Additional FTE to restore functionality	83,015	41,507	0	0	41,508	1.6
HB 09-1293 Health Care Affordability Act	55,278	0	13,820	0	41,458	0.0
FY 13-14 R10 Leased space rent increase and true-up	28,079	12,597	1,443	0	14,039	0.0
SB 13-167 ICF/IID Name change and provider fee	5,366	0	2,683	0	2,683	0.1
FY 13-14 State plan amend. Denver Health nursing	4,259	2,129	0	0	2,130	0.1
SB 13-276 Disability investigational pilot	1,743	0	0	0	1,743	0.0
HB 08-1373 Breast Cervical Cancer Prevention	(6,911,001)	(622,778)	(859,181)	(936,892)	(4,492,150)	0.0
FY 12-13 BA6 MMIS Operating rules compliance	(1,828,854)	(242,460)	(40,060)	0	(1,546,334)	0.0
FY 13-14 R12 Customer service technology	(1,620,000)	(810,000)	0	0	(810,000)	0.0
FY 12-13 BA8 MMIS Technical adjustments	(1,442,637)	(91,768)	(56,722)	0	(1,294,147)	0.0
FY 13-14 R9 Dental ASO	(1,152,144)	(288,036)	0	0	(864,108)	0.0
HB 13-1152 Nursing facility per diem rates	(1,109,836)	(554,918)	0	0	(554,918)	0.0
FY 10-11 BA15 MMIS Adjustments	(682,286)	(71,976)	0	0	(610,310)	0.0
FY 07-08 S5 Payment error rate measurement	(588,501)	(147,125)	(102,988)	0	(338,388)	0.0
FY 13-14 R11 HB 12-1281 Departmental differences	(101,505)	(50,753)	0	0	(50,752)	0.0
SB 13-166 Extend medical clean claims standards	(100,000)	(100,000)	0	0	0	0.0
HB 12-1281 Medicaid payment reform pilot	(62,000)	0	(31,000)	0	(31,000)	0.0
FY 12-13 BA6 MMIS Technical adjustments	(47,360)	0	(4,972)	0	(42,388)	0.0
FY 13-14 NP6 OIT Enterprise asset management	(4,835)	(2,417)	0	0	(2,418)	0.0
TOTAL	$22,770,280	$8,761,401	($648,683)	($936,892)	$15,594,454	1.8

The request assumes elimination of funding for H.B. 08-1373 that authorized the Breast and Cervical Cancer Prevention program, as the authority expires in FY 2014-15. *See the issue brief on the "Breast and Cervical Cancer Prevention" for more detail.*

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. The largest of these adjustments are for Services for People with Developmental Disabilities. *See the briefings for the Department of Human Services for more information.*

Centrally appropriated line items: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; merit pay; salary survey; short-term disability; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; vehicle lease payments; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; and Capitol complex leased space.

Statewide IT common policy adjustments: The request includes adjustments to line items appropriated for: purchase of services from the computer center; Colorado state network; management and administration of the Governor's Office of Information Technology (OIT); communication services payments, information technology security, and COFRS modernization.

Technical adjustments: The request includes other minor technical adjustments**.**

Indirect cost assessment: The request includes a net increase in the Department's indirect cost assessment that is used to offset General Fund in the Executive Director's Office.

PROPOSED LEGISLATION

Transfers and overexpenditures: In letters accompanying the request the Governor asked for an extension of the expiring authority for certain transfers and overexpenditures related to Medicaid and other programs. *See the issue brief "Transfer and Overexpenditure Authority" for more detail.*

Issue: Forecast trends

This issue brief provides a brief overview of forecast trends in expenditures for Medicaid, the Children's Basic Health Plan, and the Medicare Modernization Act State Contribution Payment.

SUMMARY:

- For Medical Service Premiums the Department projects an increase in General Fund expenditures of $64.3 million, with $17.6 million occurring in FY 2013-14 and another $46.7 million occurring in FY 2014-15.
- For the Children's Basic Health Plan the Department a decrease in General Fund expenditures of $9.4 million, with $3.3 million of the savings occurring in FY 2013-14 and $6.1 million occurring in FY 2014-15.
- For the Medicare Modernization Act State Contribution the Department projects total expenditures will decrease, but the General Fund obligation will increase due to the expiration of available federal bonus payments that are currently offsetting the need for General Fund.

DISCUSSION:

Medical Service Premiums

The Department's R1 provides the forecast of expenditures for Medical Service Premiums. The Request is expressed in terms of the change from the FY 2013-14 appropriation, but a portion of the increase will actually occur in FY 2013-14, for which the Department will submit a supplemental request in January. The table below shows the portion of R1 attributable to reforecasting FY 2013-14 and the portion attributable to FY 2014-15.

Medical Service Premiums Forecast by Fiscal Year

	Total	General Fund	Cash Funds	Reappropriated	Federal Funds
FY 13-14 Appropriation	4,736,824,877	1,505,860,050	593,882,063	2,936,892	2,634,145,872
FY 13-14 Revised projection	4,789,232,821	1,523,440,483	655,324,802	2,936,892	2,607,530,644
Difference	**52,407,944**	**17,580,433**	**61,442,739**	**0**	**(26,615,228)**
Percent	1.1%	1.2%	10.3%	0.0%	-1.0%
FY 13-14 Revised projection	4,789,232,821	1,523,440,483	655,324,802	2,936,892	2,607,530,644
Annualize SB 13-200 Expand Medicaid eligibility	537,548,305	154,457	78,735,072	0	458,658,776
Annualize SB 13-242 Adult dental benefit	53,348,482	(824,906)	11,720,172	0	42,453,216
Annualize substance use disorder benefit	(1,485,982)	(964,960)	(34,165)	0	(486,857)
Annualize prior year budget decisions	(2,402,886)	1,439,762	(761,789)	(936,892)	(2,143,967)
FY 14-15 Base	5,376,240,740	1,523,244,836	744,984,092	2,000,000	3,106,011,812
FY 14-15 Projection	5,504,781,392	1,569,990,545	623,109,526	2,000,000	3,309,681,321
Difference	**128,540,652**	**46,745,709**	**(121,874,566)**	**0**	**203,669,509**
Percent	2.4%	3.1%	-16.4%	0.0%	6.6%
FY 13-14 Difference	52,407,944	17,580,433	61,442,739	0	(26,615,228)
FY 14-15 Difference	128,540,652	46,745,709	(121,874,566)	0	203,669,509
R1 Medical Service Premiums	**180,948,596**	**64,326,142**	**(60,431,827)**	**0**	**177,054,281**

FY 2013-14

Some significant factors contributing to the change in the FY 2013-14 forecast of *General Fund* expenditures include:

- Per capita rates for children – For several years the Department experienced a negative trend in per capita expenditures for children and that trend was continued into the initial forecast for FY 2013-14, but actual FY 2012-13 per capita expenditures for children were slightly positive compared to the prior year, and so the revised FY 2013-14 forecast assumes per capita rates for children will be relatively neutral. Generally, new enrollees have lower per capita expenditures, but the longer people are on Medicaid the more their per capita expenditures look like the general population.
- S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid – These bills increased the Medicaid income eligibility threshold for children from 100 percent to 133 percent of the federal poverty level (FPL) and for pregnant women from 133 percent to 185 percent FPL. The primary impact was to move children and women from CHP+ to Medicaid. The Department assumed the transition would occur gradually over the course of a year, but actual transitions are occurring at a more rapid pace.
- Primary care reimbursement rates – The ACA requires states to increase primary care physician reimbursement rates to 100 percent of Medicare rates for calendar years 2013 through 2014. The cost of increasing primary care physician rates to the rates in effect January 1, 2009 must be paid with a state fund match, but the increase beyond the rates in effect on January 1, 2009 is paid for entirely with federal funds. The initial estimate of the cost of the rate increase was made before final federal guidance regarding the eligible providers and services was issued. Actual billings for eligible service codes are much higher than expected.
- Per capita rates for Elderly, Blind, and Disabled waiver – Per capita expenditures for long-term services and supports provided to people on the Elderly, Blind, and Disabled waiver are trending higher than originally forecast, due to heavier utilization of high cost services.
- Accountable Care Collaborative (ACC) expansion – A more rapid increase in enrollment than expected requires increases in service management payments. At the same time, increased savings from the ACC are offsetting costs due to higher enrollment.
- Children, low-income parents, and people with disabilities – Enrollment among these populations is trending higher than expected, but the costs are being offset by increased savings from the ACC.
- Decrease in Tobacco Tax Revenue – A portion of the revenue from the tobacco tax is deposited in the Health Care Expansion Fund and used to offset the need for General Fund for expansion populations. A decrease in tobacco tax revenue requires an offsetting increase in General Fund.
- Long-term care enrollment – The increases noted above are partially offset by decreases in the forecasted nursing bed days, enrollment in Programs for All-inclusive Care for the Elderly, and enrollment in similar long-term care services.

FY 2014-15

For FY 2014-15 many of the same factors are contributing to the forecasted increase.

Acute Care - $13.6 million General Fund

- Children, low-income parents, and people with disabilities – The primary factor driving the projected increase in General Fund acute care expenses is enrollment growth. The Department is projecting 9.0 percent enrollment growth among children, 7.3 percent growth among the lowest income parents (AFDC-A), and 3.8 percent among people with disabilities. While the enrollment growth for people with disabilities is smaller than the other two categories, the impact on the General Fund is disproportionate because of the high per capita costs for this population.
- Accountable Care Collaborative (ACC) expansion – Continued expansion of the Accountable Care Collaborative will somewhat offset increased acute care costs due to higher enrollment. The Department is projecting an additional $22.5 million in savings from the Accountable Care Collaborative in FY 2014-15__.
- Breast and Cervical Cancer Prevention Program – The statutory authority for this program expires July 1, 2014, and so the Department's request reflects a General Fund cost savings of $609,282.
- Affordable Care Act preventive services – Pursuant to the Affordable Care Act, states that cover recommended adult vaccines and preventive services with an A or B rating by the United States Preventive Services Task Force are eligible for an additional 1.0 percent federal match on these preventive services. These are required services for ACA expansion populations, but optional for existing populations. By adding just a few relatively low cost services to the standard benefit package the Department was able to meet the threshold for drawing the additional federal funds. This also allowed the Department to offer one standard Medicaid package, rather than having a separate Medicaid package for just the ACA expansion populations. The new services previously not covered include: depression screening for adults, aspirin for the prevention of cardiovascular disease, counseling about screening for breast cancer susceptibility (BRCA), BRCA testing, counseling interventions about tobacco use for non-pregnant adults, and shingles vaccines. The total cost of adding the new services to the benefit package was estimated at $1.3 million, but by adding the services the Department was able to reduce the state match by one percent on a projected $60 million in preventive care. The net impact on the General Fund is near neutral, but because of the change in the benefit package it is noted here.
- S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid – These bills increased the Medicaid income eligibility threshold for children from 100 percent to 133 percent of the federal poverty level (FPL) and for pregnant women from 133 percent to 185 percent FPL. The primary impact was to move children and women from CHP+ to Medicaid.

Community based long-term care - $15.9 million General Fund

The increase in this area is a function of enrollment and very high per capita costs. The statewide average per capita cost for community based waiver programs is projected to be $13,595. The Department also noted higher expenditures per utilizer for the Consumer Directed Attendant Support Services (CDASS).

Long-term care and insurance - $21.7 million

- Nursing – The Department is projecting no growth in nursing bed days, but higher per capita costs due to statutory rate increases.
- Program for All-inclusive Care for the Elderly (PACE) – The Department is projecting continued fast enrollment growth of 12.3 percent in FY 2014-15. In addition, PACE provider rates are projected to increase moderately to comply with federal regulations for actuarial soundness.
- Insurance – The cost of paying Medicare premiums and co-insurance for people dually eligible for Medicaid and Medicare is expected to increase largely due to inflation in Medicare rates. The Department's request also includes a projected increase in expenditures for private insurance, which the Department purchases for clients through the Health Insurance Buy-in when it is cost effective to do so.

Service management – $3.9 million General Fund

The Department forecasts an increase in contracts with single entry point agencies that provide services for people needing long-term care based on increased utilization of community based long-term care services.

Children's Basic Health Plan (CHP+)

The Department's R3 provides the forecast of expenditures for the Children's Basic Health Plan (CHP+). The table below summarizes the portions of the request attributable to FY 2013-14 and FY 2014-15.

Children's Basic Health Plan (CHP+) Forecast by Fiscal Year	Total	General Fund	Cash Funds	Federal Funds
FY 13-14 Appropriation	196,282,277	23,264,070	46,413,329	126,604,878
FY 13-14 Revised projection	178,896,554	19,954,649	43,844,144	115,097,761
Difference	**(17,385,723)**	**(3,309,421)**	**(2,569,185)**	**(11,507,117)**
Percent	-8.9%	-14.2%	-5.5%	-9.1%
FY 13-14 Revised projection	178,896,554	19,954,649	43,844,144	115,097,761
Annualize SB 13-200 Expand Medicaid eligibility	10,868,376	3,761,947	119,957	6,986,472
Annualize prior year budget decisions	307,832	61,909	45,832	200,091
FY 14-15 Base	190,072,762	23,778,505	44,009,933	122,284,324
FY 14-15 Projection	169,414,989	17,681,456	42,869,374	108,864,159
Difference	**(20,657,773)**	**(6,097,049)**	**(1,140,559)**	**(13,420,165)**
Percent	-10.9%	-25.6%	-2.6%	-11.0%
FY 13-14 Difference	(17,385,723)	(3,309,421)	(2,569,185)	(11,507,117)
FY 14-15 Difference	(20,657,773)	(6,097,049)	(1,140,559)	(13,420,165)
R3 Children's Basic Health Plan	**(38,043,496)**	**(9,406,470)**	**(3,709,744)**	**(24,927,282)**

The projected decrease in CHP+ expenditures is due to declines in caseload. The Department is forecasting a very modest increase in per capita rates FY 2014-15. CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit because to be eligible for CHP+ a person cannot be eligible for Medicaid. Actual enrollment in

FY 2011-12 and through the first part of FY 2012-13 has been lower than originally forecast by the Department. In addition, as mentioned under Medical Service Premiums, the movement of children and pregnant women from CHP+ to Medicaid as a result of S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid has happened more quickly than the Department expected. Another factor contributing to the projected decline in CHP+ enrollment is new ACA-mandated rules for calculating Medicaid eligibility using Modified Adjusted Gross Income (MAGI). The Department believes that changes in the way the MAGI defines households will cause some clients to move from CHP+ to Medicaid.

Medicare Modernization Act State Contribution Payment

The Department's R4 provides the forecast of the state's obligation under the Medicare Modernization Act for pharmacy expenses that were shifted from Medicaid to Medicare.

Medicare Modernization Act Forecast by Fiscal Year			
	Total	**General Fund**	**Federal Funds**
FY 13-14 Appropriation	107,173,869	82,492,862	24,681,007
FY 13-14 Revised projection	102,256,317	65,687,505	36,568,812
Difference	**(4,917,552)**	**(16,805,357)**	**11,887,805**
Percent	-4.6%	-20.4%	48.2%
FY 14-15 Base	102,256,317	65,687,505	36,568,812
FY 14-15 Projection	100,807,053	96,444,252	4,362,801
Difference	**(1,449,264)**	**30,756,747**	**(32,206,011)**
Percent	-1.4%	46.8%	-88.1%
FY 13-14 Difference	(4,917,552)	(16,805,357)	11,887,805
FY 14-15 Difference	(1,449,264)	30,756,747	(32,206,011)
R4 Medicare Modernization Act	**(6,366,816)**	**13,951,390**	**(20,318,206)**

The projected decline in total expenditures is the net result of a projected increase in people dually eligible for Medicaid and Medicare and a decline in the per member per month rate assessed according to the federal formula.

The change in General Fund is due to the application of a portion of federal bonus payments for meeting performance objectives for serving low income children being applied to offset the need for General Fund for this program. This line item is normally a 100 percent General Fund obligation, but for the last few years the General Assembly has used the federal bonus payments to offset the need for General Fund. In FY 2013-14 the Department's forecast raises the projection of available federal bonus payments by $11.9 million and decreases the estimated General Fund payments by a like amount. These bonus payments are for a time-limited duration and in FY 2014-15 the available funding begins to run out. The expiration of the federal bonus payments has been known for some time, but the magnitude of the General Fund impact in the Department's request is greater because of the increase in bonus payments in FY 2013-14.

Issue: Health Information Technology (R5 & R9)

This issue brief summarizes the Department's requests to use health information technology to improve client outcomes and the cost effectiveness of the delivery system.

SUMMARY:

- In R5 the Department requests funding infrastructure improvements to the state's Health Information Exchange to allow more connections between electronic health record systems.
- In R10 the Department proposes funding assistance for primary care providers and specialists to acquire and utilize technology that allows remote specialty care consultation.

DISCUSSION:

The Department submitted two requests to use health information technology to improve health outcomes and the cost effectiveness of the delivery system.

R5 Medicaid health info exchange

The Department requests funding to increase connections to Colorado's Health Information Exchange (HIE) network that allows the sharing of health data between providers using different electronic health record systems. A portion of the funding would be used to help providers adopt electronic health record systems and get them connected to the HIE. This portion of the request modifies and replaces a technical assistance program that was previously in place. A second and larger portion of the request would pay for infrastructure upgrades to increase the data capacity of the HIE and to design interfaces for the HIE to connect with additional electronic health record systems. An enhanced federal match rate of 90 percent is available for most of the costs for the request through the federal Health Information Technology for Economic and Clinical Health (HITECH) Act.

R5 Medicaid health information exchange

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Infrastructure development	$4,140,750	$8,108,000	$3,049,000	$814,000
On-going maintenance	1,450,000	1,450,000	3,450,000	3,450,000
Provider support adopting electronic health records	2,658,176	2,658,176	2,658,176	2,658,176
Phase out current provider support	(2,500,000)	(2,500,000)	(2,500,000)	(2,500,000)
Total	**$5,748,926**	**$9,716,176**	**$6,657,176**	**$4,422,176**
General Fund	1,054,892	1,451,617	1,445,717	1,222,217
Federal Funds	4,694,034	8,264,559	5,211,459	3,199,959

The HIE is not so much a big computer or data warehouse with terabytes of information in it, but rather a series of connections between independent electronic health record systems maintained by providers. In this respect the HIE might be viewed as analogous to the Internet. More data capacity is being requested to store the indexes that allow data from one electronic health record

system to be translated to a format readable by another electronic health record system. A provider who connects their electronic health record system to the HIE has to make only one connection to access information from many different electronic health record systems, rather than designing many individual interfaces to communicate with every electronic health record system where the provider wants to exchange information.

Increasing connections to the HIE makes more clinical data available to providers. For example, a primary care physician could view real-time lab results or a history of specialty care for a patient from providers using different electronic health record systems, if all the providers are connected through the HIE. This potentially makes providers more efficient, reduces duplication, and improves quality of care.

In addition to facilitating the flow of information between providers, the request indicates more decision support information would be available to policy makers. Federal standards for the meaningful use of electronic health records are pushing systems to ensure that they store key information, such as vital statistics and immunizations, in discreet fields that can be queried and aggregated. As more electronic health record systems comply with the meaningful use standards the availability and quality of decision support information will improve.

One of the specific goals of the request is to connect the claims data in the Medicaid Management Information System (MMIS) to the HIE. The Department believes this will provide benefits to both the Department and providers. Currently a challenge in dealing with data in the MMIS is the time delay between when procedures occur and when they are billed. By connecting the MMIS to the HIE, the Department could get information about, for example, hospital admissions by Medicaid clients before the bills for these visits hit the MMIS. This might improve forecasting of upcoming Medicaid claims. It is not as clear how providers could benefit from accessing the information in MMIS through the HIE. The Department mentions that a provider could glean that a patient was among the highest cost in the provider's panel. Staff suspects most providers could intuit this without a query of MMIS, based on the acuity of care, and staff is unsure how the information might change a provider's behavior toward the patient. On the other hand, a provider might not easily summarize the most expensive several patients without a query of MMIS, and perhaps that information could help a provider prioritize resources.

To use data from the HIE in conjunction with the MMIS to evaluate the cost effectiveness of a procedure or treatment protocol would require advanced understanding of, to name a few, the clinical goals, alternative treatments, long-term ramifications, influences from environmental factors, and interactions with co-occurring health issues, that are associated with a particular course of care. When asked if the Department would need additional staff to do this type of analysis, the Department indicated that this could be accomplished with existing data analysis staff. The funding in the request is for technology infrastructure and provider support and does not include Department analytical staff.

The request includes funding for contracts with the Colorado Regional Health Information Organization (CORHIO) a nonprofit designated as the lead agencies for Colorado's HIE (per Executive Order D 008 09), and the Quality Health Network (QHN) that is leading HIE efforts

on the western slope. These contracts would expand the HIE's electronic client and provider directories to cross-reference data about Medicaid clients in different electronic health record systems. The Department's request also includes funding for software to improve user interfaces, provide a better exchange of information when clients change providers, and allow grouping and analysis of clinical data. A portion of the request for funding would be an on-going subscription to CORHIO to continue using the HIE. CORHIO will manage and coordinate the infrastructure improvements.

There are several other state agencies involved in this project, including the departments of Public Health and Environment, Human Services, Regulatory Agencies, and Corrections. The largest involvement would be connecting public health reporting systems of the Department of Public Health and Environment to the HIE. The request would link the information in the Department of Public Health and Environment's databases with the MMIS to save administrative workload, reduce errors, and satisfy federal provider certification requirements.

The provider support component of the request would provide training in adopting and utilizing electronic health record technology and the HIE network. The adoption of electronic health records has increased dramatically in recent years. The Department estimates 73 percent of hospitals and 40 percent of office-based providers use electronic health records. However, many of these electronic health record systems are rudimentary and need to be improved to meet federal minimum "meaningful use" standards and only a fraction of them are connected to the HIE. The adoption rate for electronic health records is lower among "small" providers, with 57 percent of small hospitals and 33 percent of small office-based providers using electronic health records. The least served regions of the state are rural. The providers with the lowest adoption rates are critical access hospitals, specialists, behavioral health providers, and long-term care providers.

CORHIO has specific agreements with all users of the HIE to monitor and limit access to the data to authorized personnel for appropriate uses. All data and the exchange of data must meet Health Insurance Portability and Accountability Act (HIPAA) security standards.

Staff sees a connection between this request and the portion of R11 that seeks to target rate increases for specific procedures based on the cost-effectiveness of those procedures. However, the Department insists that, "This request is intended to fund technology infrastructure expansion, not changes to Medicaid reimbursement." Still, the point of the technology infrastructure expansion is two-fold to: 1) better measure and predict the impact of services on client health; and 2) improve care coordination and prevent duplicative or unnecessary treatments. The first of these deliverables will presumably be used to inform decision making about things such as rates for services.

R10 Primary care specialty collaboration

The Department proposes funding assistance for primary care providers and specialists to acquire and utilize technology that allows remote specialty care consultation. The Department argues that such technology would improve access to specialty care, particularly in rural areas, and thereby improve patient outcomes.

The request assumes the Department would pay specialists using the technology a reduced rate from an office visit. The Department believes providers would accept these lower rates because the technology would allow them to review cases more quickly. Also, because the electronic consultations would be asynchronous, providers could review them at their convenience. One of the challenges in specialty care is managing appointment cancelations so as not to lose billing time. The Department reports that Medicaid clients tend to cancel more frequently than the general population. However, a consult that is stored in a computer never cancels.

The Department believes the technology would make it more attractive for specialists to "see" Medicaid clients. At the same time that the request might increase specialty care consults it would reduce overall health care costs by paying a reduced rate for those specialty consults. The Department also believes that timely access to specialty care could avoid higher cost care from conditions that go untreated, but did not factor any savings for this into the request. Having providers use the technology would also save Medicaid clients the travel time and costs for an in person visit.

The request includes paying to acquire the necessary software for interested providers. The request assumes twenty five percent of primary care providers in the Accountable Care Collaborative, or 575 primary care providers, would be interested in using the technology and that for every 4 primary care providers there would be one specialist, or 144 specialists, using the technology. The cost to acquire the software and the assumed savings for technology-assisted consults are modeled on Doc2Doc technology used in Oklahoma, but the actual technology solution would be based on a bid process. According to the Department Oklahoma achieved savings of approximately $60 per member per month when patents received an electronic consult. The request also mentions successful implementation of a similar technology in Alaska. Much of the Alaska savings was due to avoided travel costs, which might not be applicable on a similar scale in Colorado.

In FY 2012-13 the Department spent approximately $348.9 million reimbursing primary care providers and specialists and approximately 35 percent of that amount, or $123.3 million, went to specialists.

Issue: Eligibility Process (R6)

This issue brief discusses the eligibility determination process and the lack of standardization in the way that the Department pays for eligibility determination services.

SUMMARY:

- Changes in federal policy will allow Colorado to claim an enhanced federal match rate of 75 percent (as opposed to 50 percent) for certain eligibility determination services.
- The Department proposes reinvesting the General Fund and Hospital Provider Fee savings to improve the eligibility determination process.
- New investments would include infrastructure improvement grants for counties, incentive payments for counties that meet timely processing objectives, a study of the eligibility determination system, and reimbursements for Medical Assistance sites.
- Staff believes a study of the eligibility determination system is much needed as there are inconsistencies and potentially inefficiencies in the various reimbursement methods used by the Department.

DISCUSSION:

R6 Eligibility determination enhanced match

The Department's *R6 Eligibility determination enhanced match* extends and expands on the supplemental request approved by the JBC in September regarding the reallocation of General Fund and Hospital Provider Fee funds that are no longer needed to match federal funds for eligibility determination services. The General Fund and Hospital Provider Fee funds are expected to be available because of new guidance from the Centers for Medicare and Medicaid Services (CMS) about eligibility determination activities that qualify for an enhanced 75 percent federal match rate (as opposed to the 50 percent match rate assumed in the appropriation). The Department estimates that 56 percent of county administration activities will qualify for the enhanced match rate, reducing the state's obligation by a total of $6.4 million in FY 2014-15 and increasing the federal funds by the same total. The Department proposes reinvesting the state money in eligibility determination activities to draw an additional $9.3 million in federal funds. The net result would be no change in total state funding, but an increase in federal funds of $15.7 million.

R6 Eligibility Determination Enhanced Match	FMAP	FY 13-14	FY 14-15	FY 15-16
Estimated impact of enhanced match rate		0	0	0
State Funds		(2,511,012)	(6,377,391)	(6,831,483)
General Fund		*(2,267,388)*	*(4,607,121)*	*(4,713,389)*
Hospital Provider Fee		*(243,624)*	*(1,770,270)*	*(2,118,094)*
Federal Funds		2,511,012	6,377,391	6,831,483
Reinvestment activities				
Data transfers with Connect for Health		1,055,320	180,030	0
Colorado Benefits Management System changes	90.0%	627,200	0	0
Collect verifications and finalize eligibility	75.0%	187,413	53,641	0
Determine accurate household compositions	75.0%	187,412	53,641	0
Quality control	75.0%	53,295	72,748	0
ACA backlog contingency		1,394,473	806,406	0
Backup call center	75.0%	749,649	321,844	0
Overflow team	75.0%	187,412	107,281	0
Data entry for paper applications	75.0%	187,412	107,281	0
Print and stock extra paper applications	50.0%	270,000	270,000	0
County Reimbursement		7,700,568	13,491,413	11,641,781
County Payments	75.0%	7,700,568	9,637,508	6,247,064
Infrastructure improvement competitive grants	50.0%	0	1,000,000	1,000,000
Incentive payments	N.A.	0	2,853,905	4,394,717
Study of eligibility determination payment system	75.0%	0	500,000	0
Medical Assistance site funding (beginning Jan-2015)	75.0%	0	700,000	1,500,000
Total cost of reinvestment activities		10,150,361	15,677,849	13,141,781
State Funds		2,511,012	6,377,391	6,831,483
General Fund		*2,267,388*	*4,607,121*	*4,713,389*
Hospital Provider Fee		*243,624*	*1,770,270*	*2,118,094*
Federal Funds		7,639,349	9,300,458	6,310,298
Net impact of request		10,150,361	15,677,849	13,141,781
State Funds		0	0	0
General Fund		*0*	*0*	*0*
Hospital Provider Fee		*0*	*0*	*0*
Federal Funds		10,150,361	15,677,849	13,141,781

The JBC has already seen and approved the components of the request related to addressing data transfers with Connect for Health Colorado, providing contingency funds in case the ACA implementation eligibility determination workload exceeds expectations, and increasing county administration payments. Funding for these initiatives begins in FY 2013-14 and continues in FY 2014-15. The funding for data transfers for Connect for Health Colorado and the ACA backlog contingency would be at reduced levels in FY 2014-15 as data transfer procedures improve and the expected initial wave of enrollment subsides.

New components of the request for FY 2014-15

The components of the request that are new to the JBC include:

Infrastructure improvement competitive grants

$1,000,000 Total, $$500,000 Hospital Provider Fee

These would be one-time grants to improve the infrastructure of counties for handling eligibility determinations. As an example of the kind of projects that the funding would support, the Department described creating a computer room for clients to enter their information in PEAK. The Department would convene stakeolders to help develop the criteria for ranking the applications. Rather than spreading the funds across all counties, this approach concentrates a small portion of the funding on specific capitol and information technology projects to modernize facilities, increase efficiency, and improve services.

Incentive payments

$2,853,905 General Fund

The Department proposes incentive payments for counties that meet performance objectives around timely application processing, responsiveness to Random Moment Sampling surveys, and potentially other metrics. The request assumes the incentive payments would take the form of buying down the county share of eligibility determination costs to avoid conflicts with federal rules that prohibit the Department from reimbursing counties for more than their actual costs. Current policy requires counties to pay 20 percent of eligibility determination costs, with several exceptions for specific initiatives approved by the General Assembly that have no county matching requirement. Because the county share of funds would decrease at the same time as the increase in the state share, there would be no net change in the federal funds matched.

The state is operating under a court order to improve the timeliness of application processing. To be released from the court order the state needs to process 95 percent of standard applications within 45 days and applications requiring a disability determination within 90 days.

Timely Processing of Medical Applicant Determinations								
	New Applications				Redeterminations			
Month	Timely	Untimely	Total	% Timely	Timely	Untimely	Total	% Timely
Nov-12	28,642	3,651	32,293	88.69%	106,903	8,784	115,687	92.41%
Dec-12	28,230	3,078	31,308	90.17%	101,361	7,869	109,230	92.80%
Jan-13	30,563	3,782	34,345	88.99%	102,517	10,068	112,585	91.06%
Feb-13	30,175	3,167	33,342	90.50%	89,917	7,980	97,897	91.85%
Mar-13	31,402	3,805	35,207	89.19%	104,022	6,193	110,215	94.38%
Apr-13	34,349	4,022	38,371	89.52%	93,961	7,201	101,162	92.88%
May-13	34,086	2,695	36,781	92.67%	92,050	10,311	102,361	89.93%
Jun-13	30,104	2,091	32,195	93.51%	96,202	7,321	103,523	92.93%
Jul-13	34,821	2,785	37,606	92.59%	96,300	5,044	101,344	**95.02%**
Aug-13	37,728	2,765	40,493	93.17%	102,303	6,409	108,712	94.10%
Sep-13	30,692	2,141	32,833	93.48%	95,179	6,106	101,285	93.97%
Oct-13	39,887	3,203	43,090	92.57%	106,038	6,029	112,067	94.62%
Nov-13	47,058	3,876	50,934	92.39%	97,015	4,042	101,057	**96.00%**
Total	437,737	41,061	478,798	91.42%	1,283,768	93,357	1,377,125	93.22%

The Department's current reimbursement system for county eligibility determinations is based on actual allowable costs and does not include performance or quality standards. County reimbursement is based on a Random Moment Sampling (RMS) system that takes each county's total allowable expenses for eligibility determinations for a number of public assistance programs and then allocates those expenses by program to determine the maximum reimbursement under each program. The Department of Human Services and the Department of Health Care Policy and Financing then adjust funding between the various appropriations for county administration of these public assistance programs based on the RMS. If total allowable expenses exceed the total appropriations, then funding is redistributed across the programs to maximize federal matching funds, up to the maximum allowable reimbursement for each program, as determined by the RMS system. In some cases the allowable expenses exceed the minimum cost to perform the eligibility determinations. Counties may elect to provide higher levels of service and backfill any shortfalls in state funding with county funds. The RMS can identify more allowable costs, and thus higher payments, for inefficient counties and for counties that load up on optional services.

Under the current reimbursement structure all counties have an incentive to improve efficiency, because of the requirement that counties share in the cost of eligibility determinations. If the county share requirement is reduced using additional federal matching funds, it makes sense that the increased reimbursement be based on performance and quality criteria.

Study of eligibility determination payment system
$500,000 Total Funds, $125,000 Hospital Provider Fee
The Department proposes hiring a consultant to study the way eligibility determination services are reimbursed and make recommendations for improvements. Part of the contractor's duties will be to develop a method to begin reimbursing Medical Assistance sites, which currently process eligibility applications without state compensation, but the scope of the study will be larger. The Department's process for reimbursing eligibility services has developed in a piecemeal fashion as new needs have arisen. The Department believes a comprehensive analysis may reveal ways to improve the equity and standardization of reimbursements.

Eligibility determinations are performed by three entities in the state with very different reimbursement methods: counties; the centralized eligibility vendor (Maximus); and Medical Assistance sites. Medical Assistance sites are not currently compensated by the state for their work. They operate on grant funding. County reimbursement is based on the RMS system described previously. The centralized eligibility vendor is reimbursed according to the terms of a competitively bid contract. The centralized eligibility vendor handles all CHP+ applications, which require a Medicaid denial as a condition of eligibility. In addition, the centralized eligibility vendor handles phone, on-line, and select other applications determined by the Department. These different reimbursement methods result in significant variations in payment per application processed.

Some of the differences in expenditures per application processed relate to easily identifiable factors, such as economies of scale, the complexity of applications processed, or the adequacy of the physical and technological infrastructure, but some of the differences in funding per application processed are less readily explained. Also, some of the differences are attributable to

discretionary decisions by counties that impact their efficiency or the level of optional services provided.

In addition to the sites that perform eligibility determinations, there are a number of sites that are recognized by the Department that provide eligibility support that falls just short of making an eligibility determination. Federally Qualified Health Centers (FQHCs) and hospitals perform what is called "outstationing". FQHCs receive $60,000 per site for administrative costs associated with outstationing, except for Denver Health, where certified public expenditures and matching federal funds pay for the services. For hospital outstationing a portion of the Hospital Provider Fee and matching federal funds pays for the service. Outstationing sites help people prepare an application and can perform some initial processing of the application, such as verifying citizenship and identification documentation, but they ultimately refer the application to a county or the centralized eligibility vendor for the eligibility determination. Beyond outstationing there are Certified Application Assistance Sites that are uncompensated by the state and operated by entities such as church groups, schools, community organizations, and clinics that serve low-income populations. Similar to outstationing sites, the Certified Application Assistance Sites answer questions and help people prepare applications, but they forward the applications to another body authorized to make an eligibility determination. Some higher volume providers pay counties to place workers on location alongside outstationing or Certified Application Assistance Site services. The on-site county workers can make eligibility determinations. The scope of the consultant's work would include looking at the role of eligibility support sites as well as eligibility determination sites.

Providers serving clients with low incomes have a financial incentive to help people eligible for Medicaid to enroll in order to reduce bill collection issues and the amount of uncompensated care. If under certain circumstances the private sector is willing to pay for eligibility assistance services, it raises questions about when and at what level the Department should pay for eligibility assistance.

Improvements to the on-line PEAK system further complicate the reimbursement for eligibility services. The PEAK system now has the capacity to give a real-time eligibility determination for complete and accurate applications. An outstationing or Certified Application Assistance Site that helps someone submit a complete and accurate on-line application through PEAK can help the person get an eligibility determination as easily as a county or Medical Assistance site that is authorized to enter data directly into CBMS.

Medical Assistance sites

The Department proposes to start paying Medical Assistance (MA) sites for their work in processing applications. These sites are subject to timely processing requirements, just like counties and the centralized eligibility vendor, but because the Department doesn't currently pay them, the Department's leverage to enforce timely processing is limited. The MA sites improve customer service by providing another location where people can get an eligibility determination, and they relieve some of the workload from counties and the centralized eligibility vendor. The request assumes the Department would start reimbursing Medical Assistance sites by approximately January 2015. The amount and method of payment would be determined with the input of the consultant and stakeholders.

Conclusion

There is a lack of standardization in the way the Department currently pays for eligibility determination and eligibility support services. The various payment methods have developed in a piecemeal fashion as new needs have been identified. The result is a patchwork of confusing policies for when the Department pays and at what rate. The Department's *R6 Eligibility determination enhanced match* attempts to address a number of problems with eligibility services, including modernizing the infrastructure of counties to manage applications, tying a portion of county payments to quality and performance standards, and beginning to reimburse Medical Assistance sites for eligibility determinations just as counties and the centralized eligibility vendor get paid for this service. However, staff believes the most exciting and potentially most important aspect of the Department's request is the proposed study of the eligibility determination and support system. It is a complex system with a lot of necessary niche services that could benefit from a comprehensive review to address the equity of payments and to better define the expectations from each provider.

Issue: Provider Rates (R11)

This issue brief discusses the Department's request for provider rate increases.

SUMMARY:

- The Department proposes a 1.5 percent increase on estimated expenditures for services eligible to receive a discretionary rate adjustment through the budget process. Every eligible provider would receive a 1.0 percent rate increase, but the remaining 0.5 percent would be reserved for targeted rate increases.
- The purpose of the targeted rate increases would be to: (1) encourage utilization of high-quality, cost-effective procedures and practices; and (2) address rate deficiencies that create access issues.
- Staff has concerns that the Department has not identified the specific rates that would be targeted for increases nor detailed the process and criteria that would be used to select rates for the targeted increases.
- The issue also discusses the expiring increase to primary care provider rates mandated by the Affordable Care Act.

DISCUSSION:

R11 1.5% Provider rate increase

The Department requests funding for provider rate increases equal to 1.5 percent of estimated expenditures for services eligible to receive a discretionary rate adjustment through the budget process. In the Department's proposal every eligible provider would receive an across-the-board 1.0 percent increase, but the remaining funds would be reserved for targeted rate increases determined by the Department.

The Department would use two criteria to determine the services receiving the targeted rate increases. First, the Department would target high-quality, cost-effective procedures, in order to promote greater utilization of them. Second, the Department would target procedures where there are access issues for Medicaid clients related to inappropriate reimbursement rates. Some rate increases might satisfy both objectives. The Department did not indicate how much money would be used to target high-quality, cost-effective procedures versus inadequate reimbursement rates.

Not all services would be eligible for the across-the-boar or targeted rate increase. For some services rates are set according to an external method governed by state statute or federal regulation. Examples include nursing home services where state statutes prescribe the rate setting method and capitated payments such as those to health maintenance organizations that must meet an actuarially sound standard pursuant to federal regulation. The costs to set these rates according to their external method are included in the Department's forecast requests R1 through R4.

High-quality, cost-effective procedures

The Department notes that a number of national organizations publish research-based recommendations on services and practices deemed most cost-effective in improving health outcomes, such as the U.S. Preventive Services Task Force, the American College of Physicians, the National Physicians Alliance, and the American Board of Internal Medicine. As examples of the kinds of procedures and practices highlighted in these reports, the Department cites:

- using aspirin to prevent cardiovascular disease among adults 45-79 at risk of stroke
- screening pregnant women for HIV and Hepatitis B
- providing tobacco cessation interventions for adults who use tobacco products
- delaying imaging for generalized low back pain until after the first six weeks
- not prescribing antibiotics for acute mild to moderate sinusitis
- using mammography rather than MRI technology to screen for breast cancer for average risk women
- initially prescribing established, low-cost statin medications before newer therapies
- extending after-hours clinic care to reduce emergency room utilization, and
- coordinating care for complex patients.

The Department plans to review the recommendations from these national organizations with stakeholder input to identify the most promising, and then run financial models to find the incentive payments most likely to result in the greatest overall savings.

Inadequate rates

The second way the Department would target funding would be to address discrepancies between reimbursement rates and costs. The Department indicates that some procedures are reimbursed for a higher percentage of their costs than others. Ameliorating the largest gaps between reimbursement rates and costs would help ensure that Medicaid clients have access to the services.

To identify gaps between costs and reimbursement rates the Department used Medicare rates as a proxy for costs. For Medicare a national committee examines the generic physician time, practice expenses, and insurance costs associated with various procedures. The cost for each procedure is expressed relative to the cost of other procedures, so procedure X might be 1.3 times the cost of procedure Y. The relative value for each procedure is multiplied by a base rate and then a geographic region adjustment to determine the Medicare reimbursement. The relative values for procedures are reexamined at least once every five years.

For 2012 there were 3,326 procedure codes common to both Medicaid and Medicare and while the Medicaid reimbursement rate as a percentage of Medicare varied from 2 percent to over 100 percent, the Department found that most Medicaid rates were below Medicare. When the percentage differences in rates were averaged in service categories, 23 of 27 Medicaid service categories had average reimbursement rates that were less than 80 percent of the Medicare rates. The average Medicaid rate as a percent of Medicare ranged from 21 percent for Opthalmology Exams to 97 percent for Allergy Treatment. Eleven service categories had rates of 50 percent or less of Medicare, including Chemotherapy/Photodynamic Therapy at 50 percent, Temporary

Procedures/Professional Services at 47 percent, and Dermatology at 32 percent. To the extent that Medicare rates are accurately capturing actual costs, a lower Medicaid reimbursement rate could make it difficult for Medicaid patients to find providers willing to serve them.

It is important to remember that the Medicare rates are designed for serving an elderly population, while Medicaid enrollment is skewed to children. For some procedures it may be appropriate for Medicaid and Medicare reimbursement rates to be different.

Staff analysis

The Department's intent to be more strategic in allocating limited resources for rate increases, in order to achieve improved health outcomes, is laudable, but the request to provide funding before specific targets for the rate increases have been identified is concerning for several reasons.

The Department may be overestimating the degree of consensus about the most cost-effective treatments, with the result that the process for researching, modeling, and prioritizing procedures for rate increases will take longer than expected, leading to delays in spending the money and/or ineffective spending. In the current fiscal year the Department has struggled to implement targeted rate increases in a timely fashion without the preamble of deciding which rates to increase. According to the Department the delays in the current year are due to pending approvals by the Centers for Medicare and Medicaid Services (CMS) and the rate increases will be paid retroactively to the beginning of the year once federal approval is received. If the Department is able to work with stakeholders to select the rates that will receive targeted increases in FY 2014-15 in time, a similar retroactive payment could be made in FY 2014-15, if there are delays in CMS approval. This would at least allow the Department to spend the money appropriated for targeted rate increases. However, making increased payments retroactively, rather than through the normal billing cycle, may diminish the effectiveness of those increased payments as an incentive for a high-value service. Staff is concerned both that the Department may not be able to make decisions in time to get CMS approval to spend all the money, and that a solution that relies on retroactive payments to push the money to providers may not be as effective in changing behavior as timely payments.

Even if there is a reasonable degree of consensus about the most cost-effective procedures, the limited available dollars will require a potentially controversial prioritization of procedures for rate increases. If there is dissatisfaction among some parties about the outcome of the prioritization process, it could lead to perceptions of inequity and favoritism. The Department has described broad goals for the targeted rate increases, but not the steps or measures that will be used to evaluate the available options, making it difficult to assess whether the process is likely to be viewed as fair and objective.

The request raises interesting and fundamental questions about the appropriate roles of the executive branch and legislative branch in setting rates. Both entities bring unique and desirable qualities to the task of identifying and prioritizing targeted rate increases. The Department has some expert knowledge of clinical outcomes and a capacity to solicit and evaluate expert stakeholder input. The legislature has a highly transparent, accessible, and accountable process that includes representation from every region of the state. The legislature is not supposed to "administer" the appropriation, but traditionally the Department has proposed specific rate

increases for approval or modification by the General Assembly. Staff does not see the value or necessity of changing this past practice and limiting the legislative input to providing a lump sum of funding to be awarded at the Department's discretion.

According to the Department, part of the reason for requesting a lump sum for targeted rate increases, rather than proposing specific targeted rate increases, was a lack of time to develop a detailed rate plan with input from stakeholders before the General Assembly's budget submission deadline. Department staff also indicated that the Department was reluctant to potentially waste the time of stakeholders in a prioritization process before knowing how much, if any, money might be available for targeted rate increases. The Department is trying to think strategically about how to involve stakeholders without having the process devolve into a free-for-all contest among providers.

Staff believes that before asking for funding for targeted rate increases the Department should complete the prioritization of options and provide specific recommendations with accompanying justification. The explanation that the Department was unable to meet the General Assembly's budget submission deadlines is not a reason to delegate decision-making authority to the Department. The Department has not identified a systemic reason why it would be impractical to ever meet the General Assembly's budget submission deadlines. Minimizing the involvement of the General Assembly is not a strategy for avoiding a free-for-all among providers. If the Department can't present in support of specific targeted rate increases some objective criteria that will stand up to lobbyist scrutiny and criticism, then there are probably legitimate issues with the Department's criteria that need to be addressed, and it would be naïve to assume that these issues would go away if rate setting decisions were delegated to the Department. There are some cases where the General Assembly has delegated similar authority to a Department, and the reasons are not always clear or standardized. Sometimes, the reason for delegating authority is expediency. In this case, the Department needs to plan so far in advance to allow time for CMS approval that staff sees no reason not to also get legislative approval. In short, staff sees little to no value added from delegating this rate setting decision to the Department and a significant loss in legislative authority.

If the General Assembly decides to delegate authority, then at a minimum staff believes the Department should detail the proposed process for allocating money set aside for targeted rate increases. At least then the General Assembly could ensure that the measuring criteria is objective and that the values used to prioritize one rate increase over another are consistent with the objectives of the legislature.

In addition to the primary staff concerns about the delegation of legislative authority, whether the Department can design a fair process to involve stakeholders, and whether the Department has time to implement targeted rate increases, staff has some uncertainty about whether trying to use targeted rate increases to incentivize high-quality, cost-effective procedures is the right approach. Given the discrepancies identified by the Department between Medicaid rates and actual costs, where Medicare rates are a proxy for actual costs, perhaps the priority should be paying providers an equitable rate before trying to manipulate prices to engineer different health care decisions.

Staff is unsure how much marginal differences in reimbursement rates for different procedures might contribute to the adoption of best practices compared to other methods of disseminating this information, such as medical journals, in-service training, and third party care management. Staff asked the Department for examples of insurance companies successfully improving physician practice through their reimbursement rates, but did not receive a response in time for this briefing. If the Department goes down this road there is a high moral obligation to ensure that the pricing incentives remain current. If a new and better procedure or practice is developed the rates would need to be modified to ensure Medicaid patients receive quality care. Staff expressed concern to the Department that decisions made by the Department about how to reimburse for particular procedures and practices could in turn impact the cost effectiveness of those procedures and practices relative to clinical outcomes, as a greater volume of those procedures and practices are performed. This could then become a barrier to the development of new and better procedures and practices that might be more cost effective, if the Department's rates would allow them to gain market share. The Department responded that the volume of Medicaid clients in Colorado is not great enough to significantly affect market share of a procedure or practice. Medicaid is only one payer for doctors' offices and, except for providers who specialize in serving low income populations, Medicaid is usually a small payer. This reinforces the concern about the potentially limited effectiveness of marginal differences in reimbursement rates for increasing the adoption of high-quality and cost-effective procedures and practices.

There are areas where marginal differences in pricing seem more likely to influence behavior than others, but it is difficult to evaluate the Department's request without specific recommendations. One area the Department mentioned was a possible candidate for a targeted rate increase was after-hours care. If the Department paid a premium rate for after-hours care, it seems likely that more providers would offer this service.

Primary care physician rates

One feature noticeably absent from the Department's request for provider rate increases is funding to continue higher reimbursement rates for primary care services. The Affordable Care Act required states to pay for certain primary care services at 100 percent of Medicare rates for calendar years 2013 and 2014. Any cost associated with bringing primary care reimbursement rates up to January 1, 2009 levels required state matching funds, but any additional increase to match Medicare rates beyond the Medicaid rates in effect on January 1, 2009 was financed with 100 percent federal funding. There is no explicit explanation in federal statute for the purpose of the primary care rate increase, but the Department believes it was intended to bolster network adequacy, with a possible distant second goal of increasing utilization of primary care services.

Federal regulations call for performance reporting, but the Department has not yet received guidance on the standardized measures that will be used to assess the effectiveness of the rate increase. Potential indicators of success might include increases in the number of new primary care providers accepting Medicaid patients, increases in Medicaid patients within the panels of patients seen by primary care providers, and increases in the utilization of primary care codes. However, it would be difficult to isolate the influence of the rate increase when there are other major changes happening at the same time, including the Medicaid expansion and the implementation of the Accountable Care Collaborative. It is possible that federal policy could

extend the enhanced rate for primary care services beyond 2014 if it is determined to have been successful in achieving its goal.

The enhanced rate is currently structured as a quarterly supplemental payment on top of base reimbursements. To qualify for the enhanced reimbursement, a provider must self-attest that they are a primary care physician with certain board certifications[3], or a nurse or physician's assistant personally supervised by such a physician while performing the service.

The attestation process is time-consuming and results in many providers who are performing the exact same services not receiving the enhanced rate. This is likely because the provider is not personally supervised by an eligible physician while performing the service, but it could include cases where the administrative burden of the attestation is a barrier to claiming the enhanced rate.

The table below provides two estimates for continuing the enhanced rates beyond 2014. The first scenario would continue the program without any change to the attestation process. This would best be accomplished through legislation, because the Department's current authority to make the supplemental payments derives from the federal requirement that expires at the end of 2014. The second scenario assumes that rather than using an attestation process to make supplemental payments to specific providers, the core rates for primary care service codes are simply increased to match the current Medicare rates. This would be less administratively burdensome and provide the higher reimbursement to a significantly broader array of providers, but it carries a corresponding increase in the cost. Alternatives to these scenarios could be designed with different General Fund expenditure targets in mind, but they become complicated because not all primary care rates are the same distance from Medicare rates, and so, for example, a policy that raised primary care rates to 90 percent of Medicare rates would have unequal impacts by primary care service.

Primary Care Reimbursement Rates				
Fiscal Year	Continue Supplemental Payments with Attestation 3,699 Providers		Increase Primary Care Rates with No Attestation 11,569 Providers	
	Total Funds	General Fund	Total Funds	General Fund
FY 2014-15	$11,120,597	$4,643,811	$22,138,848	$9,244,884
FY 2015-16	$46,706,507	$19,105,052	$92,983,162	$38,034,275

Staff is not necessarily recommending a continuation of the enhanced primary care rate, but because it was a significant increase that will expire at the end of 2014, staff wanted to highlight it for the JBC's attention. If the JBC establishes a goal of increasing the adequacy of Medicaid reimbursement rates, and the Medicare rates are viewed as a good proxy for adequate compensation, then primary care rates are an area where there would be negative progress toward this goal in 2015 without legislative intervention.

[3] The eligible certifications include general internal medicine, family medicine, or pediatric medicine, or a subspecialty within those specialties recognized by the American Board of Physician Specialties, American Osteopathic Association, or American Board of Physician Specialties.

Issue: Affordable Care Act Implementation

This issue brief summarizes recently released metrics regarding the implementation of the Affordable Care Act.

SUMMARY:

- Beginning January 1, 2014 two major changes in health care occur: (1) the Affordable Care act requires most people to have minimum essential health coverage; and (2) Medicaid eligibility for adults is expanded to 133 percent of the federal poverty guidelines.
- Medicaid enrollments through November for coverage starting January 1 appear consistent with assumptions used in the fiscal note for S.B. 13-200.
- Utilization of the Medicaid on-line Program Eligibility Application Kit (PEAK) has increased dramatically.
- New functionality for PEAK allows for real-time eligibility determinations of complete and accurate applications and for applicants to skip sections of the application that don't apply.
- The Department is now accepting applications by phone.
- Enrollments in private insurance through Connect for Health Colorado are significantly below internal projections, but enrollment trends in Colorado are similar to other states with state-operated exchanges.
- The Connect for Health Colorado web site is not experiencing the technical malfunctions initially experienced by federally operated exchanges.
- Based on call volume and accounts created the interest in Connect for Health appears higher than enrollments to date.
- Enrollment by people between the ages of 18 and 34, the "young invincibles" may be lagging the experience in other states.

DISCUSSION:

Connect for Health Colorado, the marketing name for the state's health care exchange, and the Department of Health Care Policy and Financing released new metrics on December 2 for the implementation of the Affordable Care Act, covering activity through November. Both entities are taking applications for coverage that begins January 1, 2014.

Background

Connect for Health Colorado provides information and enrollment support for people and businesses interested in purchasing health insurance. The plans offered through the exchange are sorted into Platinum, Gold, Silver, and Bronze levels, based on the percentage of average costs paid by the consumer, and plan features are compared in standardized formats to facilitate comparison shopping. Shoppers are not required to purchase insurance through the exchange, and there are many more coverage options available in the state than those offered through the exchange. However, the only way to qualify for special tax credits available through the Affordable Care Act (ACA) is to purchase through the exchange.

The ACA requires that most people have minimum essential health coverage beginning January 1, 2014 or pay a tax penalty. However, there is a grace period of up to three months where people can be without coverage before incurring the tax penalty. A person who uses the entire grace period could sign up for coverage beginning March 1 and avoid the tax penalty. There is a lag between when people sign up and when their insurance starts. The most recent information from Connect for Health is that people need to sign up by December 23 for their insurance to start January 1.

Affordable Care Act Federal Tax Penalties for Failure to Purchase Insurance			
Families Pay	**2014**	**2015**	**2016+**
The greater of:	$95 per adult +$47.50 per child up to $285 per family	$325 per adult +$162.50 per child up to $975 per family	$695 per adult +$347.50 per child up to $2,085 per family
OR	1.0% of family income	2.0% of family income	2.5% of family income

Families with incomes between 400 percent and 100 percent of the federal poverty guidelines will be eligible for refundable federal tax credits to defer the cost of premiums, if they purchase approved plans through the exchange. People with incomes below 250 percent of the federal poverty guidelines are also eligible for assistance with coinsurance. 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. Families who purchase insurance that is less expensive than the benchmark plan will get the same credit. Thus, the tax credits are indexed to both family income and the cost of insurance.

Tax credits are also available to small businesses who offer work-based insurance to their employees. To qualify a business must have 25 or fewer FTE, pay at least 50 percent of the cost of single coverage, and have average wages of less than $50,000 per year. The value of the credit is on a sliding scale based on workers and average income, with a maximum benefit in 2014 of 50 percent of the businesses' contribution to health insurance premiums.

The Department of Health Care Policy and Financing is implementing a Medicaid expansion authorized by S.B. 13-200 for parents with income from 101 percent through 133 percent of the federal poverty guidelines (FPL) and for adults without dependent children from 11 percent through 133 percent of the FPL. Through the Affordable Care Act Colorado qualifies for an enhanced federal match to subsidize the S.B. 13-200 Medicaid expansion and some expansions previously authorized with financing from the Hospital Provider Fee. For Colorado the populations eligible for the enhanced match are parents with income from 61 percent of the FPL and adults without dependent children.

Enhanced Federal Match Rate for Populations Newly Eligible Since the Enactment of the ACA	
Years	**Match Rate**
2014-2016	100.0%
2017	95.0%
2018	94.0%
2019	93.0%
2020+	90.0%

Enrollments through November

The table below summarizes the enrollment statistics for Connect for Health and Medicaid through November. For Medicaid the "enrollment" is approved applications by people who will be newly eligible as of January 1, i.e. parents with income from 101 percent through 133 percent FPL and adults without dependent children from 11 percent through 133 percent FPL. For Connect for Health "enrollment" is people who have committed to a coverage plan.

Affordable Care Act Metrics

	Total Enrollment	Medicaid Newly Eligible	Connect for Health
Prior to October*	9,233	9,233	NA
October	28,343	24,935	3,408
November	36,694	30,122	6,572
Cumulative	74,270	64,290	9,980

* Wait list adults without dependent children.

Medicaid

To put the Medicaid figures in context, the approved applications to date are only 34,768 short of the projected average monthly enrollment for January for people newly eligible for Medicaid assumed in the fiscal note for S.B. 13-200. Approved applications and average monthly enrollments are not the same thing, but the pace of approved applications appears consistent with the average monthly enrollment assumption for January used for S.B. 13-200.

Medicaid Expansion

Month	Approved Applications	Projected Average Monthly Enrollment S.B. 13-200
Prior to Oct	9,233	
Oct-13	34,168	
Nov-13	64,290	
Dec-13		
Jan-14		99,058
Feb-14		111,935
Mar-14		116,503
Apr-14		131,419
May-14		136,181
Jun-14		141,317

In addition to the enrollment figures, the Department released some statistics on utilization of the on-line Program Eligibility Application Kit (PEAK) and the call center. PEAK is a client interface for the Colorado Benefits Management System. It allows people to apply for Medicaid and CHP+ over the Internet. Phone applications are a new way to qualify for Medicaid that was not offered in Colorado prior to October.

Utilization of PEAK has increased dramatically, largely due to referrals from Connect for Health Colorado. In order to qualify for a federal tax credit a person must first be determined ineligible for Medicaid. People applying for a tax credit through the Connect for Health Colorado web site are referred to PEAK to determine Medicaid eligibility. The table below summarizes PEAK utilization before and after the Connect for Health Colorado web site opened. Note that this table presents "applications created" and so the figures don't exactly match the "accounts created" reported in the December 2 press release, but this metric allows for comparison of PEAK utilization pre- and post-implementation of the Connect for Health Colorado web site.

PEAK Applications	
Month	**# Created**
Jul-13	2,754
Aug-13	3,617
Sep-13	3,224
Oct-13	15,787
Nov-13	24,926

The Department recently made some changes to PEAK to significantly improve the users' experience. The first change was implemented for October 1 to allow real-time eligibility determinations of most complete applications. Prior to this feature all applications had to be processed by an eligibility worker, often resulting in a long delay before a determination. According to the Department, only a few other states have implemented a similar functionality. However, "complete applications" is the key term. The Department is finding that a large number of applications through PEAK are submitted without complete information, or they contain errors. For example, applications are being submitted without a full legal name or social security number, and/or with errors and mismatches between names and social security numbers. The Department's measuring tool indicated that in the first month a real-time eligibility determination was made for approximately 60 percent of submitted applications. However, it is important to understand that this statistic also captures applications that were submitted prematurely, perhaps because a user perceived this as necessary to save their progress. The Department is working on user interface improvements, such as better prompts for required fields and real-time quality control checks, to increase the portion of submitted applications that are complete and accurate. Also, the Department is trying to improve training for eligibility support workers, as there are significant variations in the number of complete and accurate applications submitted from different sites. The Department indicates that the number of applications receiving a real-time eligibility determination is increasing, but did not report a statistic for November.

The second improvement to PEAK was implemented November 8 to allow users to skip elements of the application that are not relevant to their circumstances. For example, the number of required responses of people 65 years of age and older and of people without a disability or need for long term care was significantly reduced. The Department reports anecdotally that the ability to skip questions has reduced the application time for some people to less than 15 minutes.

Allowing people to skip sections of the Medicaid application that don't apply to them was an attempt to respond to concerns that getting a Medicaid/CHP+ denial before a person can apply for a tax credit is cumbersome. The Department saw an opportunity to streamline the Medicaid application, which benefits all Medicaid applicants, and not just those applying for a tax credit. Connect for Health is not able to get rid of the requirement for a Medicaid/CHP+ denial. The requirement for a Medicaid/CHP+ denial is based on federal law and Connect for Health indicates that no state has been allowed to implement anything different. The Department and Connect for Health have plans to integrate their eligibility rules engines by next year to further streamline the tax credit application process.

The ability to apply for Medicaid over the phone is a new feature being offered to comply with provisions of the ACA. The Department reported the following statistics about call center activity.

Call Center		
	October	**November**
Volume for applications	7,475	6,354
Average wait time for application	2 minutes 38 seconds	4 minutes 51 seconds
Average time to complete application - PEAK worker	28 minutes	32 minutes
Average time to complete application - CBMS worker	40 minutes	41 minutes

Connect for Health Colorado

Although there is a legislative oversight committee specifically for Connect for Health Colorado, staff believes it may be useful for the JBC to receive an update on the exchange's activities. There are significant interactions between the activities of Connect for Health and the implementation of the Medicaid expansion.

For Connect for Health Colorado, internal planning documents included a worst-case projection of 11,108 enrollments by November 13 and 22,215 by December 13, compared to actual enrollments of 6,001 by November 16 and 9,980 by the end of November. Failure to meet an enrollment projection is not necessarily an indication of a performance failure if the projection was unrealistic or flawed. Exchange staff are revising a number of assumptions in the original projection model based on actual experience and will be presenting a new forecast to the Connect for Health Colorado board soon.

National standards for reporting the enrollment of the exchanges are still developing, making it difficult to make meaningful comparisons of the progress in Colorado relative to other states. Also, a consensus has not developed on the best ways to normalize the enrollment to account for

variations in factors such as population and the number of uninsured. The Colorado Health Institute identified one national analysis that compared reported enrollment to a projection by the Lewin Group of expected enrollment by the end of 2014. This is again a comparison to a projection that may have been flawed, but hopefully the margin of error in each state is similar, making the data comparable across states. The analysis was prepared by the Foundation for Governmental Accountability and as of the writing of this JBC staff briefing it had last been updated November 25, 2013, which means the enrollment for Colorado was through November 16. By the standard used in the report, Colorado had the eighth highest enrollment relative to the Lewin Group projection. This puts Colorado ahead of most states, but in the middle of the pack of states operating a state-run exchange.

State-by-State Estimates for Exchange Enrollment vs Current

Rank	State	Expected Enrollment in 2014	% of Expected Enrollment that Selected a Plan	# Selected a Plan	Current Population	As of
1	Vermont+ *	15,116	33.1%	5,000	620,000	11/15/13
2	Connecticut *	58,637	12.9%	7,572	3,529,000	11/15/13
3	California+ *	691,016	11.6%	79,891	37,370,000	11/15/13
4	Kentucky+ *	88,205	10.0%	8,780	4,291,000	11/14/13
5	Washington *	149,043	6.2%	9,230	6,711,000	11/13/13
6	New York *	411,304	5.8%	24,000	19,218,000	11/12/13
7	Rhode Island *	21,826	5.5%	1,192	1,037,000	11/13/13
8	**Colorado ***	**114,864**	**5.2%**	**6,001**	**4,986,000**	**11/18/13**
9	Nevada+ *	62,378	4.8%	2,991	2,684,000	11/21/13
10	District of Columbia+ *	9,520	3.4%	321	611,000	11/13/13
11	Maryland+ *	91,528	1.9%	1,743	5,782,000	11/15/13
12	Hawaii *	18,603	1.4%	257	1,308,000	11/15/13
13	Minnesota+ *	129,999	1.4%	1,800	5,246,000	11/13/13
14	Massachusetts+ *	82,853	1.2%	963	6,526,000	11/18/13
15	New Hampshire	32,430	0.8%	269	1,298,000	11/13/13
16	Pennsylvania	266,858	0.8%	2,207	12,621,000	11/13/13
17	Maine	35,711	0.8%	271	1,311,000	11/13/13
18	Michigan	181,985	0.7%	1,329	9,724,000	11/13/13
19	Florida	501,749	0.7%	3,571	18,844,000	11/13/13
20	Delaware+	13,898	0.7%	97	893,000	11/13/13
21	Wisconsin	132,724	0.7%	877	5,659,000	11/13/13
22	Nebraska	52,691	0.6%	338	1,810,000	11/13/13
23	Idaho *	54,857	0.6%	338	1,558,000	11/13/13
24	North Carolina	268,086	0.6%	1,662	9,377,000	11/13/13
25	Alabama	102,300	0.6%	624	4,727,000	11/13/13
26	Tennessee	167,940	0.6%	992	6,294,000	11/13/13
27	Georgia	240,216	0.6%	1,390	9,587,000	11/13/13
28	Illinois	236,810	0.6%	1,370	12,734,000	11/13/13
29	Ohio	196,605	0.6%	1,150	11,327,000	11/13/13
30	West Virginia	30,686	0.6%	174	1,821,000	11/13/13
31	Montana	37,626	0.6%	212	980,000	11/13/13
32	Virginia	184,519	0.6%	1,023	7,822,000	11/13/13
33	Arizona	140,497	0.5%	739	6,487,000	11/13/13
34	Wyoming	17,076	0.5%	85	555,000	11/13/13

State-by-State Estimates for Exchange Enrollment vs Current						
Rank	**State**	**Expected Enrollment in 2014**	**% of Expected Enrollment that Selected a Plan**	**# Selected a Plan**	**Current Population**	**As of**
35	Kansas	79,108	0.5%	371	2,765,000	11/13/13
36	Missouri	159,733	0.5%	751	5,915,000	11/13/13
37	Indiana	152,044	0.5%	701	6,368,000	11/13/13
38	South Carolina	123,923	0.5%	572	4,580,000	11/13/13
39	New Jersey	167,395	0.4%	741	8,687,000	11/13/13
40	Arkansas	58,345	0.4%	250	2,894,000	11/13/13
41	Utah	83,368	0.4%	357	2,781,000	11/13/13
42	Texas	780,959	0.4%	2,991	25,340,000	11/13/13
43	Louisiana	104,233	0.4%	387	4,455,000	11/13/13
44	New Mexico *	47,020	0.4%	172	2,028,000	11/13/13
45	Oklahoma	94,062	0.4%	346	3,718,000	11/13/13
46	Alaska	19,311	0.3%	53	692,000	11/13/13
47	North Dakota	18,203	0.2%	42	660,000	11/13/13
48	South Dakota	25,520	0.2%	58	804,000	11/13/13
49	Iowa	62,139	0.2%	136	3,001,000	11/13/13
50	Mississippi	75,297	0.2%	148	2,919,000	11/13/13
51	Oregon+ *	108,703	0.0%	0	3,809,000	11/13/13
	Total	**6,999,519**	**2.5%**	**176,535**	**307,892,000**	

Source: Foundation for Government Accountability, various public documents (uncoverobamacare.com/enrollment/)
+ = May include Medicaid enrollees and small business applications as well, separated out when reported.
* = State Based Exchange

As an indicator of performance Connect for Health also reported statistics on the availability of the web site.

Connect for Health Web Site		
	11/17-11/30	**10/1-11/30**
Unique visitors	92,093	599,347
Availability of web site	100.0%	99.70%
Web pages serviced within 5 seconds	100.0%	99.52%

Connect for Health Colorado's statistics on call volume and accounts created indicate a higher level of interest than just the enrollments, but it remains to be seen if the interest will translate to enrollments. Creating an account requires little more than entering a name and contact information, and so the accounts created may capture a lot of people who are merely curious and not necessarily planning to make a purchase. However, the calls and chats serviced is probably an indicator of a significant effort to gather information, since to get their call/chat serviced people are waiting on average 5 minutes and 49 seconds and the call/chat length is over 17 minutes.

Interest in Connect for Health		
	11/17-11/30	**10/1-11/30**
Customer accounts	14,964	86,461
Calls and chats serviced	16,858	74,769
Average call/chat wait	6 minutes 29 seconds	5 minutes 49 seconds
% of calls answered in 20 seconds	28%	40%
Average call/chat length	17 minutes 13 seconds	17 minutes 1 second

Another interesting metric that Connect for Health Colorado provided was demographics on the people who have enrolled. Colorado has received national attention for some edgy advertisements aimed at encouraging so-called young invincibles to sign up for health insurance. The young invincibles tend to have lower health care costs, and so including more of them in the risk pool will lower premiums for all. The Colorado Health Institute found demographic information for enrollments in a smattering of states. It is important to note that the statistics for Connecticut, Kentucky, and Washington include both exchange and Medicaid enrollments, and so they may not be comparable to the exchange-only enrollments reported by the other states. The Department was not able to break out the age ranges for the Colorado Medicaid new enrollments in time for this briefing. In Colorado, 18-34 year olds represent approximately 24 percent of the population and have the highest uninsured rates, with more than 1 in 4 uninsured (2013 Colorado Health Access Survey). Because young invincibles tend to be healthier, their sense of urgency to enroll may be lower than that of other populations, and so one might expect slower enrollment gains among this population. However, the enrollment trend among this population in Colorado relative to other states may be worth noting.

Exchange Enrollment by "Young Invincibles"				
	Exchange or Medicaid	**Young Invincibles Percent Enrollment**	**Ages Reported**	**Date Updated**
Kentucky	Both	32.0%	18-35	11/15
Washington	Both	30.0%	18-34	11/15
Maryland	Exchange only	26.8%	18-34	11/15
California	Exchange only	22.5%	18-34	11/12
Connecticut	Both	22.0%	18-34	11/19
Colorado	**Exchange only**	**17.0%**	**18-34**	**12/2**

Issue: Long-term Services and Supports (R9)

This issue brief discusses improvements to long-term services and supports proposed in the Department's budget request.

SUMMARY:

- The Department projects that 100 people per year will transition from institutional settings to community settings through the Colorado Choice Transitions (CCT) grant program.
- The projected savings from the CCT were predicated on federal grant funding to provide housing assistance payments (HAPs) that never materialized.
- The Department proposes General Fund for the state to make HAPs available for 75 percent of the projected CCT population each year.
- With the General Fund HAPs the Department still projects a savings from the CCT program.

DISCUSSION:

The Department's budget request assumes a number of people will move from receiving long-term services and supports in an institutional setting to a community setting through the Colorado Choice Transitions (CCT) program. The CCT is Colorado's version of the federal Money Follows the Person program. Through the CCT the Department provides enhanced community services for a period of one year to help people in institutional settings transition to a community setting. The enhanced services, which are in addition to the standard community services the participants are eligible to receive, include: intensive case management and independent living skills training; enhanced nursing services and mental health counseling; access to home modification services and assistive technologies; substance abuse counseling; and, extended dental and vision services. The Department projects 100 people will make the transition from an institutional to community setting per year, beginning with the first transitions that occurred in April 2013 (after some initial implementation delays).

The Department projects a net savings when people transition from an institutional setting to a community setting. Services in a community setting are estimated to be significantly cheaper than services in an institutional setting, even with the enhanced level of community services provided under the CCT.

In addition to the net savings, for each person successfully transitioned to a community setting the Department receives bonus federal funds equal to 25 percent of the total cost of community services in the first year of the transition. These bonus funds are deposited in a special Rebalancing Fund and may be used for the purposes negotiated in the federal grant. The Department's federal grant is for transitioning 490 people by 2016, with a possible extension through 2019. Administrative costs of running the CCT are 100 percent federally funded. As of October 8, 2013, $11,759 in bonus money had accumulated in the Rebalancing Fund. The Department estimates that the fund balance will eventually reach $4.0 million by the end of the grant period and is working with stakeholders on plans for how to spend the money.

The Department's projection of the number of people changing care settings through the CCT was based in part on the assumption that federal funds for housing assistance would be forthcoming. However, Colorado's application through the competitive process for the housing assistance money was not granted. The Department believes that the majority of the people who could transition from an institutional setting to a community setting would need housing assistance money. The Department's *R9 Medicaid community living initiative* includes a housing assistance component, without which the Department would most likely revise the forecasted CCT savings downward.

The table below summarizes the projected CCT savings and the cost of the housing vouchers.

Colorado Choice Transitions	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Demonstration Services (New Services)	852,883	2,758,743	2,932,003
Qualified Services (Existing Waiver Services)	513,380	1,668,006	1,772,972
Home Health	54,361	182,903	194,589
Subtotal - CCT program expenses (eligible for bonus payments)	**1,420,624**	**4,609,652**	**4,899,564**
Completed transitions Medical Service Premiums community services	NA	293,216	1,273,086
Completed transitions DD community services	NA	381,705	1,603,161
Total expenses	**1,420,624**	**5,284,573**	**7,775,811**
Estimated savings from avoided nursing facility expenditure	(1,073,174)	(5,544,004)	(10,254,334)
Estimated savings from avoided ICF/IID expenditure	(191,688)	(958,440)	(1,916,880)
Total savings	**(1,264,862)**	**(6,502,444)**	**(12,171,214)**
Budgeted impact	**155,762**	**(1,217,871)**	**(4,395,403)**
General Fund	77,881	(608,935)	(2,197,701)
Federal Funds	77,881	(608,936)	(2,197,702)
Federal funds earned in Rebalancing Fund	355,156	1,152,413	1,224,891
Total fiscal impact	**510,918**	**(65,458)**	**(3,170,512)**
General Fund	77,881	(608,935)	(2,197,701)
Federal Funds	433,037	543,477	(972,811)
R9 Medicaid community living initiative			
Number of Housing Assistance Payments (HAPs)		75	150
General Fund for HAPs		450,375	936,750
CCT fiscal impact with R9	**510,918**	**384,917**	**(2,233,762)**
General Fund	77,881	(158,560)	(1,260,951)
Federal Funds	433,037	543,477	(972,811)

In addition to General Fund for housing assistance, the Department's *R9 Medicaid community living initiative* requests $322,864 total funds, including $161,431 General Fund, for a new contract with the Department of Local Affairs to administer the Home Modification Benefit. Some portion of CCT clients would need home modifications in addition to Housing Assistance Payments (HAPs). The Department of Local Affairs (DOLA) would hire two FTE to perform

inspections of home modifications. The FTE would also assist with the HAPs for CCT clients, but the Department would request the funding whether the new HAPs for CCT clients are approved or not. The home modification benefit is an existing benefit that is not just for CCT clients. The Department is concerned that Medicaid case managers are not experienced in overseeing construction projects. DOLA would review the appropriateness of bids and perform inspections to ensure that home modifications are safe and priced appropriately.

Finally, the Department's request includes $469,962 total funds, including $234,981 General Fund, to counsel people in nursing homes on their options for receiving care in a community setting. Pursuant to federal regulation, nursing homes regularly ask residents if they are interested in exploring community-based options. Between April 2012 and March 2013 38,644 residents were surveyed and 2,578 indicated an interest in exploring community-based options. However, the Department does not have resources to reach out and provide options counseling for people interested in transitioning to the community.

Issue: Breast and Cervical Cancer Prevention

This issue brief discusses the financing for the Breast and Cervical Cancer Prevention (BCCP) program and issues to consider if the statutory authority for the program is renewed.

SUMMARY:

- The state authority for the BCCP expires July 1, 2014.
- A large portion of the people previously served by the BCCP will be eligible for Medicaid through the expansion authorized by S.B. 13-200, but an estimated 199 people would lose eligibility if the BCCP is not reauthorized.
- The estimated cost of renewing the program is $3.1 million, including $1.1 million state funds.
- Currently state funding comes from a variety of sources including tobacco settlement moneys, tobacco tax moneys, a specialty license plate fee, and the General Fund.
- Staff recommends that if the program is reauthorized the financing for the state share be simplified to include specialty license plate fees and the General Fund.

DISCUSSION:

The state authority for the Breast and Cervical Cancer Prevention program (BCCP) expires July 1, 2014. The BCCP allows people screened for breast or cervical cancer whose income is up to 250 percent of the federal poverty guidelines (FPL) to qualify for Medicaid. The screening process is regulated within national guidelines by the Department of Public Health and Environment, which has set rules that limit eligibility to people ages 40 through 64. The federal government provides an enhanced federal match of 65 percent for Colorado's expenditures for people diagnosed with breast or cervical cancer.

The Department estimates that a large portion of the people who otherwise would have enrolled in Medicaid through the BCCP will be eligible through the S.B. 13-200 expansion of Medicaid eligibility. Specifically, an estimated 510 people, or 71.9 percent, of the projected 709 people who otherwise would have enrolled in the BCCP in FY 2014-15 will be eligible for Medicaid through S.B. 13-200. The remaining 199 people have incomes from 134 percent through 250 percent FPL.

If the General Assembly decides to continue the BCCP for the estimated 199 people with income from 134 percent through 250 percent FPL, the estimated cost would be $3,064,600, including $1,072,610 state funds. This is based on an estimated per capita cost of $15,400 and a federal match rate of 65 percent.

The layering of incremental changes to the program over the years has resulted in a complex funding system for the program that could benefit from simplification, if the program is reauthorized. Under current law the sources of funding for the state match for the BCCP include

tobacco tax revenue, tobacco settlement funds, the General Fund, and fees from a breast cancer awareness special license plate.

From the tobacco tax 16 percent of the revenue is deposited in the Prevention, Early Detection, and Treatment Fund and 20 percent of the money in that fund is dedicated to the BCCP. Another way to say this is that 3.2 percent of total tobacco tax revenue (20 percent of 16 percent) is dedicated to the BCCP.

The remaining state portion of the cost for the program is split equally between the General Fund and the Breast and Cervical Cancer Prevention and Treatment Fund (BCCP Treatment Fund). One source of revenue to the BCCP Treatment Fund is the interest from the Tobacco Litigation Settlement Cash Fund. In FY 2008-09 this was more than$2.1 million, but changes the General Assembly made to the timing of the distribution of funds reduced the annual allocation significantly such that the revenue to the fund from the interest of the Tobacco Litigation Settlement Cash Fund in FY 2012-13 was less than $50,000. There has also been a decrease in revenue to the Tobacco Litigation Settlement Cash Fund that has contributed to the decrease in interest, but the primary cause for the drop is the change in the timing of distributions. During the years when the interest from the Tobacco Litigation Settlement Cash Fund was a significant source of revenue to the BCCP Treatment Fund the Department built up a fund balance such that there will be an estimated $3.7 million in the fund at the end of FY 2013-14.

The second source of revenue to the BCCP Treatment Fund is fees from a breast cancer awareness special license plate. This money goes into a special account of the BCCP Treatment Fund that is only to be used for an eligibility expansion authorized by H.B. 09-1164 (Primavera/Kester). As of June 30, 2013 the balance in the specialty account was $1,403,290 and the Department projects revenue for FY 2013-14 of $675,090. The bill broadened the possible locations where people could be screened for breast or cervical cancer to qualify for the program to include providers performing screening activities recognized by the Department of Public Health and Environment, as well as providers receiving federal grants through the national breast and cervical cancer early detection program. The money in the special account cannot be accessed until, among other criteria, the Department determines that the funds are sufficient to sustain the expansion. Last year the General Assembly added General Fund to the Long Bill to support the expansion and the Department implemented the expansion as of December 1, although the Department has not yet notified the General Assembly to release the money in the special account.

One way to simplify the funding for the BCCP would be to eliminate the statutory transfer from the Prevention, Early Detection, and Treatment Fund (originally Tobacco Tax). For FY 2014-15 the Department projects that $1,072,610 state funds would be required to continue the BCCP and there will be $675,090 of revenue from specialty license plates. The remaining $397,520 in costs could easily be covered from the $3.7 million balance in the BCCP Treatment Fund. Assuming both the required state funds and the revenue from specialty license plates remain fairly constant except for small annual enrollment and inflationary adjustments, the existing balance in the BCCP should be adequate to sustain the program for another 5-year authorization.

Staff would recommend that if the BCCP is reauthorized the JBC go a step further and use General Fund, rather than the balance in the BCCP Treatment Fund, to make up any difference between license plate revenue and the cost of the program. In this approach the JBC would make a one-time transfer of the balance in the BCCP Treatment Fund to the General Fund and eliminate the transfer of interest from the Tobacco Litigation Settlement Fund to the BCCP Treatment Fund. Staff does not see a strong connection between tobacco litigation settlement moneys and the BCCP, and thus no need to maintain an earmark of the money for the BCCP. By transferring the balance in the BCCP Treatment Fund the resources can be used right away, rather than parsing them out in small amounts every year for the BCCP. For most other Medicaid populations the source of the state match is General Fund. By using General Fund rather than the balance in the BCCP Treatment Fund for the remaining costs after specialty license plate revenues the JBC would avoid any future potential complication if the balance in the BCCP Treatment Fund was insufficient.

The current statutes for the BCCP Treatment Fund are overly prescriptive and have had to be modified to spend down excess fund balances and then adjust for declining revenues. The table below shows the statutory percentage of the state match for the BCCP program, after accounting for the money transferred from the Prevention, Early Detection, and Treatment Fund, that is to come from the BCCP Treatment Fund.

BCCP state match from the BCCP Treatment Fund	
Fiscal Year	**Percent**
FY 05-06	50.0%
FY 06-07	75.0%
FY 07-08	100.0%
FY 08-09	100.0%
FY 09-10	100.0%
FY 10-11	100.0%
FY 11-12	100.0%
FY 12-13	50.0%
FY 13-14	50.0%

This doesn't capture the full complexity of the funding schemata, though, because at one point a bill was passed to transfer the interest from the BCCP Treatment Fund and send it to a fund for people with disabilities. The purpose and name of the fund has changed, but it is currently the disability investigational and pilot support fund. Thus, the interest on the interest from the Tobacco Litigation Settlement Fund is being ear marked for a statutory purpose.

If the BCCP program is reauthorized, the staff recommendation is to get rid of the convoluted funding system and replace it with money from the specialty license plate and a backfill from the General Fund for any shortfall. In doing so, the General Assembly would make a one-time transfer of the balance in the BCCP Treatment Fund to the General Fund. A full transfer of the balance in the BCCP Treatment Fund would be $3.7 million, but the General Assembly could elect to leave money from the specialty license plate fee in the BCCP Treatment Fund.

Issue: Transfer and Overexpenditure Authority

This issue brief discusses the necessary renewal of expiring statutory authority for transfers and overexpenditures.

SUMMARY:

- Several statutes that authorize transfers or overexpenditures of line items when certain conditions are met are scheduled to expire at the end of FY 2013-14. The most commonly used authority for the largest dollar amounts are for Medicaid expenditures, although the statutes allow smaller dollar-capped transfers for other programs approved by the Governor.
- Overexpenditure authority for Medicaid is necessary to ensure that the Department can pay claims for eligible clients. Because eligible clients are legally entitled to the benefits, the Department cannot fail to pay the claims.
- Staff recommends that the JBC limit Medicaid overexpenditure authority to paying claims and disallow overexpenditures for administrative expenses. There is no evidence that the overexpenditure authority has been abused, but allowing overexpenditures for administrative expenses is unnecessary.
- Renewing the overexpenditure authority for Medicaid does not make it easier or harder for the Governor to access Medicaid appropriations for disaster emergencies. This ability comes from the Governor's disaster authority statutes.

DISCUSSION:

Overexpenditure and transfer authority

Staff recommends that the JBC sponsor legislation to renew several statutes that authorize transfers or overexpenditures of line items when certain conditions are met. These statutes are scheduled to repeal at the end of FY 2013-14. The portions of statute most commonly used and for the largest dollar amounts relate to the Medicaid program. As part of the reauthorization staff recommends that the JBC consider limiting the overexpenditure authority for Medicaid to disallow overexpenditures for administrative costs.

The sections of the Colorado Revised Statute that are up for renewal include:

- **24-75-105 and 107 – Allows transfers of centralized appropriations, provided the transfers are consistent with the statutory purposes of cash funds involved in the transfers.** Centralized appropriations are defined in Section 24-75-112 (1) (b) and may include salary survey, merit pay or anniversary increases, senior executive service, shift differential, group health and life insurance, capital outlay, ADP capital outlay, information technology asset maintenance, legal services, purchase of services from computer center, multiuse network payments, vehicle lease payments, leased space, lease purchase, payment to risk management and property funds, short-term disability insurance, utilities, communications services payments, amortization equalization disbursements, supplemental

amortization equalization disbursements, administrative law judge services, and centralized ADP.

- **24-75-106 and 106.5 – Allows transfers between HCPF and Human Services for "materially similar" and "corresponding" appropriations respectively.** These transfers are for higher or lower Medicaid earned funds, or for non-Medicaid expenses where expressly allowed by a footnote. Since the last reauthorization of these statutes five years ago the departments have only used the authority for Medicaid transfers, and not the authority for transfers authorized in footnotes.

- **24-75-109 and 110 – Allows overexpenditures of the appropriation under certain conditions and/or within limited dollar amounts.** The overexpenditures must be approved by the governor, consistent with the statutory purposes of the program, and accomplishable within the available fund balance. If an overexpenditure occurs the Controller must restrict appropriations for the overexpending department for the next year unless the restriction is specifically lifted by a supplemental appropriation. See the table *Overexpenditures authorized pursuant to Section 24-75-109 (1), C.R.S.* below for a list of the dollar limits on different types of overexpenditures.

The reason overexpenditure authority is granted for the Medicaid program is because the Department is not authorized to stop paying claims if the appropriations limit is reached. Most of Medicaid operates as an entitlement program, meaning that people deemed eligible have a legal enforceable right to the plan benefits. If the forecast of expenditures used to make the appropriation is incorrect, the Department must still make payments for eligible services received by eligible clients. The alternatives to overexpenditure authority for the Medicaid program would be an annual post-session emergency supplemental approved by the JBC, or a reserve appropriation for contingencies.

Unlike claims expenses, the Department does have control over administrative expenses. Administrative expenses are not a plan benefit. While there is a relationship between administrative costs and both enrollment and claims paid, the relationship is not one for one. Also, the Department should be able to know enough time in advance to request a supplemental if administrative appropriations are so inadequate as to jeopardize the Department's ability to make claims payments.

A review of Medicaid overexpenditures since the last reauthorization of the statute reveals no requests or approvals for overexpenditures for administrative expenses. A limit on overexpenditures for administrative expenses would provide the General Assembly with some security against a potential abuse of the statute and it would in no way limit how the statute has historically been used by the executive branch in the recent past.

Overexpenditures authorized pursuant to Section 24-75-109 (1), C.R.S.						Unaudited
Paragraph:	**Fund**	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**
(a) Medicaid programs - unlimited	**T**	**$12,241,709**	**$858,232**	**$42,632,483**	**$1,994,270**	**$5,896,130**
Health Care Policy and Financing						
Medical Service Premiums	GF	11,170,264	0	8,471,270	0	5,290,984
Medical Service Premiums	CF	228,644	18,341	30,676,423	1,974,111	462,861
Behavioral Health Capitation Payments	GF	709,215	738,969	2,909,851	0	0
Behavioral Health Capitation Payments	CF	0	0	0	20,159	0
Medicaid Mental Health Fee for Service Payments	GF	109,551	0	135,964	0	142,285
Pediatric Specialty Hospital	GF	0	0	42,475	0	0
Medicare Modernization Act State Contribution	GF	0	100,922	396,224	0	0
The Children's Hospital Clinic, Based Indigent Care	GF	0	0	171	0	0
Family Medicine Residency Training	GF	0	0	43	0	0
State University Teaching Hospitals-Denver Health	GF	0	0	45	0	0
State University Teaching Hospitals-University of CO	GF	0	0	17	0	0
Residential Treatment for Youth	GF	24,035	0	0	0	0
(a.5) Children's Basic Health Plan - $250,000 cap on GF	**T**	**$0**	**$0**	**$0**	**$0**	**$0**
(a.6) Medicare Modernization Act - unlimited	**T**	**$0**	**$0**	**$0**	**$0**	**$0**
(b) Human Services non-Medicaid - $1,000,000 cap	**T**	**$300,538**	**$0**	**$27,867**	**$0**	**$0**
Colorado Trails	GF	300,538	0	27,867	0	0
(c) Executive Branch non-Human Services-$3,000,000 cap	**T**	**$188,097**	**$49,929**	**$1,924**	**$230,200**	**$1,500,000**
Education						
Legal Services	CF	9,067	0	0	0	0
Workers' Compensation	CF	0	0	844	0	0
Charter School Institute	CF	0	0	0	230,200	0
Smart Start Nutrition Program	CF	0	26,019	0	0	0
Health Care Policy and Financing						
Personal Services	GF	147,605	0	0	0	0
Nurse Home Visitor Program	GF	0	0	1,080	0	0
CBMS SAS-70 Audit	GF	2,788	1,410	0	0	0
Higher Education						
Cumbres and Totlec Railroad Commission	GF	0	22,500	0	0	0
Personnel and Administration						
Workers' Compensation Claims	CF	0	0	0	0	1,500,000
Deferred Compensation Administration (TPA)	CF	10,205	0	0	0	0
Revenue						
Alternative Fuels Rebate	CF	18,432	0	0	0	0
(c.5) Human Services workers' compensation - unlimited	**T**	**$0**	**$0**	**$0**	**$0**	**$0**
(d) Judicial - $1,000,000 cap	**T**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL	**T**	**$12,730,344**	**$908,161**	**$42,662,274**	**$2,224,470**	**$7,396,130**
	GF	**12,463,996**	**863,801**	**11,985,007**	**0**	**5,433,269**
	CF	**266,348**	**44,360**	**30,677,267**	**2,224,470**	**1,962,861**

Medicaid and flood relief

In FY 2013-14 the Governor transferred $50 million General Fund from the appropriation for Medical Service Premiums to the Disaster Emergency Fund for flood relief (Executive Order D 2013-028). This was done under the Governor's disaster emergency authority in Section 24-33.5-706 (4), C.R.S. According to the Office of State Planning and Budgeting (OSPB) the decision to use Medical Service Premiums as a primary source for flood relief had nothing to do with the overexpenditure authority statute for Medicaid.

According to OSPB, the decision to use Medical Service Premiums for flood relief was based on minimizing program impacts. Both the OSPB and Legislative Council Staff revenue forecasts indicated a surplus of General Fund in FY 2013-14, but the statutes governing the Disaster Emergency Fund do not provide for transfers to the fund from excess General Fund. Therefore, the Governor needed bridge funding until the legislature reconvened. OSPB's first recourse was to money designated as the TABOR emergency reserve. However, after exhausting the Controlled Maintenance Fund, the executive branch decided that no further money from the designated TABOR emergency reserve would be used for flood relief, because there would be immediate operational impacts to the programs funded from sources identified as the TABOR emergency reserve. OSPB then look for line items that could absorb a $50 million General Fund reduction with no immediate programmatic until after the legislature was in session. The two most likely candidates were Medical Service Premiums or the Department of Education's State Share of Districts' Total Program Funding. The Governor's office was comfortable with either option and narrowly picked Medical Service Premiums. It appears that the decision was made without consideration for the overexpenditure authority granted to Medicaid, because the Governor always intended to request spending authority from the excess General Fund reserve as soon as the legislature reconvened.

If the JBC has concerns about the Governor's decision to use $50 million from Medical Service Premiums for disaster relief, then this is probably best addressed through an amendment to the statutes governing the Disaster Emergency Fund and/or the Governor's disaster emergency authority. Staff believes this would be preferable to an amendment to the Medicaid overexpenditure statute.

Statutory sections scheduled to repeal

The relevant statutory sections that are scheduled to repeal are excerpted below for easy reference:

24-75-105. Transfers required to implement conditional and centralized appropriations - repeal.

(1) Transfers of appropriations which are authorized in the 1990-91 and subsequent general appropriation acts and are required to implement appropriations conditioned on the distribution of the appropriation among, or the transfer of the appropriation between, departments, agencies, or programs, including centralized appropriations, are expressly authorized.

(2) This section is repealed, effective September 1, 2014.

24-75-106. Transfers between departments of health care policy and financing and human services for materially similar items of appropriation for medicaid programs - limitation – repeal

(1) Notwithstanding the effect of the "M" provision in the 1990-91 and subsequent general appropriation acts, the governor may transfer unlimited amounts of general fund appropriations and reappropriated funds to and from the departments of health care policy and financing and human services when required by changes from the appropriated levels in the amount of medicaid cash funds earned through programs or services provided under the supervision of the department of human services or the department of health care policy and financing if the transfer of appropriations is between one or more materially similar items of appropriation and is for purposes other than department administrative costs associated with programs or services.

(2) This section is repealed, effective September 1, 2014.

24-75-106.5. Transfers between departments of health care policy and financing and human services for corresponding items of appropriation - limitations - repeal.

(1) Subject to the provisions of subsection (2) of this section, upon approval of the governor:

(a) The executive director of the department of health care policy and financing may transfer general fund or reappropriated funds spending authority from one or more items of appropriation made to that department in the annual general appropriations act to one or more corresponding items of appropriation made to the department of human services in the act.

(b) The executive director of the department of human services may transfer general fund or reappropriated funds spending authority from one or more items of appropriation made to that department in the annual general appropriations act to one or more corresponding items of appropriation made to the department of health care policy and financing in the act.

(2) The governor may approve a transfer of spending authority between one or more corresponding items of appropriation of the departments of health care policy and financing and human services pursuant to subsection (1) of this section only if:

(a) Authority for the transfer of spending authority has been expressly granted in a footnote in the annual general appropriations act;

(b) The amount of spending authority to be transferred does not exceed the maximum amount, if any, specified in the footnote authorizing the transfer; and

(c) The transfer is not otherwise authorized pursuant to section 24-75-106.

(3) The transfers authorized by this section shall:

(a) Be in addition to any other transfers between the departments of health care policy and financing and human services authorized by law; and

(b) Apply to the 2008-09 and subsequent general appropriations acts.

(4) The governor shall report to the joint budget committee no later than October 1 after the close of the fiscal year on any transfers approved by the governor pursuant to this section.

(5) This section is repealed, effective September 1, 2014.

24-75-107. Cash fund transfers pursuant to sections 24-75-105 and 24-75-106 - repeal.

(1) All transfers pursuant to sections 24-75-105 and 24-75-106 which involve cash funds shall be consistent with statutes governing the use of cash funds.

(2) This section is repealed, effective September 1, 2014.

24-75-109. Controller may allow expenditures in excess of appropriations - limitations - appropriations for subsequent fiscal year restricted - repeal.

(1) For the purpose of closing the state's books, and subject to the provisions of this section, the controller may, on or after May 1 of any fiscal year and before the forty-fifth day after the close thereof, upon approval of the governor, allow any department, institution, or agency of the state, including any institution of higher education, to make an expenditure in excess of the amount authorized by an item of appropriation for such fiscal year if:

(a) The overexpenditure is for medicaid programs; or

(a.5) The overexpenditure is by the department of health care policy and financing for the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.; except that, to the extent that the overexpenditure allowed pursuant to this paragraph (a.5) is from the general fund, the overexpenditure from the general fund shall not exceed two hundred fifty thousand dollars in any fiscal year; or

(a.6) The overexpenditure is by the department of health care policy and financing for the required state contribution payment pursuant to the federal "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173; or

(b) The overexpenditure is by the department of human services for any purpose other than medicaid programs, but the total of all overexpenditures allowed pursuant to this paragraph (b) shall not exceed one million dollars in any fiscal year; or

(c) The overexpenditure is for any purpose of a department, institution, or agency of the executive branch other than the department of human services, but the total of all overexpenditures allowed pursuant to this paragraph (c) shall not exceed three million dollars in any fiscal year; or

(c.5) The overexpenditure is for the workers' compensation self-insurance program of the department of human services established pursuant to section 8-44-203, C.R.S.; or

(d) The overexpenditure is for any purpose of the judicial department, but overexpenditures allowed pursuant to this paragraph (d) shall be subject to the limitation in section 24-75-110; or

(e) The overexpenditure is by the department of corrections for the purchase of pharmaceuticals and the purchase of medical services from other medical facilities as part of the medical services subprogram for department institutions. The overexpenditure authorized by this paragraph (e) shall only be allowed for the 2001-02 fiscal year.

(1.5) For the purposes of this section, an overexpenditure includes any instance in which the total expenditures charged to a specific line item of appropriation are in excess of the total spending authority appropriated for that line item and any instance in which sufficient cash or cash-exempt reserves have not been earned to cover related expenditures and there is no statutory fund balance to cover such expenditures.

(2) Overexpenditures allowed pursuant to subsection (1) of this section shall be subject to the following requirements:

(a) Except as specifically provided in this section, overexpenditures shall be consistent with all statutory provisions applicable to the program, function, or purpose for which the overexpenditure is made, including the provisions of appropriation acts.

(b) No overexpenditure shall be allowed in excess of the unencumbered balance of the fund from which the overexpenditure is made as of the date of the expenditure.

(3) For any overexpenditure, whether or not allowed by the controller in accordance with subsection (1) of this section, the controller shall restrict, in an amount equal to said overexpenditure, the corresponding item or items of appropriation that are made in the general

appropriation act for the fiscal year following the fiscal year for which the overexpenditure that is allowed occurs. For the purposes of determining such corresponding item or items of appropriation, the controller shall consider, in order of importance, the fund from which the overexpenditure was allowed, the department, institution, or agency that was allowed to make the overexpenditure, and the purpose for which the overexpenditure was allowed. The department, institution, or agency shall not be allowed to expend any amount restricted pursuant to this subsection (3) unless such restriction is released in accordance with subsection (4) of this section.

(4) (a) The department, institution, or agency whose appropriation is restricted may request a supplemental appropriation for the fiscal year in which the overexpenditure occurred for the amount of any overexpenditure allowed pursuant to this section. If a supplemental appropriation is enacted for the overexpenditure or some portion thereof, the restriction on the succeeding fiscal year's appropriation shall be released in the amount of the supplemental appropriation enacted.

(b) If the amount of the restriction imposed pursuant to subsection (3) of this section was based on an estimate of the amount of the overexpenditure and the amount of such restriction exceeds the actual amount of the overexpenditure, the controller shall release that portion of the restricted amount that exceeds the actual amount of the overexpenditure.

(5) The limitation on general fund appropriations and the requirement for a general fund reserve contained in section 24-75-201.1 shall not apply to overexpenditures from the general fund for medicaid programs allowed pursuant to paragraph (a) of subsection (1) of this section or to supplemental general fund appropriations for medicaid programs enacted pursuant to subsection (4) of this section. Overexpenditures for all other purposes allowed pursuant to subsection (1) of this section and supplemental general fund appropriations for all other purposes enacted pursuant to subsection (4) of this section shall be considered appropriations for the fiscal year in which the overexpenditure was allowed and shall accordingly be subject to the limitations and requirements of section 24-75-201.1.

(6) The controller may allow overexpenditures pursuant to this section only for the fiscal years beginning July 1, 1998, July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, July 1, 2009, July 1, 2010, July 1, 2011, July 1, 2012, and July 1, 2013, and this section is repealed, effective September 1, 2014.

24-75-110. Limitation on judicial department - repeal.

(1) The total amount of moneys transferred between items of appropriation made to the judicial department pursuant to section 24-75-108 and overexpenditures by the judicial department allowed pursuant to section 24-75-109 shall not exceed one million dollars in any fiscal year.

(2) This section is repealed, effective September 1, 2014.

Appendix A: Number Pages

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Sue Birch, Executive Director

(1) EXECUTIVE DIRECTOR'S OFFICE

Primary functions: Administration of Medicaid, the Colorado Indigent Care Program, Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan

(A) General Administration

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Personal Services	20,609,604	22,338,943	24,611,433	28,570,031 *	
FTE	293.4	315.9	358.1	395.1	
General Fund	7,727,247	8,062,731	8,410,879	10,274,269	
General Fund Exempt	0	0	0	0	
Cash Funds	1,371,016	1,922,374	2,599,615	2,693,382	
Reappropriated Funds	448,289	1,176,645	1,736,842	1,768,913	
Federal Funds	11,063,052	11,177,193	11,864,097	13,833,467	
Health, Life, and Dental	2,024,577	2,216,793	2,322,539	2,620,696	
General Fund	627,749	796,479	748,152	957,604	
Cash Funds	255,164	174,652	227,912	171,776	
Reappropriated Funds	0	111,821	72,376	135,487	
Federal Funds	1,141,664	1,133,841	1,274,099	1,355,829	
Short-term Disability	32,188	33,497	42,151	64,787	
General Fund	12,334	12,334	13,671	21,323	
Cash Funds	2,503	2,503	3,764	5,049	
Reappropriated Funds	0	1,309	802	1,905	
Federal Funds	17,351	17,351	23,914	36,510	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	532,854	730,633	850,598	1,242,758	
General Fund	190,728	283,141	273,870	409,422	
Cash Funds	53,148	53,468	76,148	96,742	
Reappropriated Funds	0	37,574	16,232	36,619	
Federal Funds	288,978	356,450	484,348	699,975	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	427,325	627,713	767,027	1,165,084	
General Fund	151,785	242,160	246,370	383,833	
Cash Funds	42,482	45,949	68,744	90,695	
Reappropriated Funds	0	33,280	14,654	34,330	
Federal Funds	233,058	306,324	437,259	656,226	
Salary Survey	0	0	669,740	498,753	
General Fund	0	0	199,437	163,365	
Cash Funds	0	0	53,484	38,938	
Reappropriated Funds	0	0	10,800	14,888	
Federal Funds	0	0	406,019	281,562	
Merit Pay	0	0	372,361	412,618	
General Fund	0	0	119,442	147,216	
Cash Funds	0	0	28,027	29,990	
Reappropriated Funds	0	0	9,889	14,179	
Federal Funds	0	0	215,003	221,233	
Worker's Compensation	29,652	30,844	47,285	54,080	
General Fund	14,826	15,422	23,643	27,040	
Federal Funds	14,826	15,422	23,642	27,040	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Operating Expenses	1,503,581	1,503,436	1,764,066	2,253,167 *	
General Fund	677,693	663,213	733,525	1,038,566	
Cash Funds	71,657	43,601	131,410	63,057	
Reappropriated Funds	0	64,796	23,910	23,910	
Federal Funds	754,231	731,826	875,221	1,127,634	
Legal and Third Party Recovery Legal Services	903,975	896,802	1,262,869	1,300,844	
General Fund	334,195	284,349	420,907	420,907	
Cash Funds	123,284	162,313	210,528	229,516	
Reappropriated Funds	0	0	0	0	
Federal Funds	446,496	450,140	631,434	650,421	
Administrative Law Judge Services	449,127	510,597	550,139	373,498	
General Fund	199,865	211,949	224,892	145,128	
Cash Funds	24,698	43,350	50,178	41,621	
Federal Funds	224,564	255,298	275,069	186,749	
Purchase of Services from Computer Center	835,844	1,001,906	882,219	0 *	
General Fund	414,547	496,907	433,541	0	
Reappropriated Funds	3,375	4,046	4,189	0	
Federal Funds	417,922	500,953	444,489	0	
Multiuse Network Payments	227,900	245,162	139,002	0 *	
General Fund	113,950	122,581	69,500	0	
Federal Funds	113,950	122,581	69,502	0	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
COFRS Modernization	0	569,048	504,639	504,639	
General Fund	0	329,397	329,397	329,397	
Cash Funds	0	173,190	173,190	173,190	
Reappropriated Funds	0	2,052	2,052	2,052	
Federal Funds	0	64,409	0	0	
Information Technology Security	0	0	11,374	0 *	
General Fund	0	0	5,607	0	
Reappropriated Funds	0	0	44	0	
Federal Funds	0	0	5,723	0	
Management and Administration of OIT	631,234	0	72,129	0 *	
General Fund	315,617	0	36,065	0	
Federal Funds	315,617	0	36,064	0	
Payment to Risk Management and Property Funds	77,888	123,841	263,208	164,260	
General Fund	38,944	61,921	131,604	82,130	
Federal Funds	38,944	61,920	131,604	82,130	
Vehicle Lease Payments	0	0	0	3,291	
General Fund	0	0	0	3,291	
Leased Space	628,141	659,770	866,780	894,859	
General Fund	197,846	216,966	289,521	302,118	
Cash Funds	116,224	99,625	143,871	145,314	
Federal Funds	314,071	343,179	433,388	447,427	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Capitol Complex Leased Space	397,925	394,599	496,658	442,846	
General Fund	198,962	197,300	248,329	221,423	
Federal Funds	198,963	197,299	248,329	221,423	
General Professional Services and Special Projects	3,971,819	3,350,149	8,492,552	4,585,552 *	
General Fund	1,094,416	1,353,401	2,507,418	1,509,918	
Cash Funds	449,206	354,610	568,500	562,500	
Federal Funds	2,428,197	1,642,138	5,416,634	2,513,134	
Payments to OIT	0	0	0	1,463,483 *	
General Fund	0	0	0	720,791	
Reappropriated Funds	0	0	0	6,061	
Federal Funds	0	0	0	736,631	
SUBTOTAL - (A) General Administration	33,283,634	35,233,733	44,988,769	46,615,246	3.6%
FTE	293.4	315.9	358.1	395.1	10.3%
General Fund	12,310,704	13,350,251	15,465,770	17,157,741	10.9%
General Fund Exempt	0	0	0	0	0.0%
Cash Funds	2,509,382	3,075,635	4,335,371	4,341,770	0.1%
Reappropriated Funds	451,664	1,431,523	1,891,790	2,038,344	7.7%
Federal Funds	18,011,884	17,376,324	23,295,838	23,077,391	(0.9%)
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,671,998	4,672,189	5,297,765	5,297,765	
General Fund	1,438,076	1,383,261	1,651,255	1,651,255	
Federal Funds	3,233,922	3,288,928	0	3,646,510	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Nurse Home Visitor Program, Transfer from the Department of Human Services	1,001,532	964,536	3,010,000	3,010,000	
Reappropriated Funds	500,766	481,337	1,505,000	1,505,000	
Federal Funds	500,766	483,199	1,505,000	1,505,000	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	0	5,887	5,887	5,887	
General Fund	0	2,943	2,944	2,944	
Federal Funds	0	2,944	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,041	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,020	162,020	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	0	4,818	4,160	10,000	
General Fund	0	2,409	2,080	5,000	
Federal Funds	0	2,409	2,080	5,000	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Public School Health Services Administration, Transfer to the Department of Education	139,649	145,640	149,999	149,999	
Reappropriated Funds	0	0	149,999	149,999	
Federal Funds	139,649	145,640	0	0	
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	0	0	272,099 *	
General Fund	0	0	0	136,049	
Federal Funds	0	0	0	136,050	
SUBTOTAL - (B) Transfers to Other Departments	6,137,220	6,117,111	8,791,852	9,069,791	3.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,585,445	1,535,982	1,803,648	1,942,617	7.7%
Reappropriated Funds	515,418	495,989	1,669,651	1,669,651	0.0%
Federal Funds	4,036,357	4,085,140	5,318,553	5,457,523	2.6%

(C) Information Technology Contracts and Projects

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Medicaid Management Information System Maintenance and Projects	29,272,031	28,115,228	35,742,967	29,887,830	
General Fund	6,054,212	6,273,361	6,829,904	6,135,664	
Cash Funds	1,269,332	1,254,472	2,023,994	1,696,376	
Reappropriated Funds	92,163	100,328	293,350	293,350	
Federal Funds	21,856,324	20,487,067	26,595,719	21,762,440	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
MMIS Reprocurement Contracts	0	0	12,625,032	30,177,141	
General Fund	0	0	1,165,817	2,736,240	
Cash Funds	0	0	232,837	552,209	
Federal Funds	0	0	11,226,378	26,888,692	
MMIS Reprocurement Contracted Staff	0	0	2,999,371	3,000,435	
General Fund	0	0	273,255	273,730	
Cash Funds	0	0	54,997	55,049	
Federal Funds	0	0	2,671,119	2,671,656	
Fraud Detection Software Contract	208,931	144,054	250,000	250,000	
General Fund	54,565	36,419	62,500	62,500	
Federal Funds	154,366	107,635	187,500	187,500	
Centralized Eligibility Vendor Contract Project	2,556,603	4,695,409	6,745,159	8,342,477 *	
Cash Funds	1,263,293	2,335,093	3,357,390	3,053,888	
Federal Funds	1,293,310	2,360,316	3,387,769	5,288,589	
CBMS Modernization Project	0	0	1,907,560	1,150,000	
Cash Funds	0	0	378,780	0	
Reappropriated Funds	0	0	1,150,000	1,150,000	
Federal Funds	0	0	378,780	0	
Health Information Exchange Maintenance and Projects	0	0	0	8,228,926 *	
General Fund	0	0	0	1,302,893	
Federal Funds	0	0	0	6,926,033	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
SUBTOTAL - (C) Information Technology Contracts and Projects	32,037,565	32,954,691	60,270,089	81,036,809	34.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	6,108,777	6,309,780	8,331,476	10,511,027	26.2%
Cash Funds	2,532,625	3,589,565	6,047,998	5,357,522	(11.4%)
Reappropriated Funds	92,163	100,328	1,443,350	1,443,350	0.0%
Federal Funds	23,304,000	22,955,018	44,447,265	63,724,910	43.4%

(D) Eligibility Determinations and Client Services

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Medical Identification Cards	115,591	117,011	140,257	158,247	
General Fund	52,867	53,532	59,400	60,370	
Cash Funds	4,132	4,177	9,932	17,957	
Reappropriated Funds	1,593	1,593	1,593	1,593	
Federal Funds	56,999	57,709	69,332	78,327	
Contracts for Special Eligibility Determinations	3,509,989	3,800,160	9,865,097	11,402,297	
General Fund	828,091	826,993	969,756	969,756	
Cash Funds	661,117	827,925	3,574,868	4,343,468	
Federal Funds	2,020,781	2,145,242	5,320,473	6,089,073	
County Administration	30,602,852	25,338,161	32,591,259	41,718,342 *	
General Fund	10,157,979	9,894,404	10,731,704	10,572,620	
Cash Funds	5,299,296	0	5,604,460	5,707,810	
Federal Funds	15,145,577	15,443,757	16,255,095	25,437,912	
Hospital Provider Fee County Administration	1,939,544	2,029,164	3,630,334	9,723,802 *	
Cash Funds	969,772	1,014,582	1,755,168	3,208,371	
Federal Funds	969,772	1,014,582	1,875,166	6,515,431	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Administrative Case Management	1,391,668	1,866,788	869,744	869,744	
General Fund	695,834	933,394	434,872	434,872	
Federal Funds	695,834	933,394	434,872	434,872	
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	0	0	0	986,436 *	
General Fund	0	0	0	314,109	
Federal Funds	0	0	0	672,327	
Medical Assistance Sites	0	0	0	1,152,000 *	
Cash Funds	0	0	0	288,000	
Federal Funds	0	0	0	864,000	
Customer Outreach	4,694,853	4,917,340	5,523,166	6,247,070 *	
General Fund	2,259,497	2,371,809	2,575,246	2,786,915	
Cash Funds	101,362	86,861	186,338	336,621	
Federal Funds	2,333,994	2,458,670	2,761,582	3,123,534	
SUBTOTAL - (D) Eligibility Determinations and Client Services	42,254,497	38,068,624	52,619,857	72,257,938	37.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	13,994,268	14,080,132	14,770,978	15,138,642	2.5%
Cash Funds	7,035,679	1,933,545	11,130,766	13,902,227	24.9%
Reappropriated Funds	1,593	1,593	1,593	1,593	0.0%
Federal Funds	21,222,957	22,053,354	26,716,520	43,215,476	61.8%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	6,384,617	6,435,636	9,382,809	11,745,087 *	
General Fund	1,806,527	1,799,872	2,279,886	3,137,024	
Cash Funds	57,620	103,638	305,844	461,089	
Federal Funds	4,520,470	4,532,126	6,797,079	8,146,974	
SUBTOTAL - (E) Utilization and Quality Review Contracts	6,384,617	6,435,636	9,382,809	11,745,087	25.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,806,527	1,799,872	2,279,886	3,137,024	37.6%
Cash Funds	57,620	103,638	305,844	461,089	50.8%
Federal Funds	4,520,470	4,532,126	6,797,079	8,146,974	19.9%
(F) Provider Audits and Services					
Professional Audit Contracts	1,841,190	2,207,726	3,051,907	2,463,406	
General Fund	908,175	891,703	1,116,408	969,283	
Cash Funds	12,420	0	365,408	262,420	
Reappropriated Funds	0	212,160	0	0	
Federal Funds	920,595	1,103,863	1,570,091	1,231,703	
SUBTOTAL - (F) Provider Audits and Services	1,841,190	2,207,726	3,051,907	2,463,406	(19.3%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	908,175	891,703	1,116,408	969,283	(13.2%)
Cash Funds	12,420	0	365,408	262,420	(28.2%)
Reappropriated Funds	0	212,160	0	0	0.0%
Federal Funds	920,595	1,103,863	1,570,091	1,231,703	(21.6%)

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	315,578	531,346	700,000	700,000	
Cash Funds	157,789	265,673	350,000	350,000	
Federal Funds	157,789	265,673	350,000	350,000	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	315,578	531,346	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	157,789	265,673	350,000	350,000	0.0%
Federal Funds	157,789	265,673	350,000	350,000	0.0%
(H) Indirect Cost Assessment					
Indirect Cost Assessment	0	0	545,140	663,489	
Cash Funds	0	0	121,193	122,479	
Reappropriated Funds	0	0	29,596	21,941	
Federal Funds	0	0	394,351	519,069	
SUBTOTAL - (H) Indirect Cost Assessment	0	0	545,140	663,489	21.7%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	0	0	121,193	122,479	1.1%
Reappropriated Funds	0	0	29,596	21,941	(25.9%)
Federal Funds	0	0	394,351	519,069	31.6%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
TOTAL - (1) Executive Director's Office	122,254,301	121,548,867	180,350,423	224,551,766	24.5%
FTE	293.4	315.9	358.1	395.1	10.3%
General Fund	36,713,896	37,967,720	43,768,166	48,856,334	11.6%
General Fund Exempt	0	0	0	0	0.0%
Cash Funds	12,305,515	8,968,056	22,656,580	24,797,507	9.4%
Reappropriated Funds	1,060,838	2,241,593	5,035,980	5,174,879	2.8%
Federal Funds	72,174,052	72,371,498	108,889,697	145,723,046	33.8%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,642,032,762	3,937,400,734	4,736,824,877	5,558,328,855 *	
General Fund	833,239,176	847,647,042	1,036,017,966	1,118,842,786	
General Fund Exempt	373,508,751	507,235,957	469,842,084	469,842,084	
Cash Funds	629,762,743	639,607,454	593,882,063	623,619,502	
Reappropriated Funds	6,445,828	2,936,892	2,936,892	2,000,000	
Federal Funds	1,799,076,264	1,939,973,389	2,634,145,872	3,344,024,483	
TOTAL - (2) Medical Services Premiums	3,642,032,762	3,937,400,734	4,736,824,877	5,558,328,855	17.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	833,239,176	847,647,042	1,036,017,966	1,118,842,786	8.0%
General Fund Exempt	373,508,751	507,235,957	469,842,084	469,842,084	0.0%
Cash Funds	629,762,743	639,607,454	593,882,063	623,619,502	5.0%
Reappropriated Funds	6,445,828	2,936,892	2,936,892	2,000,000	(31.9%)
Federal Funds	1,799,076,264	1,939,973,389	2,634,145,872	3,344,024,483	26.9%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request		Request vs. Appropriation

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

The funding in this section supports the provision of behavioral health services to Medicaid-eligible clients. The majority of the funding is paid to five regional managed care organizations (called behavioral health organizations or BHOs) that are responsible for providing or arranging for medically necessary mental health services. Beginning January 1, 2014, payments to BHOs will also cover substance use disorder treatment services. This section also includes funding for fee-for-service payments for certain behavioral health services that are not covered through the managed care program. Behavioral health program administration expenses are supported through the Executive Director's Office section, and pharmaceutical expenses are supported through the Medical Services Premiums section. Funding sources include federal Medicaid funds, General Fund, the Hospital Provider Fee Cash Fund, and the Breast and Cervical Cancer Prevention and Treatment Fund.

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request		Request vs. Appropriation
Behavioral Health Capitation Payments	273,376,614	301,303,046	380,837,424	483,057,318	*	
General Fund	131,782,602	136,833,502	151,060,588	162,112,253		
Cash Funds	5,791,948	13,513,748	2,033,883	3,606,845		
Reappropriated Funds	25,046	0	0	0		
Federal Funds	135,777,018	150,955,796	227,742,953	317,338,220		
Mental Health Fee for Service Payments	3,894,039	4,569,198	4,801,046	6,334,887	*	
General Fund	1,917,565	2,253,518	2,400,523	3,167,443		
Federal Funds	1,976,474	2,315,680	2,400,523	3,167,444		
TOTAL - (3) Behavioral Health Community Programs	277,270,653	305,872,244	385,638,470	489,392,205		26.9%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	133,700,167	139,087,020	153,461,111	165,279,696		7.7%
Cash Funds	5,791,948	13,513,748	2,033,883	3,606,845		77.3%
Reappropriated Funds	25,046	0	0	0		0.0%
Federal Funds	137,753,492	153,271,476	230,143,476	320,505,664		39.3%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Program Costs					
Adult Comprehensive Services	0	0	0	347,249,465 *	
General Fund	0	0	0	157,994,385	
Cash Funds	0	0	0	31,260,696	
Federal Funds	0	0	0	157,994,384	
Adult Supported Living Services	0	0	0	58,168,084 *	
General Fund	0	0	0	33,103,805	
Federal Funds	0	0	0	25,064,279	
Children's Extensive Support Services	0	0	0	19,066,967 *	
General Fund	0	0	0	9,533,483	
Federal Funds	0	0	0	9,533,484	
Case Management	0	0	0	29,668,921 *	
General Fund	0	0	0	16,001,021	
Federal Funds	0	0	0	13,667,900	
Family Support Services	0	0	0	6,762,095 *	
General Fund	0	0	0	6,762,095	
Preventive Dental Hygiene	0	0	0	65,203 *	
General Fund	0	0	0	61,506	
Cash Funds	0	0	0	3,697	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Eligibility Determination and Waiting List Management	0	0	0	3,032,242 *	
General Fund	0	0	0	3,012,587	
Federal Funds	0	0	0	19,655	
SUBTOTAL -	0	0	0	464,012,977	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	226,468,882	0.0%
Cash Funds	0	0	0	31,264,393	0.0%
Federal Funds	0	0	0	206,279,702	0.0%
(ii) Administrative Costs					
Community and Contract Management System	0	0	0	137,480	
General Fund	0	0	0	89,362	
Federal Funds	0	0	0	48,118	
Support Level Administration	0	0	0	57,368	
General Fund	0	0	0	28,684	
Federal Funds	0	0	0	28,684	
SUBTOTAL -	0	0	0	194,848	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	118,046	0.0%
Federal Funds	0	0	0	76,802	0.0%
TOTAL - Office of Community Living	0	0	0	464,207,825	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	226,586,928	0.0%
Cash Funds	0	0	0	31,264,393	0.0%
Federal Funds	0	0	0	206,356,504	0.0%

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	288,633,447	299,175,424	311,296,186	311,296,186	
Cash Funds	144,316,724	149,587,712	155,648,093	155,648,093	
Federal Funds	144,316,723	149,587,712	155,648,093	155,648,093	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	
General Fund	3,059,880	3,059,880	3,059,880	3,059,880	
Federal Funds	3,059,880	3,059,880	3,059,880	3,059,880	
Health Care Services Fund Programs	23,510,000	0	0	0	
Cash Funds	11,755,000	0	0	0	
Federal Funds	11,755,000	0	0	0	
Pediatric Specialty Hospital	11,799,938	11,799,938	11,799,938	11,799,938	
General Fund	5,899,969	5,899,969	5,899,969	5,899,969	
Federal Funds	5,899,969	5,899,969	5,899,969	5,899,969	
General Fund Appropriation to Pediatric Specialty Hospital	0	0	0	0	
General Fund Exempt	0	0	0	0	
Appropriation from Tobacco Tax Fund to the General Fund	445,214	429,812	438,300	438,300	
Cash Funds	445,214	429,812	438,300	438,300	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Primary Care Fund	0	27,258,545	27,759,000	27,759,000	
Cash Funds	0	27,258,545	27,759,000	27,759,000	
Primary Care Grant Program Special Distribution	2,135,830	0	0	0	
Cash Funds	2,135,830	0	0	0	
Children's Basic Health Plan Administration	4,759,499	4,245,129	4,319,079	5,127,772 *	
General Fund	272,494	0	0	0	
Cash Funds	1,941,946	1,883,715	2,019,582	2,404,035	
Federal Funds	2,545,059	2,361,414	2,299,497	2,723,737	
Children's Basic Health Plan Medical and Dental Costs	182,454,122	191,570,458	196,282,277	169,414,990 *	
General Fund	29,413,207	29,398,182	22,825,770	17,246,457	
General Fund Exempt	446,100	441,600	438,300	435,000	
Cash Funds	35,148,096	37,761,085	46,413,329	42,869,374	
Federal Funds	117,446,719	123,969,591	126,604,878	108,864,159	
Comprehensive Primary and Preventive Care Grants	0	0	0	0	
Cash Funds	0	0	0	0	
TOTAL - (4) Indigent Care Program	519,857,810	540,599,066	558,014,540	531,955,946	(4.7%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	38,645,550	38,358,031	31,785,619	26,206,306	(17.6%)
General Fund Exempt	446,100	441,600	438,300	435,000	(0.8%)
Cash Funds	195,742,810	216,920,869	232,278,304	229,118,802	(1.4%)
Federal Funds	285,023,350	284,878,566	293,512,317	276,195,838	(5.9%)

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Primary functions: This division provides funding for the following three state-only Medical programs: (1) Old Age Pension Medical Program, (2) the Medicare Modernization Act State Contribution Payment, and (3) the Colorado Cares RX Program. This division also contains funding for programs that eligible for Medicaid funding but are not part of the Medical Services Premiums or Mental Health Programs.					
Old Age Pension State Medical	9,148,285	9,675,508	8,254,361	4,504,973	
General Fund	0	0	0	0	
Cash Funds	9,148,285	9,675,508	8,254,361	4,504,973	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical	0	0	0	0	
Cash Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	1,741,077	1,741,077	3,371,077	3,371,077	
General Fund	870,538	870,538	1,685,538	1,685,538	
Federal Funds	870,539	870,539	1,685,539	1,685,539	
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	1,831,714	1,831,714	1,831,714	
General Fund	915,857	915,857	915,857	915,857	
Federal Funds	915,857	915,857	915,857	915,857	
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	633,314	633,314	
General Fund	316,657	316,657	316,657	316,657	
Federal Funds	316,657	316,657	316,657	316,657	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Medicare Modernization Act State Contribution Payment	93,582,494	101,817,855	107,173,869	100,807,053 *	
General Fund	62,939,212	52,136,848	82,492,862	96,444,252	
Reappropriated Funds	0	0	0	0	
Federal Funds	30,643,282	49,681,007	24,681,007	4,362,801	
Public School Health Services Contract Administration	824,064	811,941	2,491,722	2,491,722	
Reappropriated Funds	0	0	2,491,722	2,491,722	
Federal Funds	824,064	811,941	0	0	
Public School Health Services	46,873,870	49,784,091	54,353,956	54,353,956	
Cash Funds	22,390,960	24,887,311	27,176,978	27,176,978	
Federal Funds	24,482,910	24,896,780	27,176,978	27,176,978	
TOTAL - (5) Other Medical Services	154,634,818	166,295,500	178,110,013	167,993,809	(5.7%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	65,042,264	54,239,900	85,410,914	99,362,304	16.3%
Cash Funds	31,539,245	34,562,819	35,431,339	31,681,951	(10.6%)
Reappropriated Funds	0	0	2,491,722	2,491,722	0.0%
Federal Funds	58,053,309	77,492,781	54,776,038	34,457,832	(37.1%)

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

Primary functions: This division reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this division and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division.

(A) Executive Director's Office - Medicaid Funding

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Executive Director's Office - Medicaid Funding	11,608,558	4,169,886	17,535,090	17,289,499	
General Fund	5,804,279	2,084,943	8,767,545	8,644,750	
Federal Funds	5,804,279	2,084,943	8,767,545	8,644,749	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	11,608,558	4,169,886	17,535,090	17,289,499	(1.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	5,804,279	2,084,943	8,767,545	8,644,750	(1.4%)
Federal Funds	5,804,279	2,084,943	8,767,545	8,644,749	(1.4%)

(B) Office of Information Technology Services - Medicaid Funding

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Colorado Benefits Management System	9,447,008	10,006,971	8,405,843	8,408,583	
General Fund	4,147,409	4,249,653	4,173,836	4,175,198	
Cash Funds	550,920	8,092	13,660	13,671	
Reappropriated Funds	25,562	37,834	18,809	18,809	
Federal Funds	4,723,117	5,711,392	4,199,538	4,200,905	
CBMS SAS-70 Audit	50,850	46,554	55,204	55,204	
General Fund	25,294	23,164	27,416	27,416	
Cash Funds	53	25	89	89	
Reappropriated Funds	112	155	119	119	
Federal Funds	25,391	23,210	27,580	27,580	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Colorado Benefits Management System, HCPF Only	812,400	0	611,520	611,520	
General Fund	107,460	0	0	0	
Cash Funds	298,740	0	305,760	305,760	
Federal Funds	406,200	0	305,760	305,760	
CBMS Modernization	0	0	12,669,689	564,113	
General Fund	0	0	1,886,059	282,058	
Cash Funds	0	0	48,785	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	10,734,845	282,055	
Other Office of Information Technology Services line items	555,484	500,820	572,374	591,113 *	
General Fund	277,742	250,410	286,187	295,557	
Federal Funds	277,742	250,410	286,187	295,556	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	10,865,742	10,554,345	22,314,630	10,230,533	(54.2%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,557,905	4,523,227	6,373,498	4,780,229	(25.0%)
Cash Funds	849,713	8,117	368,294	319,520	(13.2%)
Reappropriated Funds	25,674	37,989	18,928	18,928	0.0%
Federal Funds	5,432,450	5,985,012	15,553,910	5,111,856	(67.1%)

(C) Office of Operations - Medicaid Funding

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Office of Operations - Medicaid Funding	4,082,810	4,069,739	4,786,843	4,974,114 *	
General Fund	2,041,406	2,034,870	2,393,422	2,487,057	
Federal Funds	2,041,404	2,034,869	2,393,421	2,487,057	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,082,810	4,069,739	4,786,843	4,974,114	3.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,041,406	2,034,870	2,393,422	2,487,057	3.9%
Federal Funds	2,041,404	2,034,869	2,393,421	2,487,057	3.9%
(D) Division of Child Welfare - Medicaid Funding					
Administration	130,938	132,899	133,070	137,306	
General Fund	65,470	66,449	66,535	68,653	
Federal Funds	65,468	66,450	66,535	68,653	
Child Welfare Services	10,935,479	8,428,490	14,579,137	14,797,824 *	
General Fund	5,467,740	4,214,245	7,289,569	7,398,913	
Federal Funds	5,467,739	4,214,245	7,289,568	7,398,911	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	11,066,417	8,561,389	14,712,207	14,935,130	1.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	5,533,210	4,280,694	7,356,104	7,467,566	1.5%
Federal Funds	5,533,207	4,280,695	7,356,103	7,467,564	1.5%
(D.5) Office of Early Childhood - Medicaid Funding					
Division of Community and Family Support, Early Intervention Services	4,582,485	4,994,334 *			
General Fund	2,291,243	2,497,167			
Federal Funds	2,291,242	2,497,167			

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	4,582,485	4,994,334	9.0%		
FTE	0.0	0.0	0.0%		
General Fund	2,291,243	2,497,167	9.0%		
Federal Funds	2,291,242	2,497,167	9.0%		
(E) Office of Self Sufficiency - Medicaid Funding					
Systematic Alien Verification for Eligibility	33,211	25,550	33,951	33,951	
General Fund	27	(394)	0	0	
Federal Funds	33,184	25,944	33,951	33,951	
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	33,211	25,550	33,951	33,951	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	27	(394)	0	0	0.0%
Federal Funds	33,184	25,944	33,951	33,951	0.0%
(F) Behavioral Health Services - Medicaid Funding					
Administration	287,245	293,274	388,784	404,350	
General Fund	143,623	146,637	194,392	202,175	
Federal Funds	143,622	146,637	194,392	202,175	
Residential Treatment for Youth (H.B. 99-1116)	201,542	44,226	118,593	120,372 *	
General Fund	100,771	22,113	59,297	60,186	
Federal Funds	100,771	22,113	59,296	60,186	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Mental Health Institutes	4,755,640	5,217,448	4,775,751	4,775,751	
General Fund	2,377,820	2,606,566	2,387,876	2,387,876	
Federal Funds	2,377,820	2,610,882	2,387,875	2,387,875	
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	1,126,310	1,052,270	1,429,133	1,450,570 *	
General Fund	563,155	526,135	714,567	725,285	
Federal Funds	563,155	526,135	714,566	725,285	
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	6,370,737	6,607,218	6,712,261	6,751,043	0.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	3,185,369	3,301,451	3,356,132	3,375,522	0.6%
Federal Funds	3,185,368	3,305,767	3,356,129	3,375,521	0.6%

(G) Services for People with Disabilities - Medicaid Funding

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Community Services for People with Developmental Disabilities, Administration	2,705,995	2,356,594	2,897,037	0	
General Fund	1,352,998	1,178,297	1,448,519	0	
Federal Funds	1,352,997	1,178,297	1,448,518	0	
Community Services for People with Developmental Disabilities, Program Costs	329,836,283	327,987,037	374,575,651	0	
General Fund	164,927,548	163,993,519	187,287,826	0	
Cash Funds	1	0	1	0	
Federal Funds	164,908,734	163,993,518	187,287,824	0	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Community Services for People with Developmental Disabilities, Early Intervention Services	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Regional Centers	43,301,047	54,035,040	47,499,561	49,430,457 *	
General Fund	22,340,689	23,231,667	21,883,639	22,814,579	
Cash Funds	0	3,785,853	1,866,142	1,866,142	
Reappropriated Funds	0	0	0	0	
Federal Funds	20,960,358	27,017,520	23,749,780	24,749,736	
Regional Center Depreciation and Annual Adjustments	1,187,825	1,187,826	1,187,825	1,187,825	
General Fund	593,913	593,913	593,913	593,913	
Federal Funds	593,912	593,913	593,912	593,912	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	377,031,150	385,566,497	426,160,074	50,618,282	(88.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	189,215,148	188,997,396	211,213,897	23,408,492	(88.9%)
Cash Funds	1	3,785,853	1,866,143	1,866,142	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	187,816,001	192,783,248	213,080,034	25,343,648	(88.1%)

(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
Community Services for the Elderly	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	
Federal Funds	900	900	900	900	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	900	900	900	900	0.0%
Federal Funds	900	900	900	900	0.0%
(I) Division of Youth Corrections - Medicaid Funding					
Division of Youth Corrections - Medicaid Funding	1,501,271	1,503,985	1,365,389	1,389,674 *	
General Fund	750,636	751,992	682,695	694,838	
Federal Funds	750,635	751,993	682,694	694,836	
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,501,271	1,503,985	1,365,389	1,389,674	1.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	750,636	751,992	682,695	694,838	1.8%
Federal Funds	750,635	751,993	682,694	694,836	1.8%
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	500,000	500,000	500,000		
Federal Funds	500,000	500,000	500,000		
SUBTOTAL - (J) Other	500,000	500,000	500,000	0.0%	
FTE	0.0	0.0	0.0	0.0%	
Federal Funds	500,000	500,000	500,000	0.0%	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	Request vs. Appropriation
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	423,061,696	421,060,409	498,704,730	111,718,360	(77.6%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	211,088,880	205,975,079	242,435,436	53,356,521	(78.0%)
Cash Funds	849,714	3,793,970	2,234,437	2,185,662	(2.2%)
Reappropriated Funds	25,674	37,989	18,928	18,928	0.0%
Federal Funds	211,097,428	211,253,371	254,015,929	56,157,249	(77.9%)
TOTAL - Department of Health Care Policy and Financing	5,139,112,040	5,492,776,820	6,537,643,053	7,548,148,766	15.5%
FTE	293.4	315.9	358.1	395.1	10.3%
General Fund	1,318,429,933	1,323,274,792	1,592,879,212	1,738,490,875	9.1%
General Fund Exempt	373,954,851	507,677,557	470,280,384	470,277,084	0.0%
Cash Funds	875,991,975	917,366,916	888,516,606	946,274,662	6.5%
Reappropriated Funds	7,557,386	5,216,474	10,483,522	9,685,529	(7.6%)
Federal Funds	2,563,177,895	2,739,241,081	3,575,483,329	4,383,420,616	22.6%

Appendix B: Recent Legislation Affecting Department Budget

2012 Session Bills

S.B. 12-060: Allows counties to retain all fraud recoveries (rather than 50.0 percent) from cases initiated by a county department, county board, district attorney, or the Department of Health Care Policy and Financing on behalf of the county. Requires the Department of Health Care Policy and Financing and the Attorney General to submit annual reports to the legislature on client and provider fraud respectively. Appropriates for the Department of Health Care Policy and Financing, in FY 2012-13, $5,216 (including $2,608 General Fund and $2,608 Federal Funds) and 0.1 FTE for administration, and reduces appropriations for medical services by $54,156 ($2,608 General Fund, $24,470 cash funds from recoveries and recoupments, and $27,078 federal funds).

S.B. 12-159: Makes changes to the process for evaluating children receiving long-term care services and supports through the Medicaid autism waiver program and program reporting requirements. Requires the Department to annually review available funding to determine if eligibility can be expanded, and to prioritize services for people on wait lists based on objective criteria. Appropriates $6,925 ($3,463 Colorado Autism Treatment Fund and $3,462 federal funds) to the Department of Health Care Policy and Financing for Medical Service Premiums in FY 2012-13.

H.B. 12-1184: Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2011-12 appropriations contained in the FY 2011-12 Long Bill (S.B. 11-209).

H.B. 12-1202: Allows appropriations from the Tobacco Education Programs Fund to the Department of Health Care Policy and Financing to match federal funds for the Colorado QuitLine program operated by the Department of Public Health and Environment. Moves $288,658 cash funds from the Tobacco Education Programs Fund out of the Department of Public Health and Environment and into the Department of Health Care Policy and Financing in FY 2011-12 to match $288,658 federal funds, and then reappropriates the total $577,316 to the Department of Public Health and Environment to operate the QuitLine program.

H.B. 12-1246: Reverses the payday shift for state employees who are paid on a biweekly basis. Appropriates $285,719 to the Department for FY 2012-13, including $157,109 General Fund and $128,610 Federal Funds. For additional information, see the "Recent Legislation" section at the end of the Department of Personnel.

H.B. 12-1281: Creates the Medicaid Payment Reform and Innovation Pilot Program. Requires the Department of Health Care Policy and Financing to review proposals and select projects to pilot by July 1, 2013. Appropriates $213,079, ($106,540 General Fund and $106,539 federal

funds), and 0.8 FTE to the Department of Health Care Policy and Financing in FY 2012-13 to evaluate payment projects and for reporting requirements.

H.B. 12-1335: General Appropriations Act for FY 2012-13.

H.B. 12-1339: Establishes design criteria, details reporting requirements, and appropriates funding for the Colorado Benefits Management System (CBMS) improvement and modernization project. Appropriations for the Department of Health Care Policy and Financing include $3.7 million in FY 2011-12 and $8.6 million in FY 2012-13. For more detail about the bill and the appropriations see the description in the Department of Human Services section of this report.

H.B. 12-1340: For FY 2012-13, continues a 1.5 percent reduction in the General Fund portion of per diem rates paid to class I nursing facilities that was in place in FY 2010-11 and FY 2011-12. Allows the Department of Health Care Policy and Financing to increase the supplemental Medicaid payments made to nursing providers to offset this reduction. Reduces appropriations for Medical Service Premiums by $9,024,676, including $4,512,338 General Fund and $4,512,338 federal funds.

2013 Session Bills

S.B. 13-089: Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2012-13 appropriations contained in the FY 2012-13 Long Bill (H.B. 12-1335).

SB 13-166: Extends deadlines for development and implementation of recommendations from the Medical Clean Claims Task Force for standardizing claim submissions and edits to facilitate prompt payment. Provides $100,000 General Fund in FY 2013-14 to support the work of the Task Force.

S.B. 13-167: Makes changes to the provider fee for intermediate care facilities for individuals with intellectual disabilities, including transferring responsibility for administering the fee from the Department of Human Services to the Department of Health Care Policy and Financing. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

S.B. 13-177: Reduces the juvenile detention bed cap from 422 to 382. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

S.B. 13-200: Expands Medicaid eligibility for adults to 133 percent of the federal poverty level (FPL). The newly eligible populations affected by this change include adults without dependent children with income from 11 percent through 133 percent of the FPL and parents with income from 101 percent through 133 percent of the FPL. Pursuant to the provisions of the federal Affordable Care Act, Colorado is eligible for an enhanced federal match rate for certain populations as a result of the eligibility expansion authorized in S.B. 13-200. For Colorado the enhanced federal match rate applies to adults without dependent children with income from 0

percent through 133 percent of the federal poverty level and to parents with income from 61 percent through 133 percent of the FPL. The enhanced federal match rate is 100 percent from 2014 through 2016 and then it reduces in increments until it reaches 90 percent in 2020. Senate Bill 13-200 authorizes the Hospital Provider Fee to pay the state share of costs for the newly eligible populations when the enhanced federal match rate is reduced. Makes the following appropriations for FY 2013-14:

Department	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Health Care Policy and Financing	$315,141,256	($123,209)	($154,578,421)	$0	$469,842,886	19.0
Corrections	(2,471,751)	(2,471,751)	0	0	0	0.4
Human Services	(651,875)	(651,875)	0	0	0	0.0
Law	24,910	0	0	24,910	0	0.0
Personnel	12,122	0	0	12,122	0	0.0
Total	$312,054,662	($3,246,835)	($154,578,421)	$37,032	$469,842,886	19.4

S.B. 13-230: General appropriations act for FY 2013-14.

S.B. 13-232: Eliminates the repeal of a transfer of $2.0 million from the Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing for disease management programs. Refinances $2.0 million General Fund appropriations with transfers from the fund.

S.B. 13-242: Adds a dental benefit for adults on Medicaid. Requires the Department of Health Care Policy and Financing to design the benefit with input from stakeholders and implement it by April 1, 2014. Transfers money from the Unclaimed Property Trust Fund to the newly created Adult Dental Fund to pay for the benefit. Appropriates $33.9 million total funds and 1.3 FTE to the Department of Health Care Policy and Financing in FY 2013-14, including a reduction of $0.7 million General Fund, an increase of $11.2 million cash funds, and an increase of $23.4 million federal funds.

S.B. 13-264: Requires the Commission on Family Medicine to support the development of rural family medicine residency programs and appropriates $1,000,000 to support this purpose, including $500,000 General Fund and $500,000 federal funds, to the Department of Health Care Policy and Financing in FY 2013-14.

S.B. 13-276: Renames the Coordinated Care for People with Disabilities Fund the Disability Investigational and Pilot Support Fund. Repurposes the fund to support grants and loans to projects that study or pilot new and innovative initiatives to improve the quality of life and independence of people with disabilities. Transfers administration of the fund from the Department of Health Care Policy and Financing to the Department of Personnel.

H.B. 13-1117: Makes changes to the Early Childhood Leadership Council, including transferring administration from the Governor's Office to the Department of Human Services and

makes corresponding adjustments to appropriations. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

H.B. 13-1152: Adjusts the formula for calculating the per diem rate paid to nursing facilities and reduces appropriations for the Department of Health Care Policy and Financing for FY 2013-14 by $9.7 million total funds, including $4.8 million General Fund and $4.8 million federal funds.

H.B. 13-1314: Transfers the powers, duties, and functions of the Department of Human Services relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the Department of Health Care Policy and Financing. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

Appendix C: Update on Long Bill Footnotes & Requests for Information

LONG BILL FOOTNOTES

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

Aid Category	Caseload	Estimated Costs	Average Cost Per Client
Adults 65 years of age and older	42,119	$922,386,299	$21,899.53
Adults with disabilities 60 through 64 years of age	9,746	170,480,294	17,492.33
Individuals with disabilities through 59 years of age	63,956	965,943,502	15,103.25
Medicaid buy-in for people with disabilities	1,928	21,773,806	11,293.47
Categorically eligible low-income adults	73,217	272,705,455	3,724.62
Expansion adults through 60 percent Federal Poverty Level (FPL)	30,845	84,541,559	2,740.85
Expansion adults from 61 through 100 percent FPL	45,195	116,958,469	2,587.86
Adults without dependent children through 100 percent FPL	18,938	169,395,591	8,944.75
Breast and Cervical Cancer Treatment and Prevention Program	666	11,470,958	17,223.66
Eligible children	403,649	603,660,474	1,495.51
Foster care children	17,979	73,624,158	4,095.01
Pregnant adults through 185 percent of FPL	8,370	74,311,402	8,878.83
Non-citizens qualifying for emergency services	2,537	46,695,375	18,405.74
Eligible for Medicare assistance only	23,291	31,209,657	1,339.99
Subtotal Medical Services	**742,436**	**$3,565,156,999**	**$4,801.98**
Supplemental payments		872,525,795	
Total		**$4,437,682,794**	

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

9 **Department of Health Care Policy and Financing, Medical Service Premiums** -- This appropriation includes $35 million from an intergovernmental transfer from Denver Health, the purpose of which is to finance an amendment to the state plan to provide nursing home services for chronically acute, long-stay patients.

Comment: The Department has been working with Denver Health and is in the process of developing the state plan amendment. The JBC may want to request a progress update from the Department at the hearing.

10 **Department of Health Care Policy and Financing, Medical Service Premiums** -- This appropriation assumes that the Department will allow primary care providers to receive

reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older.

10a **Department of Health Care Policy and Financing, Medical Services Premiums** -- The appropriation in this line item includes $1,146,806 total funds comprised of $573,403 General Fund and $573,403 federal funds for treatment of women with breast and cervical cancer regardless of the clinic responsible for the diagnoses.

Comment: The Department implemented the change in policy necessary to allow treatment of women regardless of the clinic responsible for the diagnosis as of December 1. The Long Bill amendment that added the funding assumed a 50 percent federal match rate, but the actual federal match rate is 65 percent. Also, the Department believes a portion of the funding should have come from the Breast and Cervical Cancer Prevention Treatment Fund to be consistent with statutes governing the financing of the program. The Department's request assumes a supplemental change will be made to the FY 2013-14 appropriations. For FY 2014-15 the statutory authority for the Breast and Cervical Cancer Program expires. *See the issue brief "Breast and Cervical Cancer Prevention" for more detail.*

11 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs** -- This appropriation assumes the following: (1) A total children's caseload of 72,649 at an average medical per capita cost of $2,231.06 per year; and (2) a total adult prenatal caseload of 1,398 at an average medical per capita cost of $13,517.34 per year.

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

12 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs** -- This appropriation assumes an average cost of $183.07 per child per year for the dental benefit.

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

13 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding** -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations to the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item

transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (6) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

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

REQUESTS FOR INFORMATION

Department of Health Care Policy and Financing

Monthly caseload and expenditure reports

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 and mental health capitation line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report.

   Comment: The Department is submitting the monthly information as requested.

Accountable Care Collaborative

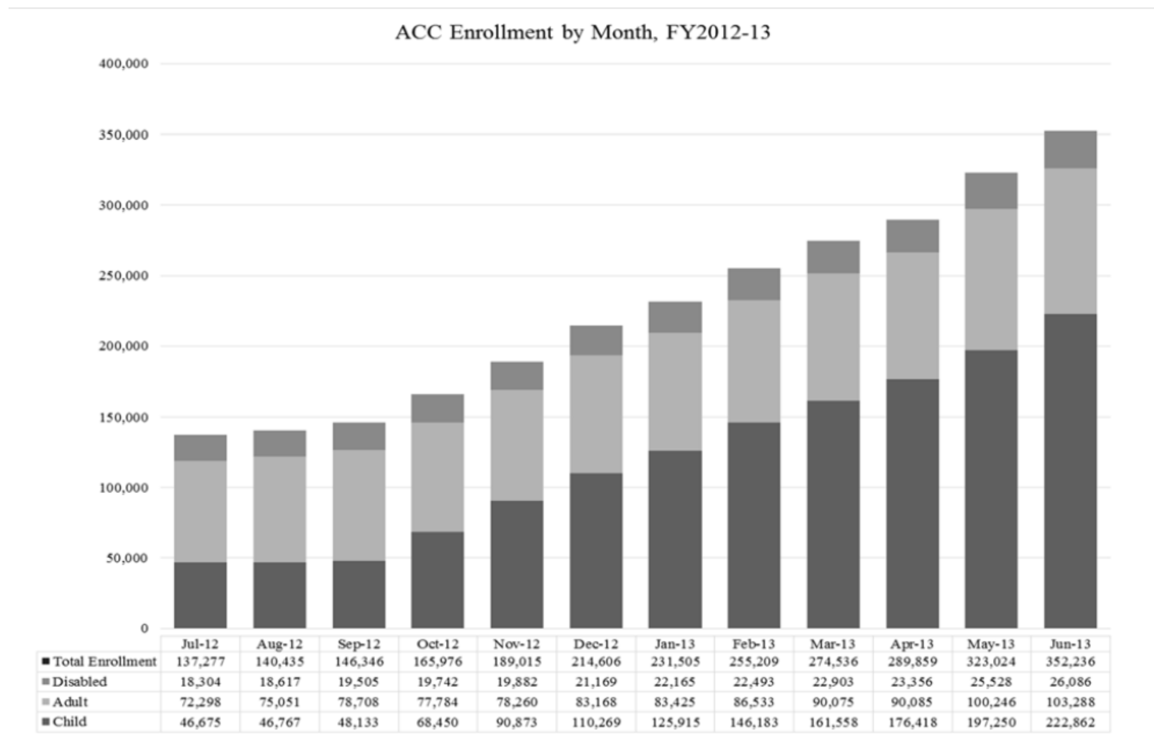
2. **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2013, to the Joint Budget Committee, providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and performance results with an emphasis on the fiscal impact.

   Comment: The Department submitted the report as requested.

   Background
   The Accountable Care Collaborative (ACC) pays for care coordination with a component of the compensation tied to improved health outcomes. Within the ACC there are seven Regional Care Collaborative Organizations (RCCOs) that are paid a per member per month fee to manage care, develop a network of providers, provide support services to those providers, and perform state reporting functions. The RCCOs create formal contracts with providers to be Primary Care Medical Providers (PCMPs) and informal relationships with specialists and ancillary providers to assist with referrals. The support given to providers includes analytical tools to identify effective interventions, client

materials, administrative assistance, and ideas for clinical practice redesign to improve outcomes. The PCMPs function as medical homes for clients and also receive a per member per month fee to coordinate care that includes a payment component based on achieving improved health outcomes. Part of the care coordination provided by RCCOs and PCMPs includes looking beyond health needs to connect clients with wraparound services such as housing assistance, long-term services and supports, behavioral health care, ,child care, transportation, food assistance, and other community services. To assist with care coordination and the performance funding the Statewide Data Analytics Contractor (SDAC) collects information and disseminates it to ACC providers and the Department. The client level data helps identify high needs clients and potentially effective interventions. At a population level the data helps identify high performing PCMPs and RCCOs and best practices. Access to the information is monitored based on role-based security protocols and protected under federal health privacy laws.

Enrollment
At the end of FY 2012-13 47 percent of Medicaid clients were enrolled in the ACC, compared to 20 percent the prior fiscal year. The chart below shows enrollment by month.



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Total Enrollment	137,277	140,435	146,346	165,976	189,015	214,606	231,505	255,209	274,536	289,859	323,024	352,236
Disabled	18,304	18,617	19,505	19,742	19,882	21,169	22,165	22,493	22,903	23,356	25,528	26,086
Adult	72,298	75,051	78,708	77,784	78,260	83,168	83,425	86,533	90,075	90,085	100,246	103,288
Child	46,675	46,767	48,133	68,450	90,873	110,269	125,915	146,183	161,558	176,418	197,250	222,862

Administrative fees and costs
The table below summarizes actual administrative costs for the program in FY 2012-13 and projected administrative costs through FY 2014-15. These figures are from the Department's narrative for R1 and include incentive payments paid in FY 2012-13 that

were earned in FY 2011-12 in addition to the FY 2012-13 expenses described in the Department's footnote report.

Accountable Care Collaborative Administrative Expenses			
	FY 2012-13	FY 2013-14	FY 2014-15
Regional Care Colaborative Organizations	29,718,299	51,672,311	66,208,196
Primary Care Medical Providers	8,140,044	14,972,185	19,292,183
Statewide Data Analytics Contractor	3,000,000	3,200,000	3,250,000
Administration	40,858,343	69,844,496	88,750,379

The request assumes FY 2014-15 per member per month fees to the RCCOs of $9.30 and to the PCMPs of $3.00, with an additional $1.00 in incentive payments available to each if they meet performance goals for improved health outcomes.

Performance/savings

The Department reports the following performance outcomes for clients enrolled in the ACC compared to other clients:

- 15-20% reduction for hospital readmissions
- 25% reduction in high cost imaging services
- 22% reduction in hospital admissions for patients with chronic obstructive pulmonary disease who have been in the ACC for six months or more
- 9 percent reduction in hospital admissions for patients with diabetes who have been in the ACC for six months or more
- 5 percent reduction in hospital admissions for patients with hypertension who have been in the ACC for six months or more

The Department's financial modeling estimates FY 2012-13 ACC activities resulted in savings of $44 million. Because the budget is based on cash accounting the estimated savings assumed in the budget request are slightly different.

Accountable Care Collaborative Estimated Savings			
	FY 2012-13	FY 2013-14	FY 2014-15
Administration	40,858,343	69,844,496	88,750,379
Estimated Savings	(47,777,380)	(81,934,534)	(103,549,895)
Net Impact	(6,919,037)	(12,090,038)	(14,799,516)
Average monthly enrollment	226,112	415,894	535,894

Other issues

The Department is exploring CMS approval for a pilot program enrolling people dually eligible for both Medicaid and Medicare in the ACC. This requires coordination between the two programs so that the costs of coordinating care don't accrue to one program while the savings benefits accrue to the other. The Department indicates that the per member per month rates for coordinating care for this population would probably be higher than the current standard, but did not provide any estimates of costs or savings.

The Department also reports that it is investigating connecting the SDAC to information collected by Single Entry Point (SEP) agencies that assist clients with long-term services and supports, by Community Centered Boards (CCBs) that work with people with intellectual and developmental disabilities, and by Behavioral Health Organizations (BHOs). This would provide a more complete picture of health needs and utilization patterns. It is not clear from the report if the Department believes that making these data connections with the SDAC would require additional funding resources.

Colorado Choice Transitions Program rebalancing fund

3. **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit to the Joint Budget Committee by November 1, 2013, a report on the specific projects funded with dollars in the Colorado Choice Transitions Program rebalancing funds. The report is requested to include the following information: description of the project, estimated timeline of the project and any deliverables, and anticipated improvements the project will contribute to Colorado's long-term care system.

   Comment: The Department submitted the report as requested.

   As of October 8, 2013, $11,758.84 had accrued in the rebalancing fund. None of the money has been spent. The Department is in the process of working with stakeholders to determine the best way to use the money to improve services. The Department estimates approximately $4 million will accumulate in the rebalancing fund by the end of the federal grant. *See the issue brief "Long-term Services and Supports" for more information.*

Comprehensive medication management services

4. **Department of Health Care Policy and Financing, Medical Service Premiums** – The Department is requested to report to the Joint Budget committee by November 1, 2013 on the costs and savings associated with providing comprehensive medication management services in conjunction with the Regional Care Collaborative Organizations to recipients in managed care or fee-for-service Medicaid who are taking at least five prescription drugs to treat two or more chronic medical conditions. The analysis should address both the costs and savings for the state as a whole and specifically for the Regional Care Collaborative Organizations. The report may include information concerning information technology infrastructure, connectivity, electronic records, and any other issues relating to implementation of comprehensive medication management services. In preparing the report the Department is requested to consult representatives from regional care collaboration organizations, chain pharmacies, independent pharmacies, physician organizations, and the schools of pharmacy of the University of Colorado and Regis University.

   Comment: The Department conducted the stakeholder outreach and submitted the report as requested.

The stakeholder outreach as well as additional research by the Department identified several new sources of information about the effectiveness of comprehensive medication management (CMM) and medication therapy management (MTM) programs, but the Department's conclusion remains largely unchanged:

> *As discussed in the Department's response to question 36 of the Joint Budget Committee's questions to the Department in December 2012 (JBC Response), regarding the literature on effective MTM programs, the Department found that the results on MTM/CMM programs are mixed. The return on investment varies from nothing to significant amounts. There is concern that the wide variation is due in large part to flaws in the cost avoidance methodologies. Sample selection details, attrition information, and selection bias are all potential factors that were seen in the reports reviewed by the Department.*

The Department did not provide a direct response regarding the costs and savings of comprehensive medication management.

The Department believes that the most effective MTM/CMM program would ensure that pharmacists have access to full patient records and preferably established relationships with other members of the medical team treating the client. For this reason, the Department appears to believe that the best way to develop a program would be regionally through the RCCOs, rather than through a statewide approach. The report highlights varying degrees of coordination between primary care and pharmacy services already occurring in the RCCO regions and ongoing communication between RCCOs and pharmacists about how to improve care.

The RFI response discusses the challenges of providing pharmacists access to complete patient records when Medicaid patients are seen by a wide variety of providers who are not all connected electronically. The RFI mentions the Department's *R5 Medicaid health info exchange* and the impact it could have on improving access to health records.

Finally, the RFI response addresses the strengths and weaknesses of a couple of specific programs brought to the attention of the Department by stakeholders, including a Minnesota MTM program and the Medicare Part D MTM report. The Department's findings support the conclusion that to be effective an MTM/CMM program needs to provide pharmacists with comprehensive access to patient medical histories and be integrated with primary care services.

Disbursement to each hospital from the Safety Net Provider Payments line item

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

   Comment: This report is due February 1.

Public school health services

6. **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. The program pays for medically necessary services that are part of a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of covered services include direct medical services, rehabilitative therapies, and Early and Periodic Screening, Diagnostic and Treatment Services. Medical necessity is determined through the federally and state regulated IEP or IFSP process. In FY 2012-13 the program served 13,970 children. Due to delays in the way the eligible costs are determined and the funds are distributed the Department reported FY 2011-12 total federal funds matched with certified public expenditures, rather than FY 2012-13 funds. The total federal fund distributed were $18,365,036 and this amount was distributed to 54 school health services program providers.

Appendix D: Indirect Cost Assessment Methodology

The Department does not have a traditional departmental indirect cost recovery plan. All of the funding for the Department's FTE is currently provided in one line item. The amounts from various fund sources that are used to support the FTE are calculated individually, rather than through an indirect cost allocation plan. The only indirect assessments that appear in the Indirect Cost Recoveries line item are related to the statewide indirect plan.