COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2014-15 STAFF FIGURE SETTING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

Department Overview

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

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

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

Department Summary of Staff Recommendations

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 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	337.9
Other legislation	342,355,358	(8,147,884)	(141,319,117)	2,000,000	489,822,359	20.2
HB 14-1236 (Supplemental)	39,975,365	(488,469)	68,023,135	0	(27,559,301)	0.0
14-15 Long Bill	93,282,182	11,624,641	25,375,797	0	56,281,744	0.0
TOTAL	**$6,670,900,600**	**$2,074,295,768**	**$981,915,538**	**$10,483,522**	**$3,604,205,772**	**358.1**

Department of Health Care Policy and Financing

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$6,670,900,600	$2,074,295,768	$981,915,538	$10,483,522	$3,604,205,772	358.1
Annualize SB 13-200 Expand Medicaid eligibility	618,864,754	4,576,671	67,713,456	0	546,574,627	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	47,087,216	16,527,152	30,802,356	0	(242,292)	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	21,143,314	7,705,969	(690,751)	(925,510)	15,053,606	2.8
R1 Medical service premiums	145,038,837	37,771,888	(105,587,267)	0	212,854,216	0.0
R2 Behavioral health programs	69,016,132	18,695,449	2,416,589	0	47,904,094	0.0
R3 Children's Basic Health Plan	(15,696,420)	1,511,214	(21,857,884)	0	4,650,250	0.0
BA10 FMAP change	(13,252)	(31,213,978)	(9,029,319)	(22,801)	40,252,846	0.0
R4 Medicare drug repayment	(1,083,796)	32,284,546	0	0	(33,368,342)	0.0
R5 Medicaid health info exchange	5,748,926	1,054,893	0	0	4,694,033	0.0
R6 Eligibility admin enhanced match	6,258,360	0	0	0	6,258,360	0.0
R7 IDD Supported living services	26,770,914	13,115,073	0	0	13,655,841	0.0
R7 SPAL increase	3,479,768	1,704,739	0	0	1,775,029	0.0
R8 IDD Increase funded FPE	2,973,374	1,417,599	0	0	1,555,775	0.0
R9 Medicaid community living initiative	569,219	281,852	0	0	287,367	0.0
R10 Primary care specialty collaboration	537,497	221,770	3,371	0	312,356	0.0
R11 Provider rate increase	113,090,582	40,071,964	1,012,994	0	72,005,624	0.0
R12 Admin contract reprocurements	4,296,941	1,134,165	991,260	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 Hospital backup program	125,000	62,500	0	0	62,500	0.0
R16 IDD Operating/membership funds	147,702	72,732	0	0	74,970	0.0
R17 Computer and software renewal	295,711	147,856	0	0	147,855	0.0
BA5 IDD Caseload adjustment	(1,682,152)	(823,064)	0	0	(859,088)	0.0
BA6 Leased space	1,756,056	877,533	493	0	878,030	0.0
BA10 FMAP change (reinvestment in primary care rates)	44,427,696	18,565,366	0	0	25,862,330	0.0
BA11 CHP+ oral health benefits	5,340,492	1,334,347	511,597	0	3,494,548	0.0
BA12 Enroll dual eligibles in ACC	11,039,215	173,111	0	0	10,866,104	0.0
BA13 Disability determination contract reprocurement	321,990	160,995	0	0	160,995	0.0
BA14 Customer service technology true-up	715,468	357,734	0	0	357,734	0.0
Human Services programs	16,349,618	6,313,537	1,237,258	0	8,798,823	0.0
Youth transitions from child welfare to IDD	4,830,718	2,219,685	0	0	2,611,033	0.0
Centrally appropriated line items	2,327,369	890,169	73,902	143,918	1,219,380	0.0

Department of Health Care Policy and Financing						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Pain management capacity program	500,000	246,212	0	0	253,788	0.0
Rate setting study	150,000	75,000	0	0	75,000	0.0
Statewide IT common policy adjustments	145,389	72,685	0	6	72,698	0.0
Indirect cost assessment	116,606	(116,606)	1,286	108,951	122,975	0.0
Technical adjustments	5,840	2,920	0	0	2,920	0.0
Transfer from Public Health	0	2,000,000	0	(2,000,000)	0	0.0
Facility survey and certification	(1,723)	(381)	0	0	(1,342)	0.0
Early intervention coordinated payments	(68,292)	0	(34,146)	0	(34,146)	(1.0)
Tobacco tax forecast	(945,700)	(2,624,057)	1,678,357	0	0	0.0
TOTAL	**$7,866,917,051**	**$2,255,483,150**	**$962,805,889**	**$7,788,086**	**$4,640,839,926**	**395.1**
Increase/(Decrease)	$1,196,016,451	$181,187,382	($19,109,649)	($2,695,436)	$1,036,634,154	37.0
Percentage Change	17.9%	8.7%	(1.9%)	(25.7%)	28.8%	10.3%
FY 2014-15 Executive Request	**$7,659,253,224**	**$2,217,501,268**	**$953,672,550**	**$9,656,254**	**$4,478,423,152**	**395.1**
Request Above/(Below) Recommendation	($207,663,827)	($37,981,882)	($9,133,339)	$1,868,168	($162,416,774)	0.0

R1 Medical service premiums: The recommendation provides for projected changes in caseload, per capita expenditures, and financing.

R2 Behavioral health programs: *See figure setting for Behavioral Health Community Programs for more information.*

R3 Children's Basic Health Plan: The recommendation provides for projected changes in caseload, per capita expenditures, and financing.

BA10 FMAP change: The recommendation adjusts funding to account for an increase in the federal match rate for non-administrative expenses of Medicaid and CHP+.

R4 Medicare drug repayment: The recommendation provides 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 recommendation includes 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 admin enhanced match: The recommendation reinvests 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: *See figure setting for the Office of Community Living for more information.*

R8 IDD Increase funded FPE: *See figure setting for the Office of Community Living for more information.*

R9 Medicaid community living initiative: The recommendation funds: (1) counseling regarding community-based living options; (2) housing assistance payments; and (3) improved oversight of the home modifications benefit.

R10 Primary care specialty collaboration: The recommendation provides funding for primary care providers and specialists to acquire and utilize technology that allows remote specialty care consultation.

R11 Provider rate increase: The recommendation provides funding for a 3.0 percent across-the-board provider rate increase.

R12 Admin contract reprocurements: The recommendation provides funding to allow for an overlap between several expiring administrative service contracts and the new contracts to ensure smooth transitions.

R13 Utilization-review services: The recommendation provides additional funding for utilization reviews that determine whether services are covered by Medicaid.

R14 Family Support restoration: *See figure setting for the Office of Community Living for more information.*

R15 Hospital backup program: The recommendation includes funding for consulting services to study the Hospital Backup Program (HBU) with an aim of moving patients to lower acuity settings. 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.

R16 IDD Operating/membership funds: *See figure setting for the Office of Community Living for more information.*

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

BA5 IDD Caseload adjustment: *See figure setting for the Office of Community Living for more information.*

BA6 Leased space: The recommendation provides money to continue and annualize the supplemental authorizing the Department to move some staff to 303 E. 17th Street.

BA10 FMAP change (reinvestment in primary care rates): The recommendation reinvests a portion of the savings from the change in the federal match rate for Medicaid and CHP+ in primary care provider rates.

BA11 CHP+ oral health benefits: The recommendation provides money to expand the CHP+ dental benefit to comply with federal standards and increase the annual maximum to $1,000.

BA12 Enroll dual eligibles in ACC: The recommendation provides funding to enroll approximately people dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination. The Department has received a federal demonstration grant to pay for a significant portion of the start-up costs and administrative expenses, but additional state funding is required as a match.

BA13 Disability determination contract reprocurement: The recommendation provides funding to allow for an overlap between several expiring administrative service contracts and the new contracts to ensure smooth transitions.

BA14 Customer service technology true-up: The recommendation provides funding for call center technology to address higher than expected volume.

Human Services programs: *See figure setting for the Department of Human Services for more information.*

Youth transitions from child welfare to IDD: *See figure setting for the Office of Community Living for more information.*

Pain management capacity program: The recommendation reinvests a portion of the savings from the change in the federal match rate for Medicaid and CHP+ in a program aimed at increasing the capacity of physicians to serve clients in need of pain management.

Rate setting study: The recommendation provides funding for the Department to research and develop a plan for addressing rate disparities that limit client access to cost-effective services.

Statewide IT common policy adjustments: The recommendation provides funding for transfers to the Office of Information Technology.

Indirect cost assessment: The recommendation accounts for changes in the statewide indirect cost assessment on the Department.

Technical adjustments: The recommendation makes various technical adjustments to appropriations.

Transfer from Public Health: The recommendation adjusts fund sources to account for the end of a transfer from the Department of Public Health and Environment that was offsetting the need for General Fund.

Facility survey and certification: The recommendation makes an adjustment for a change in the Department of Public Health and Environment's costs of providing facility surveys and certifications

Early intervention coordinated payments: *See figure setting for the Office of Community Living for more information.*

Tobacco tax forecast: The recommendation makes adjustments for a change in the forecast of available tobacco tax revenues.

(1) Executive Director's Office

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. Major funding sources for this division include the General Fund, federal funds received for the Medicaid and Children's Basic Health Plan programs, the Health Care Expansion Fund, the Children's Basic Health Plan Trust Fund, and various other cash funds.

Executive Director's Office	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$172,537,481	$43,628,621	$19,225,100	$5,035,980	$104,647,780	337.9
Other legislation	7,812,942	139,545	3,431,480	0	4,241,917	20.2
HB 14-1236 (Supplemental)	10,970,693	413,218	(3,053)	0	10,560,528	0.0
14-15 Long Bill	662,466	0	0	0	662,466	0.0
TOTAL	**$191,983,582**	**$44,181,384**	**$22,653,527**	**$5,035,980**	**$120,112,691**	**358.1**
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$191,983,582	$44,181,384	$22,653,527	$5,035,980	$120,112,691	358.1

Executive Director's Office	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Annualize SB 13-200 Expand Medicaid eligibility	3,673,055	195,116	1,540,267	0	1,937,672	0.0
Annualize SB 13-242 Adult dental benefit	(534,128)	0	(128,181)	0	(405,947)	0.7
Annualize substance use disorder benefit	(100,000)	(50,000)	0	0	(50,000)	0.0
Annualize HB 13-1314 IDD transfer	3,291	3,291	0	0	0	0.0
Annualize prior year budget decisions	9,396,366	(487,547)	96,171	11,382	9,776,360	1.8
BA10 FMAP change	0	0	0	(22,801)	22,801	0.0
R5 Medicaid health info exchange	5,748,926	1,054,893	0	0	4,694,033	0.0
R6 Eligibility admin enhanced match	6,258,360	0	0	0	6,258,360	0.0
R9 Medicaid community living initiative	205,146	102,573	0	0	102,573	0.0
R10 Primary care specialty collaboration	300,000	150,000	0	0	150,000	0.0
R12 Admin contract reprocurements	1,734,749	257,415	606,807	0	870,527	0.0
R13 Utilization-review services	1,691,977	838,378	0	0	853,599	0.0
R15 Hospital backup program	125,000	62,500	0	0	62,500	0.0
R16 IDD Operating/membership funds	0	0	0	0	0	0.0
R17 Computer and software renewal	295,711	147,856	0	0	147,855	0.0
BA6 Leased space	1,756,056	877,533	493	0	878,030	0.0
BA10 FMAP change (reinvestment in primary care rates)	150,000	75,000	0	0	75,000	0.0
BA12 Enroll dual eligibles in ACC	513,525	128,382	0	0	385,143	0.0
BA13 Disability determination contract reprocurement	321,990	160,995	0	0	160,995	0.0
BA14 Customer service technology true-up	715,468	357,734	0	0	357,734	0.0
Centrally appropriated line items	2,327,369	890,169	73,902	143,918	1,219,380	0.0
Pain management capacity program	500,000	246,212	0	0	253,788	0.0
Rate setting study	150,000	75,000	0	0	75,000	0.0
Statewide IT common policy adjustments	145,389	72,685	0	6	72,698	0.0
Indirect cost assessment	116,606	(116,606)	1,286	108,951	122,975	0.0
Technical adjustments	5,840	2,920	0	0	2,920	0.0
Facility survey and certification	(1,723)	(381)	0	0	(1,342)	0.0
Early intervention coordinated payments	(68,292)	0	(34,146)	0	(34,146)	(1.0)
TOTAL	**$227,414,263**	**$49,225,502**	**$24,810,126**	**$5,277,436**	**$148,101,199**	**359.6**
Increase/(Decrease)	$35,430,681	$5,044,118	$2,156,599	$241,456	$27,988,508	1.5
Percentage Change	18.5%	11.4%	9.5%	4.8%	23.3%	0.4%
FY 2014-15 Executive Request:	**$261,654,956**	**$67,486,421**	**$41,878,990**	**$5,145,604**	**$147,143,941**	**395.1**
Request Above/(Below) Recommendation	$34,240,693	$18,260,919	$17,068,864	($131,832)	($957,258)	35.5

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, employee-related expenses and benefits, operating expenses, and general contract services. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

Line items set by JBC common policy

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases the common policy allocates costs to agencies for a centralized service based on prior year actual utilization by the Department of that service. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

Request: The Department requests:

- Annualizations of prior year bills and budget actions, including:
  - FY 13-14 NP OIT Enterprise asset maintenance
  - SB 13-200 Medicaid eligibility expansion
  - HB 13-1314 Transfer developmental disabilities
- Application of the OSPB common policies

Recommendation: *Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below.* Note that the JBC's common policy is pending for several of the line items.

Line items set by JBC common policy					
	TOTAL	**GF**	**CF**	**RF**	**FF**
Health, Life, and Dental	$2,523,213	$920,169	$166,066	$129,013	$1,307,965
Short-term Disability	65,094	21,425	5,071	1,914	36,684
Amortization Equalization Disbursement	1,248,682	411,369	97,200	36,796	703,317
Supplemental AED	1,170,639	385,658	91,125	34,496	659,360
Salary Survey	1,012,847	333,368	78,906	29,778	570,795
Merit Pay	412,001	147,180	29,854	14,163	220,804
Workers' Compensation	*pending*				
Legal Services	*pending*				
Administrative Law Judge Services	*pending*				
Purchase of Services from Computer Center	*pending*				
Multi-use Network Payments	*pending*				
Management and Administration of OIT	*pending*				
Information Technology Security	*pending*				
Payment to Risk Management and Property	*pending*				
Capitol Complex Leased Space	*31,512 square feet at 1570 Grant Street*				

For legal service hours staff recommends an increase for the annualization of S.B. 13-200 Medicaid eligibility expansion.

Personal Services

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

Request: The Department requests:

- *R12 Administrative contract reprocurements*
- *BA12 Enroll dual eligibles in ACC*
- Annualizations of prior year budget decisions, including:
  - FY 13-14 R6 Additional FTE to restore functionality
  - FY 13-14 R11 HB 12-1281 Departmental differences
  - FY 13-14 State plan amendment Denver Health nursing
  - SB 13-167 ICF/IID Provider fee
  - SB 13-242 Adult dental benefit
  - HB 13-1314 Transfer developmental disabilities
  - prior year salary survey and merit pay increases
- A fund source adjustment to account for changes in indirect cost recoveries

To build the request the Department used an FY 2013-14 base that was slightly different than the appropriation by $90 higher in the Personal Services line item and $90 lower in the Health, Life and Dental line item. There were also small variances that netted to zero between the Department's base assumptions for specific cash fund sources and the appropriation. This was a technical error in the request that is noted here to explain a slight difference between the request and the JBC staff recommendation, which begins from the FY 2013-14 appropriation.

Recommendation: All of the staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table.

Executive Director's Office, General Administration, Personal Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$23,323,977	$8,410,879	$1,955,887	$1,736,842	$11,220,369	337.9
Other legislation	1,287,456	0	643,728	0	643,728	20.2
14-15 Long Bill	113,700	0	0	0	113,700	0.0
TOTAL	**$24,725,133**	**$8,410,879**	**$2,599,615**	**$1,736,842**	**$11,977,797**	**358.1**
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$24,725,133	$8,410,879	$2,599,615	$1,736,842	$11,977,797	358.1

Executive Director's Office, General Administration, Personal Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Annualize SB 13-242 Adult dental benefit	30,052	0	15,026	0	15,026	0.7
Annualize HB 13-1314 IDD transfer	0	0	0	0	0	0.0
Annualize prior year budget decisions	1,138,237	406,373	78,696	32,071	621,097	1.8
R12 Admin contract reprocurements	57,168	14,292	14,292	0	28,584	0.0
BA12 Enroll dual eligibles in ACC	72,080	18,020	0	0	54,060	0.0
BA13 Disability determination contract reprocurement	28,584	14,292	0	0	14,292	0.0
Indirect cost assessment	0	(116,606)	0	116,606	0	0.0
Early intervention coordinated payments	(62,880)	0	(31,440)	0	(31,440)	(1.0)
TOTAL	**$25,988,374**	**$8,747,250**	**$2,676,189**	**$1,885,519**	**$12,679,416**	**359.6**
Increase/(Decrease)	$1,263,241	$336,371	$76,574	$148,677	$701,619	1.5
Percentage Change	5.1%	4.0%	2.9%	8.6%	5.9%	0.4%
FY 2014-15 Executive Request:	**$28,588,051**	**$10,292,289**	**$2,693,382**	**$1,768,913**	**$13,833,467**	**395.1**
Request Above/(Below) Recommendation	$2,599,677	$1,545,039	$17,193	($116,606)	$1,154,051	35.5

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below. In addition, the recommendation includes annualizations for SB 13-242 that provided for an adult dental benefit and H.B. 13-1314 that transferred services for people with intellectual and developmental disabilities from Human Services to the Department. The annualizations for these bills are shown separately from other anualizations due to the high level of legislative interest and the magnitude of the annualizations Department-wide. The Department requested an annualization in this line item for H.B. 13-1314 that transferred services for people with developmental disabilities from the Department of Human Services to the Department of Health Care Policy and Financing. The recommendation is to instead put funding for this purpose in the newly created Office of Community Living, consistent with the JBC's action during the figure setting for services for people with developmental disabilities.

Annualize Prior Year Budget Decisions	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 13-14 R6 Additional FTE to restore functionality	$116,297	$58,148	$0	$0	$58,149	1.6
FY 13-14 R11 HB 12-1281 Departmental differences	2,125	1,062	0	0	1,063	0.0
FY 13-14 State plan amendment Denver Health nursing	8,962	4,481	0	0	4,481	0.1
SB 13-167 ICF/IID Name change and provider fee	5,286	0	2,643	0	2,643	0.1
Prior Year Salary Survey	1,005,567	342,682	76,053	32,071	554,761	0.0
TOTAL Annualizations	$1,138,237	$406,373	$78,696	$32,071	$621,097	1.8

➔ **R12 Admin contract reprocurements**

➔ **BA13 Disability determinations contract**

Request: In both R12 and BA13 the Department requests one-time funding to allow a transition period between the outgoing vendors for contracts scheduled to expire in FY 2014-15 and potential new vendors who may be selected through the competitive procurement process. If the contracts are awarded to the same vendors, then no transition funding would be spent. The Department is concerned that a disruption in contract services could delay eligibility determinations and access to services.

The first expiring contract is for the enrollment broker responsible for informing newly eligible Medicaid clients of their plan choices. If a client elects to use a PCCP or HMO plan the enrollment broker processes the selection. The enrollment broker contract is funded through the Customer Outreach line item in the Eligibility Determinations and Client Services subdivision of the Executive Director's Office.

The second expiring contract is for eligibility and enrollment services for the Children's Basic Health Plan (CHP+) and selected Medicaid applications not handled by counties. Among other duties, this contractor handles on-line and mail-in Medicaid applications. In the rebid process, the Department plans to combine the contracts for enrollment broker and for eligibility and enrollment services. Currently, a single vendor holds both contracts and the Department feels that the services are closely related. Funding for the eligibility and enrollment services contract is split between two line items: (1) the Centralized Eligibility Vendor Contract Project in the Information Technology Contracts and Projects subdivision of the Executive Director's Office; and (2) the Children's Basic Health Plan (CHP+) Administration in the Indigent Care division.

The third expiring contract is for administration of the Consumer Directed Attendant Support Services (CDASS). The CDASS vendor provides training to clients on how to select providers for in-home personal care, homemaker, and health maintenance services, and also acts as the financial manager paying providers for services rendered. Funding for the CDASS contract is provided in the Medical Service premiums line item.

In BA 13 the Department identifies a fourth expiring contract with the vendor responsible for disability determinations.

The Department indicates that previous contract renewals that did not provide for a transition period have resulted in service disruptions. As an example, the Department cites the renewal of the contract for non-emergent medical transportation (NEMT), where the incoming vendor took over before the vendor's computer system to coordinate services was fully functional, resulting in service delays.

In addition to paying for an overlap between the outgoing and incoming contract vendors, the Department would like to acquire the services of three temporary contract transition managers. The transition managers would be responsible for ensuring a smooth handoff of data and functions. As evidence of the need for transition managers, the Department cites the last reprocurement of eligibility and enrollment services where several thousand applications and

documents mailed to the outgoing vendor did not reach the incoming vendor, resulting in unreviewed cases. Also, boxes of applications and supporting documentation that were reviewed for eligibility were left unfiled before the transition, creating problems with locating records for internal reviews and auditing. The Department estimated the cost of the transition managers at the monthly salary for a General Professional IV for six months.

Actual payments for the transition period will be determined through the competitive bid process, but for budgeting purposes the Department assumed the payments would equal 25 percent of the first year value of the five-year contracts. This is equivalent to saying that the incoming vendor will fully overlap with the outgoing vendor for 3 months, but it is possible that successful bidders may propose a shorter overlap period, or a partial overlap period that lasts longer. In the past the Department has estimated the costs of reprocurring similar contracts by adding 10 percent to the total five-year value of the contract for start-up costs with the assumption that the payments for start-up costs would be spread over the life of the contract. The proposed new method for estimating start-up costs, which uses 25 percent of the first year value of the contract, results in half the total budget for start-up costs compared to the old method, but the money is assumed to be front-loaded in the transition year. The Department believes that structuring the contracts in this manner would ease cash flow issues for the successful vendors and potentially increase the pool of providers willing to bid on the contracts.

Recommendation: Staff recommends the Department's request with slight modifications. First, staff recommends using the same fund sources for the transition manager responsible for the enrollment broker/eligibility and enrollment services contract as for the actual contract. Second, staff recommends placing the funding for the transition manager for disability determinations in the Personal Services line item, as requested for all the other transition manager services, rather than in the General Professional Services and Special Projects line item. All of the recommended funding is one-time for FY 2014-15 only. The recommended funding minimizes the risk of service disruptions during a potential change in contractors. If there is no change in contractors the funding will not be spent. The request is very similar to a supplemental already approved by the JBC for transition costs associated with behavioral health contracts.

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

R12/BA13 Admin contract reprocurements	Total	General Fund	Hospital Provider Fee	CHP+ Trust	Federal Funds
Transition Managers (General Professional IV for 6 months)					
Enrollment Broker/Eligiblity and Enrollment Services	$28,584	$0	$8,469	$5,823	$14,292
Consumer Directed Attendant Support Services	28,584	14,292	0	0	14,292
Disability determination services	28,584	14,292	0	0	14,292
SUBTOTAL - EDO Personal Services	85,752	28,584	8,469	5,823	42,876
Transition costs (25% of expected 1st year contract value)					
Customer Outreach	486,245	243,123	0	0	243,122
Centralized Eligibility Vendor Contract Project	1,191,335	0	592,515	0	598,820
Utilization and Quality Review Contracts	293,406	146,703	0	0	146,703
Medical Service Premiums	1,753,500	876,750	0	0	876,750

R12/BA13 Admin contract reprocurements	Total	General Fund	Hospital Provider Fee	CHP+ Trust	Federal Funds
CHP+ Administration	808,693	0	0	384,453	424,240
SUBTOTAL - Transition costs	4,533,179	1,266,576	592,515	384,453	2,289,635
TOTAL - R12/BA13 Admin contract reprocurements	**$4,618,931**	**$1,295,160**	**$600,984**	**$390,276**	**$2,332,511**

➔ BA12 Enroll dual eligibiles in ACC

Request: The Department requests funding to enroll approximately 40,000 people dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination. The Department has received a federal demonstration grant to pay for a portion of the administrative costs, but additional state funding is required. The demonstration applies to clients eligible for full Medicaid benefits and not to eligibility categories with slightly higher incomes that receive assistance only with Medicare premiums and cost sharing.

The Department has not previously made efforts to enroll people dually eligible for Medicare and Medicaid in the ACC, in part because the initial savings from providing coordinate care would mostly benefit the federal government's Medicare program, which covers the majority of acute care for this population, rather than Medicaid. Only some years after the initial cost of providing coordinated care would Medicaid see savings on long-term care. Also, to provide coordinated care the Department would need to cooperate with Medicare on access to beneficiary information.

With the demonstration grant the Department will have money to cover the majority of startup costs until savings in Medicaid long-term care expenses are expected to accrue, and for clients who elect to join the ACC the federal government will share beneficiary information necessary to coordinate care. The demonstration is scheduled to last from July 1, 2014 through December 31, 2017, but either the federal government or the state could end the arrangement early. At the end of the three years the state and federal government could mutually agree to continue the demonstration. The federal match rates under the demonstration are as follows:

- CY 2014 – 100%
- CY 2015 – 75%
- CY 2016 and beyond – regular Medicaid match rate

In the Department's request the demonstration grant funds in CY 2014 and CY 2015 would be off the state budget, and so the full fiscal impact is not apparent by looking at just the requested change to the Long Bill appropriation. The overall picture is further muddied because the federal match rates change by calendar year, rather than fiscal year.

The Department anticipates savings in Medical Service Premiums as a result of providing coordinated care through the ACC to people dually eligible for Medicare and Medicaid. The payments for care coordination to the Regional Care Collaborative Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs) would be similar to the current payments for other clients in the ACC. By FY 2015-16 the expected savings from changes in long term care

utilization as a result of care coordination are anticipated to at least offset the payments to the RCCOs and PCMPs, and by FY 2016-17 these savings are expected to reduce overall Medicaid expenditures.

In addition to expected savings from changes in long term care utilization, the Department is negotiating with the federal government for the state, RCCOs, and PCMPs to share in any savings to Medicare that may result from care coordination. However, since the parameters of a shared savings agreement have not been set, the Department did not include an estimate of the savings in the request.

Recommendation: Staff recommends approval of the request, except staff recommends including the federal grant funds in the budget, in part because the federal funds require a state match, and in part to show the full fiscal impact of the demonstration. The staff recommendation will require a supplemental add-on to the Long Bill, since some of the CY 2014 costs will occur in FY 2013-14.

The staff recommendation to approve the request is based on the evidence provided by the Department suggesting that care coordination provided through the ACC improves client health and results in savings. The savings to date have been in acute care, but it is not a large leap to assume that care coordination will have a similar impact on long term care utilization.

Another factor in the staff recommendation is that the federal demonstration grant will cover the majority of start-up costs, reducing the risk to the General Fund if the projected savings are different than projected. As a result of the staff recommendation to include the federal demonstration funds in the budget the staff recommendation for BA12 will be higher for each line item than the Department's request.

The table below summarizes the staff-recommended appropriations by category and line item. The amounts in this table are the totals for each year. In the summary table for the line item there is a row for the FY 2013-14 amount and a row for the incremental change from FY 2013-14 to FY 2014-15.

BA12 Enroll dual eligibles in ACC					
	FY 13-14	FY 14-15	FY 15-16	FY 16-17	Cumulative
Personal Services					
Beneficiary rights and protection alliance	$113,700	$185,780	$114,160	$84,160	$497,800
Operating					
Out-of-state travel	5,512	11,024	11,024	11,024	38,584
In-state travel	5,490	9,607	4,118	0	19,215
General Professional Services and Special Projects					
Actuarial analysis and rate reform	106,200	192,100	146,800	121,800	566,900
Customer Outreach					
Stakeholder engagement	247,208	436,774	220,567	62,000	966,549
Enrollment broker	134,356	240,706	212,700	212,700	800,462
Utilization and Quality Review					
Evaluation and program improvement	50,000	100,000	100,000	100,000	350,000

BA12 Enroll dual eligibles in ACC					
	FY 13-14	FY 14-15	FY 15-16	FY 16-17	Cumulative
Medical Service Premiums					
Statewide data and analytics contractor	167,500	217,500	100,000	100,000	585,000
Service coordination payments to RCCOs and PCMPs	0	10,410,240	10,041,600	10,041,600	30,493,440
Savings in Medical Service Premiums	0	65,450	(10,041,600)	(10,041,600)	(20,017,750)
TOTAL	599,064	11,470,670	633,267	474,700	13,177,701
General Fund	0	173,111	313,803	345,842	832,756
Federal Funds	829,966	11,696,070	595,566	345,842	13,467,444

→ **Indirect cost adjustment:** *Staff recommends a fund source adjustment to account for a change in the indirect costs assessed to the Department for statewide overhead according to the state plan.* Pursuant to JBC policy, the money collected from indirect cost assessments is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The source of reappropriated funds is a transfer from the Statewide Indirect Cost Assessment line item. See the explanation for the Statewide Indirect Cost Assessment line item for more detail. The staff recommendation differs slightly from the request because the Department requested the decrease in General Fund but failed to request the corresponding and offsetting increase in reappropriated funds.

→ **Early intervention coordinated payments:** *Staff recommends a reduction for the end of start-up costs associated with developing a coordinated payment system for early interventinon services.* Senate Bill 07-004 (Schaffer/Todd) provided authority that expired in FY 2009-10 and then was repealed in FY 2012-13 for appropriations from tobacco settlement moneys via the Short-term Innovative Health Program Grant Fund to the Department for creating a system for coordinating payments from public and private sources for early intervention services for children at risk of developmental delays. Most of the work was done by the Department of Human Services, but the Department of Health Care Policy and Financing had (1) an advisory role, (2) a responsibility to ensure that Medicaid and CHP+ could make payments in the coordinated system, and (3) a charge to modify CHP+ benefits to ensure that they met the coverage standards of the bill. Despite the statutory authority expiring, appropriations continued to be made from the Short-term Innovate Health Program Grant Fund to the Department in FY 2009-10 through FY 2011-12. The Department did not spend the money. In FY 2013-14 the error was discovered immediately prior to the Long Bill introduction and as a matter of expediency to correct the problem without changing the totals for the line item the fund source was changed from the Short-term Innovate Health Program Grant Fund to the Hospital Provider Fee, under the authority granted by the JBC to the executive director for the JBC to correct small technical errors. If funding were to continue in FY 2014-15 for the Department for the system of coordinated payments for early intervention services, then the most appropriate source would be the General Fund, rather than the Hospital Provider Fee. However, after discussions with the Department's budget staff, both the Department and the JBC staff believe that the funding should be discontinued in FY 2014-15. The work necessary to include Medicaid and CHP+ in the coordinated payment system has been completed and the ongoing responsibilities of the Department under S.B. 07-004 are minimal. Therefore, staff recommends the following reductions in appropriations:

Early Intervention Coordinated Payments	Total	Hospital Provider Fee	Federal Funds	FTE
Personal Services	($62,880)	($31,440)	($31,440)	(1.0)
Short-term Disability	(240)	(120)	(120)	
Amortization Equalization Disbursement	(1,754)	(877)	(877)	
Supplemental Amortization Equalization Disbursement	(1,584)	(792)	(792)	
Salary Survey	(1,670)	(835)	(835)	
Merit Pay	(874)	(437)	(437)	
Operating	(960)	(480)	(480)	
TOTAL	($69,962)	($34,981)	($34,981)	(1.0)

Operating Expenses

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Request: The Department requests

- *R5 Medicaid health info exchange*
- *BA6 Leased space*
- *BA12 Enroll dual eligibles in ACC*
- *R16 IDD Operating/membership funds*
- *R17 Computer and software renewal*
- Annualizations of prior year budget decisions, including:
  - FY 13-14 R6 Additional FTE to restore functionality
  - FY 13-14 State plan amendment Denver Health nursing
  - SB 13-167 ICF/IID Provider fee
  - SB 13-200 Expand Medicaid eligibility
  - SB 13-242 Adult dental benefit
  - HB 13-1314 Transfer developmental disabilities
  - FY 13-14 Interim supplemental leased space

Recommendation: The staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. For the recommendation on *R5 Medicaid health info exchange* see the line item Health Information Exchange Maintenance and Projects. For the recommendation on BA6 Leased space see the Leased Space line item. For the recommendation on *BA12 Enroll dual eligibles in ACC* and on *Early intervention coordinated payments* see the Personal Services line item. The recommendation on *R16 IDD Operating/membership funds* was made during figure setting for the Office of Community Living.

Executive Director's Office, General Administration, Operating Expenses	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$1,607,344	$733,525	$53,049	$23,910	$796,860	0.0
Other legislation	156,722	0	78,361	0	78,361	0.0
HB 14-1236 (Supplemental)	728,014	364,007	0	0	364,007	0.0
BA12 Enroll dual eligibles in ACC	11,002	0	0	0	11,002	0.0
TOTAL	**$2,503,082**	**$1,097,532**	**$131,410**	**$23,910**	**$1,250,230**	**0.0**
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$2,503,082	$1,097,532	$131,410	$23,910	$1,250,230	0.0
Annualize prior year budget decisions	(765,919)	(383,000)	40	0	(382,959)	0.0
Annualize SB 13-200 Expand Medicaid eligibility	(128,140)	0	(64,070)	0	(64,070)	0.0
Annualize SB 13-242 Adult dental benefit	(8,646)	0	(4,323)	0	(4,323)	0.0
Annualize HB 13-1314 IDD transfer	0	0	0	0	0	0.0
R5 Medicaid health info exchange	20,000	2,000	0	0	18,000	0.0
BA6 Leased space	1,420,402	710,201	0	0	710,201	0.0
BA12 Enroll dual eligibles in ACC	9,629	2,407	0	0	7,222	0.0
R16 IDD Operating/membership funds	0	0	0	0	0	0.0
R17 Computer and software renewal	295,711	147,856	0	0	147,855	0.0
Early intervention coordinated payments	(960)	0	(480)	0	(480)	0.0
TOTAL	**$3,345,159**	**$1,576,996**	**$62,577**	**$23,910**	**$1,681,676**	**0.0**
Increase/(Decrease)	$842,077	$479,464	($68,833)	$0	$431,446	0.0
Percentage Change	33.6%	43.7%	(52.4%)	0.0%	34.5%	0.0%
FY 2014-15 Executive Request:	**$3,675,976**	**$1,751,174**	**$63,057**	**$23,910**	**$1,837,835**	**0.0**
Request Above/(Below) Recommendation	$330,817	$174,178	$480	$0	$156,159	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below. In addition, the recommendation includes annualizations for S.B. 13-200 to expand Medicaid eligibility, S.B. 13-242 that provided for an adult dental benefit, and H.B. 13-1314 that transferred services for people with intellectual and developmental disabilities from Human Services to the Department. The annualizations for these bills are shown separately from other anualizations due to the high level of legislative interest and the magnitude of the annualizations Department-wide. The Department requested an annualization in this line item for H.B. 13-1314 that transferred services for people with developmental disabilities from the Department of Human Services to the Department of Health Care Policy and Financing. The recommendation is to instead put funding for this purpose in the newly created Office of Community Living, consistent with the

JBC's action during the figure setting for services for people with developmental disabilities. The JBC staff's annualization of the FY 13-14 interim supplemental for leased space is lower than the Department's request to reflect the JBC's action not to approve additional human resources and accounting staff associated with the move of services for people with intellectual and developmental disabilities from Human Services to the Department.

Annualize Prior Year Budget Decisions	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 13-14 R6 Additional FTE to restore functionality	($33,282)	($16,641)	$0	$0	($16,641)
FY 13-14 State plan amendment Denver Health nursing	(4,703)	(2,352)	0	0	(2,351)
FY 13-14 Interim supplemental leased space	(728,014)	(364,007)	0	0	(364,007)
SB 13-167 ICF/IID Name change and provider fee	80	0	40	0	40
TOTAL Annualizations	($765,919)	($383,000)	$40	$0	($382,959)

➔ R17 Computer and software renewal

Request: The Department requests on-going funding to replace the Department's desktops on a 5-year rotating schedule and renew core office software licenses annually. The Department has never received funding specifically for information technology refreshment. Due to limited resources the Department generally waits to replace hardware until it breaks and to replace software until it is unsupported. This results in unplanned downtime, network instability, security risks, and sluggish performance from IT assets.

Recommendation: Staff recommends approval of the request in concept, but at a slightly lower dollar amount to be consistent with the JBC's common policy regarding computer costs. The JBC's common policy for standard operating costs is to match the assumptions used by Legislative Council Staff (LCS) in fiscal notes for proposed legislation unless there is a compelling reason for an exception. LCS assumes that new computers will cost $900 per FTE while the Department's request is based on guidance from OIT of $1,162.22 per FTE. The difference between the staff recommendation and the Department's request is $27,271 including $13,635 General Fund.

The estimated cost of the renewal plan is 12 percent of the FY 2013-14 appropriation and it seems unreasonable to expect the Department to absorb this within existing resources. Also contributing to the staff recommendation is the significant growth in the Department's FTE in recent years. As the initially purchased hardware and software for these FTE ages and needs replacement the increased costs will compound the Department's current challenges in finding sufficient funds for computer and software replacement. For the Department to continue to replace only broken computers and software, rather than implementing a standardized replacement plan, is at a minimum less than optimal.

Leased Space

This line item pays for the Department's leased space at 225 E. 16th Street and 303 E. 17th Ave.

Request: The Department requests

- *BA6 Leased space*

- Annualizations of prior year budget decisions, including:
  - FY 13-14 R10 Leased space rent increase and true-up

Recommendation: Staff recommends the requested funding. The recommendation on BA6 is discussed below.

➔ BA6 Leased space

Request: The Department requests funding to continue and annualize the supplemental funding that allowed for the purchase of space at 303 E. 17th Avenue, and additional funds for an expected increase in costs associated with expiring contracts 225 E 16th Street in FY 2014-15.

Recommendation: Staff recommends approval of the request to continue the migration of staff to 303 E. 17th Ave.

General Professional Services

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Coordinated Care for People with Disabilities Fund, Nursing Home Penalties, and gifts, grants, and donations. The federal match rate varies based on the specific contracts.

Request: The Department requests:

- *R5 Health Information Exchange*
- *R10 Primary care specialty collaboration*
- *R15 Hospital backup program*
- *BA10 Enhanced FMAP*
- *BA12 Enroll dual eligibles in ACC*
- *BA13 Disability determinations contract*
- *BA14 Customer service technology true-up*
- Annualizations of prior year budget decisions

Recommendation: The staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. For the recommendation on *R5 Medicaid health info exchange* see the line item Health Information Exchange Maintenance and Projects. For the recommendation on *R10 Primary care specialty collaboration* see the Medical Service Premiums line item. For the recommendation on *BA10 Enhanced FMAP* see the State of Health Projects line item. For the recommendation on *BA12 Enroll dual eligibles in ACC* and *BA13 Disability determinations contract* see the Personal Services line item.

Executive Director's Office, General Administration, General Professional Services and Special Projects					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
FY 2013-14 Appropriation					
SB 13-230 (Long Bill)	$8,192,552	$2,407,418	$468,500	$5,316,634	0.0

Executive Director's Office, General Administration, General Professional Services and Special Projects	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Other legislation	300,000	100,000	100,000	100,000	0.0
14-15 Long Bill	106,200	0	0	106,200	0.0
TOTAL	**$8,598,752**	**$2,507,418**	**$568,500**	**$5,522,834**	**0.0**
FY 2014-15 Recommended Appropriation					
FY 2013-14 Appropriation	$8,598,752	$2,507,418	$568,500	$5,522,834	0.0
Annualize SB 13-200 Expand Medicaid eligibility	50,000	0	25,000	25,000	0.0
Annualize substance use disorder benefit	(100,000)	(50,000)	0	(50,000)	0.0
Annualize prior year budget decisions	(1,782,000)	(910,000)	(31,000)	(841,000)	0.0
R5 Medicaid health info exchange	(2,500,000)	(250,000)	0	(2,250,000)	0.0
R10 Primary care specialty collaboration	300,000	150,000	0	150,000	0.0
R15 Hospital backup program	125,000	62,500	0	62,500	0.0
BA10 FMAP change (reinvestment in primary care rates)	150,000	75,000	0	75,000	0.0
BA12 Enroll dual eligibles in ACC	85,900	21,475	0	64,425	0.0
BA14 Customer service technology true-up	715,468	357,734	0	357,734	0.0
Rate setting study (see R11)	150,000	75,000	0	75,000	0.0
TOTAL	**$5,793,120**	**$2,039,127**	**$562,500**	**$3,191,493**	**0.0**
Increase/(Decrease)	($2,805,632)	($468,291)	($6,000)	($2,331,341)	0.0
Percentage Change	(32.6%)	(18.7%)	(1.1%)	(42.2%)	0.0%
FY 2014-15 Executive Request:	**$5,501,079**	**$1,978,419**	**$562,500**	**$2,960,160**	**0.0**
Request Above/(Below) Recommendation	($292,041)	($60,708)	$0	($231,333)	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below. In addition, the recommendation includes annualizations for S.B. 13-200 to expand Medicaid eligibility and FY 13-14 R7 Substance use disorder benefit. The annualizations for these initiatives are shown separately from other anualizations due to the high level of legislative interest and the magnitude of the annualizations Department-wide.

Annualize Prior Year Budget Decisions	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 13-14 R12 Customer service technology improvements	($1,620,000)	($810,000)	$0	$0	($810,000)
HB 12-1281 Medicaid payment reform pilot program	(62,000)	0	(31,000)	0	(31,000)
SB 13-166 Extend deadlines medical clean claims standards	(100,000)	(100,000)	0	0	0
TOTAL Annualizations	(1,782,000)	(910,000)	(31,000)	0	(841,000)

The increase for S.B. 12-159 is for program evaluations of the Children with Autism waiver program. The first report is due June 1, 2013. The source of funds for the state match is the Colorado Autism Treatment Fund, which receives a statutory allocation from tobacco settlement dollars.

➔ R15 Hospital backup program

Request: The Department requests funding for consulting services to study the Hospital Backup Program (HBU). The HBU serves ventilator-dependent and medically complex clients who are acutely stable and 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. According to the Department, the 20+ year old design of the program does not optimally incorporate modern medical and technological advances, and so there is room to improve health outcomes and reduce costs. Also, current average annual expenses per client are high at approximately $250,000. 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. Potential reforms discussed in the request include incentives for providers who accomplish ventilator weaning for their clients, expansion of the program to serve children, and adding a comprehensive training program for client family members to improve the success of home-based care. 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.

Recommendation: Staff recommends approval of the request. The current costs per client are high and the Department believes some reforms could reduce them while improving health outcomes. In particular, the Department believes the number of clients being weaned from ventilators is not as high as expected, given research on the successes of this approach, and the Department would like to ensure that the right supports are in place so that ventilator weaning can occur safely at a more frequent rate. Potential savings can't be estimated until the program is redesigned, which will be the work of the contractor. The Department does not have the appropriate in-house clinical expertise to redesign the program.

➔ BA14 Customer service technology true-up

Request: The Department requests funding for call center technology to address higher than expected volume. Last year the JBC approved *FY 13-14 R12 Customer service technology improvement* to upgrade the Department's severely out-of-date call center technology. Actual call volume has been triple the original estimate, causing problems with storage capacity for verbal attestations, funding shortfalls for components of the system that are financed on a per minute basis, and excess delays in completing maintenance and system change requests.

The Department attributes the misestimate of call volume to an increase in average call length associated with the implementation of the Affordable Care Act and a limitation of the previous call technology that lacked information on callers receiving a busy signal. Compounding the

difficulties associated with higher call volume, the Department's original estimate of maintenance costs was too low in light of the requirements of H.B 12-1288 that specify minimum criteria for project plans and business requirements, business continuity planning, and an assigned project manager.

Recommendation: Staff recommends approval of the request. The call center technology is a key component of the Department's customer services. The components of the staff recommendation are summarized in the table below.

BA14 Customer Service Technology True-up	
Item	Cost
Interactive Voice Response minutes	$550,000
Verbal attestation storage	3,468
Development hours	200,000
OIT Business analyst	62,000
OIT Senior IT project manager	80,000
Projected need	895,468
Current appropriation	180,000
Funding shortfall	$715,468
General Fund	357,734
Federal Funds	357,734

(B) TRANSFERS TO OTHER DEPARTMENTS

This subsection funds programs administered or financed by departments other than the Department of Health Care Policy and Financing, except for programs administered by the Department of Human Services, which are appropriated in Division 6.

Public Health and Environment

Facility Survey and Certification

This line item pays the Department of Public Health and Environment to monitor a variety of long-term care providers for safety and compliance with Medicaid regulations, including nursing homes, hospices, home health agencies, alternative care facilities, personal care/homemaking agencies, and adult day services. This monitoring is performed as part of the Department of Public Health and Environment's larger function of establishing and enforcing standards of operation for health care facilities pursuant to Section 25-1.5-103, C.R.S. Financing for the Medicaid-related regulation is provided as follows:

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

Request: The Department requested a nonprioritized budget amendment to adjust the appropriation for changes in health, life, and dental.

Recommendation: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending the amount reflected in the numbers pages for this line item is the Department's request. The table below summarizes the estimated portions of the line items in DPHE that are financed from this appropriation and the pending items.

Public Health and Environment Facility Survey and Certification			
Line Item	Total	MGF	MFF
Administration and Support			
Administration			
HLD	$434,356	$132,544	$301,812
STD	6,538	1,994	4,544
AED	121,685	37,217	84,468
SAED	106,580	34,743	71,837
Salary Survey	95,422	28,628	66,794
Merit Pay	44,124	13,237	30,887
Vehicles	Pending		
Indirect Costs	40,000	0	40,000
Health Facilities and EMS			
Health Facilities Programs			
Medicaid/Medicare Certification Program	5,461,548	1,424,567	4,036,981
Transfer To Dept. of Public Safety	Pending		
Indirect Costs	569,894	0	569,894
TOTAL - Facility Survey and Certification	$6,880,147	$1,672,930	$5,207,217

Prenatal Statistical Information

This line item pays the Department of Public Health and Environment to collect and analyze data, through the Vital Statistics office, on the effectiveness of the Enhanced Prenatal Care program, more commonly known as Prenatal Plus. This program provides case management, nutrition, and mental health counseling for women assessed as at-risk for delivering low birth weight infants. The services address lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect pregnancy. Services are paid for in the Medical Services Premiums line item. This appropriation covers only the data collection and evaluation performed by the Department of Public Health and Environment. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding based on the JBC's decisions during figure setting for the Department of Public Health and Environment.

Human Services

Nurse Home Visitor Program

This line item pays a portion of the cost for nurses to visit first-time mothers in families with incomes up to 200 percent of the federal poverty guidelines to provide education on nutrition and general child care and to promote the health and development of children. Funding for the program is appropriated to the Department of Human Services and then a portion is transferred

to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. Although the Department of Human Services is the lead agency for financing, the program is actually administered by the University of Colorado Health Sciences Center. The federal match rate is 50 percent.

Request: The Department requests *BA10 Enhanced FMAP* to account for the increase in the federal match rate effective October 1, 2014.

Recommendation: Staff recommends the requested total funding and the adjustment to the fund sources for the change in the FMAP. Based on prior year actual expenditures, this is probably more spending authority than the line item needs, but if fewer Medicaid-eligible clients are served, then the Department of Human Services will transfer less to the Department of Health Care Policy and Financing and use the tobacco settlement monies instead to serve clients who are not eligible for Medicaid.

Regulatory Agencies

Nurse Aide Certification

This line item pays for the Department of Regulatory Agencies to certify nurse aides working in facilities with Medicaid patients. The Department of Regulatory Agencies also receives payments from Medicare. The reappropriated funds are fees for background checks transferred from the Department of Regulatory Affairs. Only non-certified nurses are required to pay the fees. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

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

Reviews

This line item pays the Department of Regulatory Affairs to conduct sunset reviews of programs administered by the Department of Health Care Policy and Financing. The federal match rate depends on the program being reviewed.

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

Recommendation: Staff recommends the request based on the statutory sunset reviews required in FY 2014-15. The money is transferred to the Executive Director's Office of the department of Regulatory Agencies.

Education

Public School Health Services Administration

This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and

Financing and the Department of Education. Pursuant to Section 25.5-5-318, C.R.S., up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are allocated between the two departments according to an interagency agreement. The source of funding used to match the federal funds is certified public expenditures by school districts. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

Request: The Department requests continuation funding.

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

Local Affairs

Home Modifications Benefit administration and Housing Assistance Payments

This proposed new line item would pay the Department of Local Affairs to administer the existing Medicaid home modifications benefit. In addition, the Department of Local Affairs would assist clients of the Colorado Choice Transitions (CCT) program in acquiring housing with the proposed new Housing Assistance Payments.

Request: The Department requests *R9 Medicaid community living initiative* to create this new line item.

Recommendation: Staff recommends a different amount than the request as discussed in the recommendation on *R9 Medicaid community living initiative* below.

➔ R9 Medicaid community living initiative

Request: The Department requests funding for:

- 2.0 FTE at the Department of Local Affairs to administer the existing Medicaid home modifications benefit
- Counseling for people in nursing homes on their options for receiving care in a community setting
- 75 Housing Assistance Payments (HAPs), growing to 225 in FY 2016-17, to help people in the Community Choice Transitions (CCT) program find affordable accommodations

The Department believes that contracting with the Department of Local Affairs to administer the home modifications benefit will dramatically improve the oversight of the program and ensure that Medicaid is getting appropriate value for clients from the outlay. The home modifications benefit pays for physical adaptations up to a $10,000 lifetime limit that allow a client in a home and community based services waiver to stay in a community setting, such as building ramps, installing grab bars, widening doorways, and adding specialized electric or plumbing systems. Currently, the benefit is overseen by Medicaid case managers not experienced in construction projects. The Department of Local Affairs would review the appropriateness of bids and

perform inspections to ensure that home modifications are safe and priced appropriately, which are functions beyond the scope and capacity of Medicaid case managers.

The options counseling is to follow up with people in nursing homes who express interest in living 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 currently have resources to reach out and provide options counseling for people interested in transitioning to the community. Without the requested funding there is no follow-up after the nursing home surveys to help clients who express an interest in transitioning to the community.

The Housing Assistance Payments are to ensure that clients in the Community Choice Transitions program are able to find affordable accommodations in the community. The federal grant for the CCT program is based on the assumption that 100 people per year will transition from institutional settings to the community. The Department's forecast of Medicaid expenditures also assumes savings from a transition of 100 clients per year. However, the projection that 100 clients could transition per year was originally based on Colorado receiving an increase in federal funds for HAPs, but 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. If General Fund is not provided for HAPs, the Department would need to revise the forecast of how many people will transition to a community setting through the CCT.

If the General Fund for HAPs is provided, the Department projects a net savings in General Fund from the CCT, although not as great of a net savings as would have occurred if Colorado had received an increase in federal funding for the HAPs. The table below summarizes the Department's projection of the costs and savings associated with 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.

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)**

Colorado Choice Transitions			
	FY 2013-14	FY 2014-15	FY 2015-16
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)

Recommendation: Staff recommends approval of the request with modifications. First, the staff calculation of the new FTE at the Department of Local Affairs is lower than the request due to application of the JBC's common policies. Second, staff reduced the estimated cost of following up with clients who respond to the nursing home survey that they are interested in pursuing community-based care options by one third. While staff believes it is important to provide this follow-up service, staff suspects that expressing interest on a survey is easier than actually changing settings and the interest of some clients will wane once the counseling begins and the actions necessary to achieve a transition are discussed. The Department estimated three hours of options counseling per client, but staff lowered the estimate to two hours. Third, staff recommends placing the funding for the HAPs in the Department of Local Affairs, rather than Health Care Policy and Financing. HAPs are not a Medicaid benefit that draws a federal match and staff believes they would be well outside the existing statutory authority for the Department of Health Care Policy and Financing. Finally, the staff calculation of the impact of the change in the FMAP rate is slightly different than the Department's request for unknown reasons due to incomplete documentation from the Department of how they arrived at their figures. The table below summarizes the components of the staff recommendation by fiscal year. There will also be a reapproproiated funds impact and an increase of 2.0 FTE in the Department of Local Affairs that is not reflected in the table from the transfer of administration funds and the per inspection fees.

R9 Medicaid Community Liviing Initiative			
	FY 2014-15	FY 2015-16	Federal Match
Health Care Policy and Financing			
Transfers to Other Departments			
Administration of the home modifications benefit	$205,146	$206,185	50.0000%
Medical Service Premiums			
Community living options counseling	313,308	319,302	50.7575%
Per inspection fee for home modifications benefit	50,765	51,935	50.7575%
Subtotal - Medical Service Premiums	364,073	371,237	

R9 Medicaid Community Liviing Initiative			
	FY 2014-15	FY 2015-16	Federal Match
TOTAL - Health Care Policy and Financing	569,219	577,422	
General Fund	281,852	285,899	
Federal Funds	287,367	291,523	
Local Affairs			
Division of Housing			
Housing Assistance Payments (HAPs)	450,375	936,750	0.0000%
TOTAL	$1,019,594	$1,514,172	
General Fund	732,227	1,222,649	
Federal Funds	287,367	291,523	

The funding for Local Affairs to administer the home modifications benefit addresses a shortcoming in the current program where Medicaid case managers are not qualified to ensure that home modifications are done safely and at an appropriate price. The cost of administering the home modification benefit includes the transfer to the Department of Local Affairs plus an appropriation in the Medical Services Premiums line item for a per inspection fee. The total of the two components is $254,111, which is 6.3 percent of the $4,056,591 the Department spent on home modifications in FY 2012-13.

To do the work of surveying nursing home patients to determine who might be interested in transitioning to a community setting but then not follow up with those who express an interest would be a waste, because it leaves potential savings unexplored, as well as bad customer service.

The housing assistance payments are recommended because with them there is a net projected savings from the Colorado Choice Transitions initiative. Without the housing assistance payments the Department would need to revise the projected impact of the Colorado Choice Transitions program.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

Information Technology Contracts

This line item pays for maintenance of the Medicaid Management Information System (MMIS) and the Web Portal. MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor

that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives a 65 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

Request: The Department requests continuation funding with annualizations of prior year budget actions

Recommendation: Staff recommends the requested continuation funding with the annualizations detailed in the table below.

Annualize Prior Year Budget Decisions					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 12-13 BA6 MMIS Operating rules compliance	($1,828,854)	($242,460)	($40,060)	$0	($1,546,334)
FY 12-13 BA8 MMIS Technical adjustments	(1,442,637)	(91,768)	(56,722)	0	(1,294,147)
FY 13-14 R9 Dental ASO	(1,152,144)	($288,036)	$0	$0	($864,108)
FY 10-11 BA15 MMIS Adjustments	(682,286)	(71,976)	0	0	(610,310)
SB 13-242 Adult dental benefit	(555,534)	0	(138,884)	0	(416,650)
SB 13-200 Medicaid eligibility expansion	(201,600)	0	(100,800)	0	(100,800)
FY 12-13 BA6 MMIS Technical adjustments	(47,360)	0	(4,972)	0	(42,388)
HB 09-1293 Health Care Affordability Act	55,278	0	13,820	0	41,458
TOTAL Annualizations	($5,855,137)	($694,240)	($327,618)	$0	($4,833,279)

Medicaid Management Information System (MMIS) Reprocurement Contracted Staff
Medicaid Management Information System Reprocurement Contracts

These two line items to pay for the renewal of the Department's claims processing hardware and software.

Request: The Department requests annualization of FY 13-14 R5 Medicaid Management Information System Reprocurement.

Recommendation: Staff recommends the requested annualization consistent with the JBC's action last year.

Fraud Detection Software Contract

This line item pays for maintenance and upgrades of software that detects payment, utilization, and referral patterns that may be indicators of fraud, waste, or abuse. It also monitors compliance issues and statistics related to fraud investigative costs.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Centralized Eligibility Vendor Contract

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). Beginning in FY 2011-12, it also includes money for determining Medicaid eligibility for Adults without Dependent Children (AwDC) and the

Medicaid Buy-in for People with Disabilities (Buy-in). The source of cash funds is the Hospital Provider Fee. The federal match rate for eligibility determinations is 50.0 percent for Medicaid and 65.0 percent for CHP+. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. Therefore, the federal government reimburses 88.0 percent the contract for CHP+ eligibility determinations at the Medicaid match rate and 12.0 percent at the CHP+ match rate.

Request: The Department requests:

- *R6 Eligibility admin enhanced match*
- *R12 Admin contract reprocurements*
- Annualization of S.B. 13-200 Expand Medicaid eligibility

Recommendation: Staff recommends the request. For the recommendation on *R6 Eligibility admin enhanced match* see the County Administration line item. For the recommendation on *R12 Admin contract reprocurements* see the Personal Services line item.

CBMS Modernization Project

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

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility.

Recommendation: Staff recommends the requested funding with the annualizaiton.

Health Information Exchange Maintenance and Projects

This proposed new line item would expand the capacity of the Health Information Exchange (HIE) network that allows the sharing of health data between providers.

Request: The Department requests *R5 Health Information Exchange* to create the line item.

Recommendation: Staff recommends the requested funding per the analysis of R5 below.

➔ R5 Health Information Exchange

Request: 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.

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.

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 for the Department to continue using the HIE. CORHIO will manage and coordinate the infrastructure improvements.

The provider support component of the request would provide training in adopting and utilizing electronic health record technology and the HIE network.

There are potential benefits for several other state agencies from this project, including the departments of Public Health and Environment, Human Services, Regulatory Agencies, and Corrections. Some of those agencies have submitted requests for technology improvements with benefits that would be magnified by a connection to the HIE. However, there are also benefits from those requests that are independent of the HIE, and so the requests have not been submitted as a single unified project.

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.

Recommendation: Staff recommends approval of the request. Significant federal funding is available for a relatively small state investment to dramatically improve communications between electronic health record systems. There are enormous potential gains in efficiency and quality of care from providers adopting electronic health records and gaining instant access to accurate, timely, accessible, and consistent patient records. These gains are magnified with the electronic health record system adopted by a provider is able to communicate with other electronic health record systems so that all providers are able to see the same information about a patient.

R5 Health Information Exchange						
Item	FY 14-15	FY 15-16	FY 16-17	FY 17-18	Total	FFP
Build and Maintain HIE Infrastructure						
Directory of HIE Systems and Reporting Tools						
Client directory	$200,000	$250,000	$0	$0	$450,000	90.0%
Provider directory	300,000	500,000	0	0	800,000	90.0%
Clinical data repository	0	500,000	500,000	0	1,000,000	90.0%
Transition of Care/Continuity of Care Document tools	125,000	125,000	0	0	250,000	90.0%
Clinical Quality Measure analytical tool	0	125,000	125,000	0	250,000	90.0%
Clinical data analytical tools	0	0	576,000	576,000	1,152,000	90.0%
Interface engine	195,000	195,000	0	0	390,000	90.0%
Public health reporting capacity increase	164,000	0	0	0	164,000	90.0%
Public health reporting data validation	218,000	218,000	218,000	218,000	872,000	90.0%
Subtotal: Directory of HIE Systems and Reporting Tools	1,202,000	1,913,000	1,419,000	794,000	5,328,000	90.0%
Interfaces						
Medicaid provider interfaces	1,500,000	1,500,000	1,500,000	0	4,500,000	90.0%
Critical access hospital interfaces	138,750	125,000	110,000	0	373,750	90.0%
QHN to CORHIO interface	40,000	20,000	20,000	20,000	100,000	90.0%
Interfaces with the expanded client/provider directories (MMIS, APCD, and systems at DPHE, DHS and DORA)	1,260,000	4,550,000	0	0	5,810,000	90.0%
Subtotal: Interfaces	2,938,750	6,195,000	1,630,000	20,000	10,783,750	90.0%
Ongoing Costs						
Operations and maintenance	0	0	2,000,000	2,000,000	4,000,000	75.0%
HIE network data and analytics	800,000	800,000	800,000	800,000	3,200,000	50.0%
APCD data and analytics	400,000	400,000	400,000	400,000	1,600,000	50.0%
Subtotal: Ongoing Costs	1,200,000	1,200,000	3,200,000	3,200,000	8,800,000	Mix
Coordination and Oversight						
2 FTE at CORHIO	250,000	250,000	250,000	250,000	1,000,000	90.0%
Subtotal: Coordination and Oversight	250,000	250,000	250,000	250,000	1,000,000	90.0%
Support Providers						
Provider EHR Incentive Payments, Outreach, and Training						
EHR Incentive Payment Program Cost Savings	(1,391,824)	(1,391,824)	(1,391,824)	(1,391,824)	(5,567,296)	90.0%
Outreach, education, and technical services	1,550,000	1,550,000	1,550,000	1,550,000	6,200,000	90.0%
Subtotal: Incentives, Outreach, and Training	158,176	158,176	158,176	158,176	632,704	90.0%
Total Request	$5,748,926	$9,716,176	$6,657,176	$4,422,176	$26,544,454	
General Fund	1,054,893	1,451,618	1,445,718	1,222,218	5,174,447	
Federal Funds	4,694,033	8,264,558	5,211,458	3,199,958	21,370,007	

Part of the modifications to the electronic health record incentive payment program include moving money from the General Professional Services and Special Projects line item to the newly created Health Information Exchange line item and providing $20,000 in the Operating Expenses line item for travel costs for Department staff.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

Medical Identification Cards

Funding in this line item pays for production of plastic authorization cards for Medicaid and the Old Age Pension State Medical Program. The source of cash funds is the Hospital Provider Fee. The source of reappropriated funds is a transfer from the Old Age Pension Medical Program in

the Other Medical Services division. The federal match rate is 50.0 percent for Medicaid cards. There is no federal match for the Old Age Pension State Medical Program.

Request: The Department requests continuation funding.

Recommendation: Staff recommends continuation funding. The number of cards required each year is dependent not only on caseload, but also turnover. Periodically the Department will submit requests to update the estimate based on changing patterns in the number of cards needed, but not typically every year.

Contracts for Special Eligibility Determinations

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital.

In FY 2011-12 there was a significant increase in the appropriation from the Hospital Provider Fee for disability determination services in anticipation of increased workload with the Medicaid buy-in program for people with disabilities.

Request: The Department requests *BA13 Disability determination contract reprocurement* and annualization of S.B. 13-200 Expand Medicaid eligibility

Recommendation: Staff recommends the request, including the annualization. For the recommendation on *BA13 Disability deterimination contract reprocurement* see the Personal Services line item.

County Administration

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds so that in FY 2013-14 county funds represent 14 percent of the appropriation. The traditional federal match was 50 percent, but a recent reinterpretation by the Centers for Medicare and Medicaid Services (CMS) expanded the activities eligible for a 75 percent match as maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility and *R6 Eligibility determination enhanced match* to annualize and expand on the

interim supplemental approved by the JBC that reinvested the General Fund savings achieved as a result of the higher federal match when CMS reinterpreted the qualifying activities.

Recommendation: Staff recommends approval of the request. The recommendation on *R6 Eligibility determination enhanced match* is described in more detail below.

➔ R6 Eligibility determination enhanced match

Request: The Department proposes reinvesting General Fund and Hospital Provider Fee moneys no longer needed to match federal funds for eligibility determination services as a result 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 traditional 50 percent match rate for administration. The Department estimates that 56 percent of current county administration activities will qualify for the enhanced match rate. During the interim the JBC approved a supplemental reinvesting the $2.5 million in state fund savings in FY 2013-14 to draw an additional $7.6 million in federal funds, to address data transfer issues with Connect for Health, provide contingency funds in case the ACA implementation eligibility determination workload exceeds expectations, and increasing county administration payments.

For FY 2014-15 the Department is projecting $6.4 million in state fund savings and requesting that these be reinvested to match an additional $9.3 million in federal funds. The net result in FY 2014-15 would be no change in total state funding, but an increase in federal funds of $15.7 million. For FY 2014-15 the Department would fund the diminishing second-year costs of the FY 2013-14 interim supplemental and proposes the following new initiatives:

- Infrastructure improvement competitive grants -- These would be one-time grants to improve the infrastructure of counties for handling eligibility determinations.
- Incentive payments -- 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. 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.
- Study of eligibility determination payment system -- 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.
- 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.

The table below summarizes the components of the request and the dollars associated with each initiative.

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

Recommendation: Staff recommends the request. In total the allowable county administration expenses for public assistance programs exceed appropriations. The Department's request will increase reimbursements for counties with no net increase in General Fund appropriations. Also, it will introduce a performance component to the reimbursement for counties and provide competitive grants designed to make counties more efficient. In addition, the request will begin paying Medical Assistance sites for work that is very similar to what the counties provide, addressing an equity issue in the current financing of eligibility determination services. Finally, the request includes financing for a contractor who will make recommendations on how to reimburse Medical Assistance sites, but more importantly, look comprehensively at the way eligibility determination services are reimbursed statewide. There are currently significant variations in the Department's reimbursement per application processed and not all of the variations are easily explained by factors such as economies of scale, the complexity of applications processed, or the adequacy of the physical and technological infrastructure. Further complicating the picture are recent improvements to the Department's online application system that have increased the automation and accessibility of the eligibility determination process. Staff believes the compensation process for eligibility determination services would benefit from a comprehensive review and potential reform.

Hospital Provider Fee County Administration

This line item was created to separate the funding for eligibility determinations for expansion populations authorized through the Health Care Affordability Act (H.B. 09-1293) from the funding for other populations. The state match for eligibility determinations for the expansion populations authorized by H.B. 09-1293 is funded entirely with the Hospital Provider Fee with no local county match. The federal participation rate is 50.0 percent.

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility and *R6 Eligibility determination enhanced match* to annualize and expand on the interim supplemental approved by the JBC that reinvested the General Fund savings achieved as a result of the higher federal match when CMS reinterpreted the qualifying activities.

Recommendation: Staff recommends approval of the request. For the recommendation on *R6 Eligibility determination enhanced match* see the County Administration line item.

Administrative Case Management

This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency

This line item was added as a result of the JBC's action on an interim supplemental dealing with the enhanced match for eligibility determination services.

Request: The Department requests *R6 Eligibility determination enhanced match* to annualize the interim supplemental actions approved by the JBC.

Recommendation: Staff recommends the request consistent with the JBC's action during the interim.

Medical Assistance Sites

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

Request: The Department requests *R6 Eligibility admin enhanced match* to create the line item.

Recommendation: Staff recommends the request. For the analysis of *R6 Eligibility admin enhanced match* see the County Administration line item.

Customer Outreach

This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

Request: The Department requests:

- *R12 Admin contract reprocurements*
- *BA12 Enroll dual eligibles in ACC*
- Annualize SB 13-200 Expand Medicaid eligibility
- Annualize FY 13-14 R11 H.B. 12-1281 Departmental differences

Recommendation: The staff recommendation differs from the Department's request due to including the federal grant funds associated with *BA12 Enroll dual eligibiles in ACC*. For the recommendations on *BA12 Enroll dual eligibiles in ACC* and *R12 Admin contract reprocurements* see the Personal Services line item.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

Professional Services Contracts

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

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

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

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

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

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

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility, *R13 Utilization review services*, and *BA12 Enroll dual eligiblies in the ACC*

Recommendation: The staff recommendation differs from the Department's request due to including the federal grant funds associated with *BA12 Enroll dual eligibiles in ACC*. See the Personal Services line item for a discussion of *BA12 Enroll dual eligibiles in the ACC.* The recommendation on *R13 Utilization review services* is discussed in more detail below.

➔ R13 Utilization review services

Request: 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.

Regarding long-term services and supports, the Departments estimates that the caseload has increased 131 percent since funding for this service was last adjusted. This leads to delays in clients receiving reviews and complications for providers who must complete reviews within 60 days. Of the total requested funds $1,313,360 is for long-term care utilization review.

For drug utilization review much of the work is currently done in-house and retrospectively due to the funding limitations of the contract. However, due to the workload and expertise required the Department indicates that the review of complex cases is inconsistent and in some instances nonexistent. The Department's current contract for $166,000 is well below the least expensive similar contract in other states of $430,000 in Arkansas. Of the total requested funds $378,617 is for drug utilization review.

Recommendation: Staff recommends approval of the request. The funding for long-term services and supports has not kept pace with enrollment growth and the funding for drug utilization review is currently substandard.

(F) PROVIDER AUDITS AND SERVICES

Professional Audit Contracts

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.
- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.
- Payment Error Rate Measurement Project -- Each state must estimate the number of Medicaid payments that should not have been made or that were made in an incorrect amount, including underpayments and overpayments, every three years according to a staggered schedule set up by the federal government.
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.

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

Request: The Department requests annualization of one-time funding for payment error rate measurement.

Recommendation: Staff recommends the request with the annualization.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

Estate Recovery

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis of 10.9 percent. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

(G.5) STATE OF HEALTH PROJECTS

This is a new subdivision requested by the Department in *BA10 Enhanced FMAP* for the reinvestment of General Fund savings from a change in the federal match rates for Medicaid and CHP+ into a suite of initiatives that the Department describes as "State of Health" projects.

Transfer from General Fund to State of Health Cash Fund

This is a new line item that the Department proposes creating through legislation authorizing an appropriation from the General Fund to a newly created State of Health Cash Fund.

Request: The Department requests BA10 Enhanced FMAP to account for the savings from the change in the federal match rate and reinvest the savings in State of Health projects.

Recommendation: Staff does not recommend funding for this proposed line item. See the analysis of *BA10 Enhanced FMAP* below for more detail.

➔ BA10 FMAP change

The Department's BA10 makes adjustments to the budget to account for an increase in the federal match rates for Medicaid and CHP+ and proposes several initiatives to spend the General Fund savings.

Federal match rate

The Department received notice in November that the federal match rates for Colorado's Medicaid and CHP+ programs will increase for Federal Fiscal Year (FFY) 2014-15, saving an estimated $35.7 million General Fund in state FY 2014-15. The Department made this estimate before the February revised forecast of Medicaid enrollment and expenditures was complete. The JBC staff will revise the estimated savings once all figure setting decisions are made. The

federal match rate for Medicaid is increasing from 50 percent to 51.01 percent and for CHP+ from 65 percent to 65.71 percent.

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

The table below shows how Colorado's per capita personal income has fared relative to the national average in recent years. If Colorado's per capita income increases faster than the national average, then the ratio and corresponding FMAP will eventually decrease, and vice versa. However, the FMAP formula uses a three-year average of the most recent calendar year state and national per capita personal income, and so the impact of an increase in per capita income can be overshadowed by a decrease in a prior year. For the FFY 2014-15 calculations the relevant years are 2010 through 2012. Using the three-year average of per capita income reduces the rate of change in a state's FMAP.

Per Capita Income			
Calendar Year	National Average	Colorado	Ratio Colordo/ National Ave.
2006	$ 38,127	$ 40,627	106.56%
2007	$ 39,804	$ 42,199	106.02%
2008	$ 40,873	$ 43,406	106.20%
2009	$ 39,357	$ 41,515	105.48%
2010	$ 40,163	$ 41,717	103.87%
2011	$ 42,298	$ 44,179	104.45%
2012	$ 43,735	$ 45,775	104.66%

In addition to economic factors in Colorado relative to the nation, the FMAP is being influenced by a level shift in the assumptions by the Department of Commerce's Bureau of Economic Analysis (BEA) about per capita personal income. At the end of each federal fiscal year the BEA releases a report on per capita income that is used to calculate the FMAP for the federal fiscal year starting in the next calendar year. So, for FFY 2014-15 the September 2013 report was used. The BEA frequently restates personal income based on new data and/or changes in the methodology. The September 2013 BEA report restated per capita personal income back to 2000. The restatement of per capita personal income is at least part of why Colorado is

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

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

qualifying for a higher FMAP in FFY 2014-15. In fact, if the restated per capita incomes from the September 2013 BEA report had been used to calculate the current FFY 2013-14 FMAP, Colorado would have qualified for a 50.77 percent FMAP rather than the current 50.0 percent FMAP. However, once the FMAP rate is set, no retroactive adjustments are made for any subsequent restatement of per capita income. Knowing that part of the change in Colorado's FMAP for FFY 2014-15 is attributable to a level change in per capita personal income assumptions has some bearing on projecting whether Colorado will be eligible for a similar FMAP in the future.

It is not unusual for a state's FMAP to increase or decrease from year to year, though it hasn't happened in recent memory for Colorado. Colorado experienced a long stretch from FFY 1999-00 to the present where the base FMAP, not including fiscal relief from the Jobs and Growth Tax Relief Reconciliation Act of 2003 or the American Recovery and Reinvestment Act of 2009, remained unchanged at the Medicaid minimum 50 percent. However, for most states an annual change in the FMAP is typical. In FFY 2014-15 the FMAP for 38 states will change, ranging from an increase of 1.42 percent for Missouri to a decrease of 2.39 percent for Iowa. The following table shows states with FMAP changes of more than 1.0 percent.

States with FMAP changes of more than 1.0 percent			
	FFY 2013-14	FFY 2014-15	Difference
Missouri	62.03	63.45	1.42
Nevada	63.10	64.36	1.26
Arizona	67.23	68.46	1.23
Louisiana	60.98	62.05	1.07
Colorado	50.00	51.01	1.01
Georgia	65.93	66.94	1.01
Vermont	55.11	54.01	(1.10)
Nebraska	54.74	53.27	(1.47)
Delaware	55.31	53.63	(1.68)
Pennsylvania	53.52	51.82	(1.70)
Oklahoma	64.02	62.30	(1.72)
South Dakota	53.54	51.64	(1.90)
Iowa	57.93	55.54	(2.39)

Prior to FFY 1990-00 Colorado had long periods of time with FMAP rates above 50 percent. In the table below the shaded quarters show the FMAP with the enhanced federal match for budget relief purposes pursuant to the Jobs and Growth Tax Relief Reconciliation Act of 2003 and the American Recovery and Reinvestment Act of 2009 respectively. Without the enhanced matches for budget relief, Colorado would have qualified for a 50 percent FMAP in those quarters.

History of Federal Match Rates for Colorado's Medicaid Program											
State Fiscal Year	Ave. FMAP	FMAP by Quarter				State Fiscal Year	Ave. FMAP	FMAP by Quarter			
		Q1	Q2	Q3	Q4			Q1	Q2	Q3	Q4
FY 65-66	50.00	50.00	50.00	50.00	50.00	FY 90-91	53.22	52.11	53.59	53.59	53.59
FY 66-67	50.00	50.00	50.00	50.00	50.00	FY 91-92	54.49	53.59	54.79	54.79	54.79
FY 67-68	53.98	50.00	55.31	55.31	55.31	FY 92-93	54.51	54.79	54.42	54.42	54.42
FY 68-69	55.31	55.31	55.31	55.31	55.31	FY 93-94	54.33	54.42	54.30	54.30	54.30
FY 69-70	56.01	55.31	56.24	56.24	56.24	FY 94-95	53.40	54.30	53.10	53.10	53.10
FY 70-71	56.24	56.24	56.24	56.24	56.24	FY 95-96	52.61	53.10	52.44	52.44	52.44
FY 71-72	57.27	56.24	57.61	57.61	57.61	FY 96-97	52.35	52.44	52.32	52.32	52.32
FY 72-73	57.61	57.61	57.61	57.61	57.61	FY 97-98	52.06	52.32	51.97	51.97	51.97
FY 73-74	57.32	57.61	57.22	57.22	57.22	FY 98-99	50.94	51.97	50.59	50.59	50.59
FY 74-75	57.22	57.22	57.22	57.22	57.22	FY 99-00	50.15	50.59	50.00	50.00	50.00
FY 75-76	55.32	57.22	54.69	54.69	54.69	FY 00-01	50.00	50.00	50.00	50.00	50.00
FY 76-77	54.69	54.69	54.69	54.69	54.69	FY 01-02	50.00	50.00	50.00	50.00	50.00
FY 77-78	53.96	54.69	53.71	53.71	53.71	FY 02-03	50.74	50.00	50.00	50.00	52.95
FY 78-79	53.71	53.71	53.71	53.71	53.71	FY 03-04	52.95	52.95	52.95	52.95	52.95
FY 79-80	53.30	53.71	53.16	53.16	53.16	FY 04-05	50.00	50.00	50.00	50.00	50.00
FY 80-81	53.16	53.16	53.16	53.16	53.16	FY 05-06	50.00	50.00	50.00	50.00	50.00
FY 81-82	52.50	53.16	52.28	52.28	52.28	FY 06-07	50.00	50.00	50.00	50.00	50.00
FY 82-83	52.28	52.28	52.28	52.28	52.28	FY 07-08	50.00	50.00	50.00	50.00	50.00
FY 83-84	50.57	52.28	50.00	50.00	50.00	FY 08-09	57.29	50.00	58.78	58.78	61.59
FY 84-85	50.00	50.00	50.00	50.00	50.00	FY 09-10	61.59	61.59	61.59	61.59	61.59
FY 85-86	50.00	50.00	50.00	50.00	50.00	FY 10-11	59.71	61.59	61.59	58.77	56.88
FY 86-87	50.00	50.00	50.00	50.00	50.00	FY 11-12	50.00	50.00	50.00	50.00	50.00
FY 87-88	50.00	50.00	50.00	50.00	50.00	FY 12-13	50.00	50.00	50.00	50.00	50.00
FY 88-89	50.00	50.00	50.00	50.00	50.00	FY 13-14	50.00	50.00	50.00	50.00	50.00
FY 89-90	51.58	50.00	52.11	52.11	52.11	FY 14-15	50.76	50.00	51.01	51.01	51.01

The Department is unsure what to expect will happen to the FMAP in future years, because the Department does not currently do a forecast of per capita personal income. For BA10 and the February Medicaid forecast the Department assumed that the FFY 2015-16 FMAP would remain at 51.01 percent, but there is no economic modeling behind that assumption. Because of the Department's uncertainty about the future of the FMAP, the initiatives proposed in BA10 to spend the savings from the higher FMAP are for short-duration projects.

While the Department did not provide a forecast of the FMAP, Legislative Council Staff (LCS) was able to provide some preliminary trends for state and national per capita personal income that could be used to derive an FMAP forecast (the shaded cells in the table below). These trends are preliminary and potentially subject to change before the official LCS March forecast. While Legislative Council Staff projects that Colorado's per capita personal income will grow through calendar year 2017, the projected growth is not as strong as the projected national growth according to the Moody's forecast that LCS uses for national estimates. The LCS per capita personal income trends suggest Colorado could be eligible for an FMAP above 50 percent for the next several years.

FMAP with LCS Per Capita Personal Income Growth Trends						
Per Capita Personal Income Assumptions					FMAP Projection	
Calendar Year	Colorado Income	Colorado Growth	National Income	National Growth	Federal Fiscal Year	FMAP
2011	44,179		42,298			
2012	45,775	3.6%	43,735	3.4%	FFY 14-15	51.01
2013	46,620	1.8%	44,663	2.1%	FFY 15-16	50.86
2014	48,389	3.8%	46,756	4.7%	FFY 16-17	51.17
2015	50,369	4.1%	49,561	6.0%	FFY 17-18	52.15
2016	52,191	3.6%	52,052	5.0%	FFY 18-19	53.42
2017	53,995	3.5%	54,129	4.0%	FFY 19-20	54.53

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

Special Match Rates	
Activity/Population	Rate
Breast and Cervical Cancer Treatment	CHIP Rate
Clinical Preventive Services for Adults	FMAP + 1%
Family Planning Services	90%
Money Follows the Person Rebalancing Demonstration	FMAP + 25% in rebalancing fund
Services provided through Indian Health Service and Tribal Facilities	100%
Primary care physician evaluation and management and vaccinations through December 31, 2014	100%
Newly eligible under ACA	100%
Administrative Match Rates	
Adoption and use of electronic health record (EHR) technology	100%
Immigration status verification	100%
Citizenship verification	90%
Medicaid health information technology planning	90%
Upgrading eligibility and enrollment systems through December 31, 2015	90%
Design, development, and installation of MMIS and citizenship verification systems	90%
Management and operation of MMIS and citizenship verification systems	75%
Eligibility software, operations, maintenance, and staff	75%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Translation and interpretation services for children	75%
Other program administration activities	50%

Primary Care Reimbursement

From the estimated $35.7 million in General Fund savings as a result of the increase in the FMAP, the Department proposes reinvesting $18.5 million in reimbursement rates for primary care services, plus $75,000 to study the impact of the rate changes on access for Medicaid clients.

As required by the Affordable Care Act (ACA), the Department increased reimbursement rates for primary care physician services to match Medicare rates for calendar years 2013 and 2014, but in CY 2015 the rates are currently scheduled to revert to their previous levels. Under the ACA Colorado received federal funds for 100 percent of the cost associated with increasing rates from 2009 levels to the Medicare rates. However, because Colorado had made rate reductions since 2009 there was a General Fund cost for the incremental increase required to get back to the 2009 rates. According to the Department, the purpose of the ACA requirement to increase primary care physician service rates was to ensure access for Medicaid clients, especially for those newly eligible as a result of the Medicaid expansion.

The Department believes the design of the original ACA requirement was administratively burdensome and treated services inequitably based on the provider, reducing the potential positive impact of the policy on access. To qualify for the higher reimbursement a service needed to be performed by a provider who self-attested that they were eligible and belonged to specific specialties. The Department proposes removing the attestation and paying the higher rates based on the type of service provided, rather than who provides it. This would allow, for example, independent advanced practice nurses, nephrologists, or HIV doctors to qualify for the higher reimbursement, if they are providing primary care services as the medical home for clients.

The Department proposes removing the self-attestation requirement and paying primary service codes at rates matching Medicare for calendar year 2015 through FY 2015-16. Part of the rationale for the time limit on the provider rates is the Department's concern that the FMAP rate may return to 50 percent in future years. Also, the Department doesn't have more than anecdotal evidence about whether the change in primary care rates has been effective in impacting client access to services. Prior to the expiration of the enhanced rates the Department would complete a study of the impact of the policy on client access and then decide whether to request funding in future years.

If the redesigned reimbursements are approved, the Department estimates 11,569 providers would be impacted and the average increase in reimbursements per provider per quarter would be $1,914 compared to reimbursement at the expiration of the ACA-required rates.

Primary Care Reimbursement		
	FY 2014-15	FY 2015-16
Primary Care Rate Increase	$44,277,696	$92,983,162
General Fund	18,490,366	38,030,113
Federal Funds	25,787,330	54,953,049
Study of Effectiveness	150,000	0
General Fund	75,000	
Federal Funds	75,000	
TOTAL	$44,427,696	$92,983,162
General Fund	18,565,366	38,030,113
Federal Funds	25,862,330	54,953,049

"State of Health" Initiatives

After paying for the primary care rates, the Department proposes depositing the remaining $17.1 million General Fund savings from the change in the FMAP in a newly created cash fund for "State of Health" initiatives. Creating the cash fund would require a bill. There are more savings in FY 2014-15 from the change in the FMAP rate than are needed for the primary care rate proposal, but in FY 2015-16 the annualization of the primary care rate proposal will eat up all of the projected savings from the change in the FMAP rate. The Department would like to spend the additional FMAP savings in FY 2014-15 on the "State of Health" initiatives, but is unsure how quickly it can launch the initiatives. The purpose of the cash fund is to set the money aside for these initiatives and allow it to roll forward to the next fiscal year, if necessary. The Department proposes continuous spending authority from the cash fund. The Department is not assuming a federal match for any of these initiatives, but specifically requests that no limitations be placed on the Department's ability to accept and expend federal matching funds should expenditures from the cash fund qualify for a match. It should also be noted that the way the Department proposes structuring the cash fund would allow money to be reprioritized and moved between the initiatives financed from the cash fund.

The State of Health initiatives are:

- Dental Provider Network Adequacy ($5,000,000) – The Department proposes the following one-time bonus payments to new and existing dentists and hygienists who take on additional Medicaid clients:

Dental Provider Network Adequacy		
	Dentists	Hygienists
5 new Medicaid clients	$1,000	$500
50-99 new Medicaid clients	$500	$250
100+ new Medicaid clients	$1,500	$750

  The initial tier payments are intended to address perceptions that enrolling to become a Medicaid provider is administratively burdensome. To earn the second and third tier bonuses a provider must treat new patients at least two times in a 12-month period.

  The Department expresses a concern that despite increases in dental rates last year the participation of dental providers in Medicaid remains low. The Department has been

working closely with the Colorado Dental Association to determine why participation is not higher and an oft-repeated concern is the hassle of filling out the initial application forms. The Department hopes the first tier payments will eliminate the administrative burden as an excuse for not enrolling as a provider.

- After Hours Primary Care Incentive Program ($5,000,000) – The Department proposes paying primary care providers an additional $7 per visit outside of traditional business hours to create an incentive for more providers to offer after-hours care. At this rate, the requested funding could support 714,285 visits. The Department does not currently track after-hours visits, and so does not know how this compares to existing practice. If the incentive reduced ER visits by 1 percent it would save 891 ER visits per year. The Department believes that short-duration funding might be sufficient to promote change, based on surveys of providers who offer after-hours care. These providers indicate that staff initially resisted the concept, but came to support it once the change was made, due to the flexibility in hours that it offers and the job satisfaction from providing highly needed services. The additional $7 per visit would not be available to providers paid on a basis other than fee-for-service. For example, FQHCs that receive an encounter rate based on cost would not be eligible for the bonus, but if opening after-hours care increased an FQHC's costs the encounter rate would be modified. The effectiveness of the incentive would be studied with an emphasis on reducing ER visits to determine whether to seek continuation funding when the money runs out.

- Pain Management Capacity Program ($1,000,000) – This money would be used to build the capacity of primary care providers to treat patients with persistent or chronic pain. A 2013 study by the National Survey on Drug Use and Health found Colorado had the second highest rate of drug abuse in the country. In response to a small-scale Department survey 78 percent of primary care providers who responded identified pain management as the most difficult specialty to access. The Department also indicates that the complications of dealing with patients who misuse prescription drugs can significantly impact provider job satisfaction and willingness to treat Medicaid patients. According to the Department, there are several successful models for how to improve provider capacity to deal with pain management, with one of the most well-known being Project ECHO. All of the models under consideration by the Department involve case-based learning where providers present via teleconference to instructors and peers. The Department is still exploring potential avenues for federal matching funds, including the possibility of a 75 percent federal match for training medical personnel.

- Social-emotional Learning Program for Early Childhood Education ($6,089,710) -- This money would support a collaborative effort between Health Care Policy and Financing, Public Health and Environment, Education, and Human Services to close cognitive, behavioral, emotional, and health gaps between children with low income and the general population. Materials provided by the Department subsequent to the request describe the program as the "Colorado Opportunity Project." The concept is based on the Brookings Institution's Center on Children and Families Social Genome Model where a group of programs with research-proven efficacy is coordinated across multiple government agencies and applied to a cohort of children. The emphasis is on programs in state and county government that already exist and the funding is for coordination of these programs and then

research and evaluation of the results, rather than offering new services. The Department provided the following estimated budget:

Estimated Total Budget for Implementing the Colorado Opportunity Project	
Item	Cost
Temporary Employee for Oversight of Program Implementation	$100,211
Training	321,000
Coordination of Programs Included in the Framework	1,000,000
Stakeholder Meeting Facilitation	136,000
Development of Database	3,800,000
Grants to Counties, Community Partners for Enhanced Casework	475,747
Program Evaluation	256,752
Total Cost	$6,089,710

Recommendation:
Staff recommends:

- An adjustment to the budget for the increase in the FMAP. Staff used similar methods to the Department for estimating the impact on each line item, but the staff calculations will differ from the Department where the total recommendation differs from the request.
- The requested funding for primary care reimbursement and the associated study of the effectiveness of the reimbursement. This is a relatively simple proposal that is consistent with previous CMS guidance and should be implementable by January 2015. Not implementing the request would have the effect of reducing provider rates. The proposed funding keeps the reimbursements for providers closer to their actual costs, and the Department believes the higher provider rates have had a positive impact on client access to services. The proposed reform to remove the self-attestation requirement will eliminate a counter-productive administrative hassle for providers and the Department as well as extend the higher rates to a wider range of providers.
- An appropriation of $500,000 total funds, including $$246,212 General Fund, in FY 2014-15 and FY 2015-16 for the Department's proposed Pain Management Capacity Program, contingent on federal matching funds. Staff believes the likelihood of federal matching funds for this initiative is reasonably high and if federal funds are available it can be implemented without specific authorizing legislation. However, due to the time required to submit a proposal and receive approval from CMS, staff assumes only half the requested total funding would be spent in the first fiscal year. The Pain Management Capacity Program appears to be both the initiative the Department has researched the most and the most urgent need. Patients improperly using pain medication can become abusive, dangerous, and prone to law breaking. According to the Department, there are well-researched treatment approaches for pain management that have proven successful in reducing drug abuse. If knowledge of these practices could be disseminated effectively, the adoption of these practices has the potential to significantly improve health outcomes for clients as well as the providers' experience of dealing with the clients. The Department did not submit a detailed budget for this proposal, but a total of $1,000,000 over two years is not an unreasonable amount to assume for a training and capacity building program, and education programs of this nature can generally be scaled to match available funding. For comparison, S.B. 13-264 provided $1,000,000 for the Commission on Family Medicine to develop rural residency programs. If federal funds

are not available, then the executive branch could submit a request for legislative authorization for a General Fund only program next year. Staff would argue that this is an education need for providers beyond just Medicaid, and so a General Fund only program might better be housed in the Department of Higher Education with a more global mission.

Staff does not recommend legislation to create the requested cash fund or direct appropriations for any of the other "State of Health" initiatives. Staff does not believe it is necessary or beneficial from a statewide budgeting perspective to reserve and earmark the savings from the change in the FMAP rate specifically for the Department of Health Care Policy and Financing. If the JBC wants to set aside some of the savings from the change in the FMAP for use in a future year, there are already methods of doing so without creating a new cash fund. There may be other better uses for this money in FY 2014-15 or FY 2015-16 and staff believes the proposed "State of Health" initiatives should compete with those other potential uses, rather than having access to a dedicated cash fund. Also, if the JBC decides to fund some or all of the initiatives, staff believes the funding for each should be designated in a separate appropriation, rather than commingled in a continuously appropriated cash fund where the money can be reallocated.

Staff has an overarching concern for all of the "State of Health" initiatives that the Department lacks specific statutory authority for a General Fund-only program. If it would be beyond the Department's existing statutory authority and a bad policy precedent to implement a supplemental payment for hospice providers without a bill, then similar arguments apply to giving General Fund-only incentive payments to dentists and hygienists without authorizing legislation, for example. So, the staff recommendation to avoid creating a cash fund does not necessarily eliminate the need for a bill, if these initiatives do not qualify for a federal match under Medicaid.

Staff has another overarching concern that the "State of Health" initiatives have been thrown together hastily without the planning and forethought typical of the Department's November budget requests. The initial budget amendment provided only very broad descriptions of the initiatives. All of the supporting calculations focused on estimating the impact of the FMAP change and the cost of the primary care provider rates with no figures on how the money for the initiatives would be spent. The JBC staff sent questions in mid-January aimed at getting some basic information about the purpose, scope, justification, and design of the initiatives and it took the Department over a month to respond because details such as which providers would be eligible for the initiatives and how much providers might earn from the initiatives were still being worked out. Although the Department's response on March 4, 2014 provided some clarification of what the Department hopes to accomplish, it is clear that many of the details for how the Department will achieve those goals are still being ironed out, and the budget details for the projects, such as they are, were backed into from the initial allocations. Although some of the proposals sound promising, staff has concerns that the ideas are not fully developed and ready for implementation and wonders if they should instead be considered by the Department for a future request.

Regarding the Dental Provider Network Adequacy, staff does not feel the same level of urgency as the Department to rush forward with incentive payments. Part of the current perceived low level of provider participation is attributable to a limited Medicaid benefit. With the

implementation of a new adult dental benefit in FY 2013-14, the expansion of Medicaid eligibility to adults without dependent children, and the increase in dental provider rates approved by the JBC last year, staff suspects that the Medicaid participation rates of dentists will gradually increase. The Department estimates that "only" 15.4 percent of licensed dentists currently participate in Medicaid, but could not compare this participation rate to other fields of medicine in the month and a half between when the question was asked and the figure setting presentation. Staff would also point out that prior to the expansions in Medicaid eligibility and the new adult dental benefit, the covered Medicaid clients represented significantly less than 15.4 percent of the general population. When the adult dental benefit is implemented, there will be many clients with pent-up demand and these clients may have trouble identifying providers immediately, but these clients will also be highly motivated and willing to make the sacrifices in time to identify providers and potentially travel in order to get services. For the Medicaid population without pent up demand, the dental network may not initially be adequate to provide services that are convenient enough to actually be used. But, with a new benefit a ramp up time is to be expected. The Department already has plans to pay the Administrative Services Organization (ASO) for the dental benefit to increase the capacity of the dental network, including incentive payments for recruiting more providers. Also, the Colorado Dental Association has launched a campaign to encourage dental providers to take Medicaid patients. Staff believes that expansion of the dental provider network for Medicaid clients is likely to happen gradually with or without the proposed incentive payments. The incentive payments might speed up the expansion, but it is difficult to estimate the marginal impact or the potential long-term value of getting clients connected to preventive care somewhat more quickly.

Another staff concern with the Dental Provider Network Adequacy proposal is the design to give money from the first tier payments to existing providers. Staff believes this is unlikely to have any impact whatsoever on the rate of provider participation in Medicaid and amounts to a giveaway without justification or analysis for the necessity other than a political consideration.

For the After Hours Primary Care Incentive Program staff is concerned that the Department is asking for money with very little sense of the baseline level of service on which to base an estimate of the cost of the incentive payments, or any evidence to suggest that the bonus payments have been sized correctly to effect provider change. On the surface this proposal appears promising from both the perspective of encouraging more after-hours care and improving the appropriateness of provider reimbursements. The change was recommended by the Department's Provider and Community Relations Subcommittee. The proposed bonus per after-hours visit is analogous to shift differential payments to state employees who work evenings and weekends. However, if the proposal goes forward, staff would like to see the appropriation based on an estimate of the actual cost in a given fiscal year, rather than a capped funding total that could span multiple fiscal years that seems arbitrary selected. Also, if the funding is not capped, but rather based on actual utilization, staff believes the likelihood of federal matching funds is high. Staff is concerned that rushing forward with this proposal might unnecessarily tie up more General Fund than is not necessary to implement the bonus payments. Staff would like to see the Department analyze and pursue this concept further and submit a more complete request at a future date.

From the staff perspective, the Social-emotional Learning Program for Early Childhood Education is the most nebulous of the Department's proposal, down to the name that seems to be morphing into the Colorado Opportunity Project. Staff is not sure how the coordination of services will differ from what is currently provided, or ought to be provided, by case managers. If the problem the Department is attempting to address is that case managers are not appropriately coordinating services, then perhaps the focus should be on improving training or reducing the caseloads for the case managers, rather than creating a new infrastructure to coordinate services. There is no projection of an increase in utilization of services, and so it appears that the coordination of services will result in clients accessing the same level of services as they would without the coordination. It is not clear to staff how the coordination would change the experience of participating clients.

The Department indicates this program would not be administered as a Medicaid benefit, and so staff is not sure why the Department of Health Care Policy and Financing should be the lead agency. The Department did not provide information on the specific programs that would be coordinated, but provided the following as examples of programs that might be coordinated:

- The Nurse Family Partnership
- Colorado's Assuring Better Child Health and Development
- Early and Periodic Screening, Diagnostic and Treatment
- Colorado Early Learning and Development Guidelines
- Seeds and Roots of Empathy Program
- Early Literacy and Math Programs
- Learning Experiences & Alternate Program for Preschoolers and their Parents (LEAP)

Over half the money would go into the development of a database, and so it appears that the request is primarily funding a research project to track the development of the participating children.

Staff believes the Department has not sufficiently articulated the purpose of the Social-emotional Learning Program for Early Childhood Education, the need for it, or how the funding would achieve the goals. Staff believes the Department needs to define and refine the proposal further and then decide whether to submit a request for the next budget cycle.

Pain Management Capacity Program

This is a new line item recommended by the JBC staff to provide training and build the capacity of physicians to deal with clients requiring pain management. See the recommendation on *BA 10 FMAP change* above.

Request: The Department did not request funding.

Recommendation: The rationale for the new line item is discussed under the recommendation on *BA10 FMAP change* above

(H) INDIRECT COSTS

Statewide Indirect Cost Assessment

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB). The table below shows the FY 2014-15 changes in the indirect cost assessment on the Department of Health Care Policy and Financing by fund source.

Statewide Indirect Cost Assessment			
	FY 2013-14 Indirect	Incremental Change	FY 2014-15 Indirect
TOTAL	545,140	118,349	663,489
Cash Funds	121,193	1,286	122,479
Hospital Provider Fee	*97,463*	*1,069*	*98,532*
CHP+ Trust	*14,033*	*109*	*14,142*
Nursing Facility Fee	*3,311*	*26*	*3,337*
Primary Care Fund	*3,159*	*24*	*3,183*
Autism Treatment Fund	*1,823*	*14*	*1,837*
Breast & Cervical Cancer	*1,404*	*11*	*1,415*
Adult Dental Fund	*0*	*19*	*19*
ICF/IID Provider Fee	*0*	*14*	*14*
Reappropriated Funds	29,596	(7,655)	21,941
Human Services	*29,596*	*(10,421)*	*19,175*
Public School Health Services	*0*	*2,766*	*2,766*
Federal Funds	394,351	124,718	519,069

(2) Medical Service Premiums

This division provides funding for physical health and long-term care services for individuals qualifying for the Medicaid program. Mental health services are financed in the next division. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table would be the same as the line item summary table.

Medical and Long-term Care Services for Medicaid Eligible Individuals

Appropriations in this section are a function of three factors:

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

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

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

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

Request: The Department requests:

- *R1 Medical Services Premiums* to make adjustments for changes in the caseload and expenditure forecast. The November request was based on data through June 2013. On February 7, 2014 the Department submitted an unofficial revised forecast incorporating data through December 2013 into the projection model.
- *R7 IDD Supported living services*, *R8 IDD Increase funded FPE,* and *BA5 IDD Caseload adjustment* that were discussed during figure setting for the Office of Community Living.
- *R9 Medicaid community living initiative* to fund: (1) counseling regarding community-based living options; (2) housing assistance payments; and (3) improved oversight of the home modifications benefit.
- *R10 Primary care specialty collaboration* to provide assistance for primary care providers and specialists to acquire and utilize technology that allows remote specialty care consultation.
- *R11 Provider rate increase* to increase provider funding by a total of 1.5 percent, with 1.0 percent distributed to all eligible providers across the board and 0.5 percent reserved for targeted rate increases.
- *R12 Admin contract reprocurements* to provide an overlap in funding between expiring administrative service contracts and potential new contracts to ensure a smooth transition.
- *BA10 FMAP change* to reflect a change in the federal match rate for Medicaid from 50 percent to 51.01 percent effective October 1, 2014.
- *BA10 FMAP change (reinvestment in primary care rates)*, which is a portion of *BA10 FMAP change* that has been broken out by the JBC staff for presentation purposes, to reinvest a portion of the General Fund savings from the change in the FMAP.

- *BA12 Enroll dual eligibiles in ACC* to enroll approximately 40,000 people dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- Annualizations of prior year legislation and budget decisions, including SB 13-200 that expanded Medicaid eligibility and SB 13-242 that added an adult benefit.

Recommendation: The staff recommendation is summarized in the table below and select components of the recommendation are detailed in the arrowed items below the table. For the recommendations on *R7 IDD Supported living services*, *R8 IDD Increase funded FPE, BA5 IDD Caseload* adjustment, and Youth transitions from child welfare to IDD see the figure setting for the Office of Community Living. For the recommendation on *R9 Medicaid community living initiative* see the Home Modifications Benefit administration and Housing Assistance Payments line item. For the recommendation on *R12 Admin contract reprocurements* see the Personal Services line item. For the recommendation on *BA10 FMAP change* and *BA10 FMAP change (reinvestment in primary care rates)* see the State of Health Projects line item. For the recommendation on *BA12 Enroll dual eligibiles in ACC* see the Personal Services line item.

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$4,438,829,600	$1,514,486,517	$719,515,157	$936,892	$2,203,891,034	0.0
Other legislation	297,995,277	(8,626,467)	(125,633,094)	2,000,000	430,254,838	0.0
HB 14-1236 (Supplemental)	52,407,944	17,580,433	61,442,739	0	(26,615,228)	0.0
14-15 Long Bill	52,189,863	15,972,565	(28,361)	0	36,245,659	0.0
TOTAL	**$4,841,422,684**	**$1,539,413,048**	**$655,296,441**	**$2,936,892**	**$2,643,776,303**	**0.0**
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$4,841,422,684	$1,539,413,048	$655,296,441	$2,936,892	$2,643,776,303	0.0
Annualize SB 13-200 Expand Medicaid eligibility	537,548,305	154,457	78,735,072	0	458,658,776	0.0
Annualize SB 13-242 Adult dental benefit	53,348,482	(824,906)	11,720,172	0	42,453,216	0.0
Annualize substance use disorder benefit	(1,485,982)	(964,960)	(34,165)	0	(486,857)	0.0
Annualize prior year budget decisions	(2,402,886)	1,439,762	(761,789)	(936,892)	(2,143,967)	0.0
R1 Medical service premiums	145,038,837	37,771,888	(105,587,267)	0	212,854,216	0.0
R7 IDD Supported living services	7,658,975	3,752,132	0	0	3,906,843	0.0
R8 IDD Increase funded FPE	(1,933,750)	(986,405)	0	0	(947,345)	0.0
R9 Medicaid community living initiative	364,073	179,279	0	0	184,794	0.0
R10 Primary care specialty collaboration	237,497	71,770	3,371	0	162,356	0.0
R11 Provider rate increase	99,784,832	33,372,602	1,012,994	0	65,399,236	0.0
R12 Admin contract reprocurements	1,753,499	876,750	0	0	876,749	0.0
BA5 IDD Caseload adjustment	126,472	62,278	0	0	64,194	0.0

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
BA10 FMAP change	(13,252)	(23,864,382)	(6,398,241)	0	30,249,371	0.0
BA10 FMAP change (reinvestment in primary care rates)	44,277,696	18,490,366	0	0	25,787,330	0.0
BA12 Enroll dual eligibles in ACC	10,525,690	44,729	0	0	10,480,961	0.0
Youth transitions from child welfare to IDD	439,146	215,137	0	0	224,009	0.0
Transfer from Public Health	0	2,000,000	0	(2,000,000)	0	0.0
Tobacco tax forecast	0	(2,609,357)	2,609,357	0	0	0.0
TOTAL	**$5,736,690,318**	**$1,608,594,188**	**$636,595,945**	**$0**	**$3,491,500,185**	**0.0**
Increase/(Decrease)	$895,267,634	$69,181,140	($18,700,496)	($2,936,892)	$847,723,882	0.0
Percentage Change	18.5%	4.5%	(2.9%)	(100.0%)	32.1%	0.0%
FY 2014-15 Executive Request:	**$5,602,533,355**	**$1,579,385,626**	**$614,787,554**	**$2,000,000**	**$3,406,360,175**	**0.0**
Request Above/(Below) Recommendation	($134,156,963)	($29,208,562)	($21,808,391)	$2,000,000	($85,140,010)	0.0

→ **14-15 Long Bill:** The recommended supplemental add-on to the Long Bill would provide for the following staff recommendations discussed in other parts of this figure setting document:

14-15 Long Bill Add-on to Amend 13-14 Appropriations	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
R1 Medical Service Premiums (updated for February forecast)	52,022,363	14,408,764	1,535,440	0	36,078,159
BA12 Enroll dual eligibles in ACC	167,500	0	0	0	167,500
Tobacco forecast	0	1,563,801	(1,563,801)	0	0
TOTAL 14-15 Long Bill Add-on	52,189,863	15,972,565	(28,361)	0	36,245,659

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below. In addition, the recommendation includes annualizations for S.B. 13-200 that expanded Medicaid eligibility, SB 13-242 that provided for an adult dental benefit, and the FY 13-14 Long Bill decision to add a substance use benefit. The annualizations for these prior year budget actions are shown separately from other anualizations due to the high level of legislative interest and the magnitude of the annualizations Department-wide.

Annualize Prior Year Budget Decisions	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 13-14 R13 Provider rate increase	$6,995,457	$3,361,072	$63,038	$0	$3,571,347
HB 08-1373 Breast and Cervical Cancer Fund	(6,774,287)	(609,282)	(824,827)	(936,892)	(4,403,286)
FY 13-14 BA14 Colorado Choice Transitions	(1,514,220)	(757,110)	0	0	(757,110)
HB 13-1152 Nursing facility per diem rates	(1,109,836)	(554,918)	0	0	(554,918)
TOTAL Annualizations	($2,402,886)	$1,439,762	($761,789)	($936,892)	($2,143,967)

Last year's provider rate increase has an annualization to account for services billed in FY 2013-14 and paid in FY 2014-15.

➔ R1 Medical Service Premiums

Request: The Department requests a change to the appropriation based on a new forecast of caseload and expenditures under current law and policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. Once the eligibility criteria and plan benefits are set, the state and federal government must pay the resulting costs. The budget is based on an estimate of those costs, but Section 24-75-109 (1) (a), C.R.S., allows the Department to overexpend the Medicaid appropriation if necessary to pay the plan benefits. R1 represents the Department's forecast of expenditures based on the eligibility criteria and plan benefits in current law and policy and proposed changes to the eligibility criteria or plan benefits are contained in other requests.

On February 7, 2014 the Department submitted an update to the forecast. Although the update is not an "official" request to change the appropriation and it was submitted after the General Assembly's budget request deadlines, it represents the most current forecast available. The November 1 request incorporated data through December 2013 while the February 7, 2014 update includes data through at least December 2013. The February 7, 2014 forecast without the FMAP change is approximately $5.4 million General Fund higher than the November 1, 2013 forecast for FY 2014-15.

The table below summarizes the changes in expenditure projected in the forecast.

Medical Service Premiums February 2014 Forecast	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 13-14 Appropriation	4,789,232,821	1,523,440,483	655,324,802	2,936,892	2,607,530,644
FY 13-14 Revised projection	4,841,255,184	1,537,849,247	656,860,242	2,936,892	2,643,608,803
Difference	**52,022,363**	**14,408,764**	**1,535,440**	**0**	**36,078,159**
Percent	1.1%	0.9%	0.2%	0.0%	1.4%
FY 13-14 Revised projection	4,841,255,184	1,537,849,247	656,860,242	2,936,892	2,643,608,803
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	5,428,263,103	1,537,653,600	746,519,532	2,000,000	3,142,089,971
FY 14-15 Projection	5,573,301,940	1,575,425,488	640,932,265	2,000,000	3,354,944,187
Difference	**145,038,837**	**37,771,888**	**(105,587,267)**	**0**	**212,854,216**
Percent	2.7%	2.5%	-14.1%	0.0%	6.8%

One factor contributing to the change from the November forecast to the February forecast is new information the Department is gathering about the impact of a federally mandated change in the way states calculate income for purposes of Medicaid and CHP+ eligibility. Pursuant to Colorado law the income eligibility thresholds as a portion of the federal poverty guidelines (FPL) are 133 percent for kids and 185 percent for pregnant women for Medicaid and 250 percent for CHP+, but federal guidance is resulting in higher effective eligibility thresholds fr

these populations. The Department is able to implement the federal guidance based on general state statutes authorizing compliance with Medicaid rules and more specific authority allowing the Medical Services Board to develop income- and resource-counting methods. The new federal guidance comes from the interaction between ACA provisions requiring a maintenance of effort on eligibility for children and pregnant women and a requirement that states change the way they calculate income for eligibility determination purposes. The new method for calculating income uses a standardized federal formula for Modified Adjusted Gross Income (MAGI) in place of various state systems that used income disregards that were not standard across states or eligibility categories.

According to federal regulations, to complete the transition to the MAGI-based methodology, states were required to develop MAGI-based income eligibility standards for the applicable eligibility groups that "are not less than the effective income levels" that were used to determine Medicaid and CHP+ income eligibility as of the enactment of the Affordable Care Act. Using the Standardized MAGI Conversion Methodology provided by CMS, Colorado has determined that the old income disregards on average increased the effective eligibility of clients compared to the new MAGI calculation by 7 percent of the FPL for children and 10 percent of the FPL for pregnant women on Medicaid and by 10 percent of the FPL for CHP+. Therefore, to comply with the federal maintenance of effort requirement, CMS is directing Colorado to adjust the income eligibility brackets upward by these amounts.

In addition, the MAGI calculation includes a standard 5 percent income disregard. Rather than saying that to meet the maintenance of effort standard Colorado needs to increase the income eligibility thresholds by the difference between the old income disregards and the new 5 percent income disregard under MAGI, CMS argues that the new 5 percent income disregard is applied after the adjustment to the eligibility brackets. The interaction of the new income disregard and the maintenance of effort requirement raises the effective eligibility for Medicaid and CHP+ for children and pregnant women by 5 percent for all states compared to what they were doing before.

In Colorado this means that the effective eligibility threshold for children is not the 133% of FPL as described in state statutes, but rather 133% + 7% + 5% = 147% of FPL. A similar calculation means the effective eligibility for pregnant women for Medicaid is 200% of FPL and for all participants in CHP+ 265% of FPL. There is no similar maintenance of effort requirement for non-pregnant adults, and so their effective income eligibility threshold is 133% + 5% = 138%.

As the Department learns more about how the MAGI conversion impacts eligibility it is revising the forecast trends. This applies to both the Medicaid and CHP+ forecasts.

The bullets below highlight a few major changes in the Department's forecast for **FY 2013-14**. Because the total forecast represents the accumulation of many different trends, both positive and negative, and these bullets are only highlighting a select few of those trends that are large magnitude by themselves, the bullets will not add to the total change.

- **Growth in Low Income Adult Caseload** ($16M total funds, $8M General Fund) -- Many adults have moved from higher income eligibility categories to lower income eligibility

categories. The Department believes this to be the result of implementing standardized income determination processes (referred to as Modified Adjusted Gross Income [MAGI] standardization) as required by the Affordable Care Act. Unfortunately, because different types of income are treated differently under the national standard, the full impact of MAGI was not known prior to implementation as each client is impacted differently. There is a fiscal consequence to the State as a result of this migration as higher income populations are funded with either hospital provider fee or federal funds whereas the lower income populations are funded with General Fund and matching federal funds.

- **Growth in Children's caseload** ($27.5M total funds, $13M General Fund) -- Medicaid caseload for children has multiple upward pressures which include the following: ongoing recession recovery (slowed growth in Medicaid caseload lags economic recovery), increasing population, migration of clients from the CHP+ program due to SB 11-008, continuous eligibility implementation, MAGI implementation causing additional children to migrate from CHP+ to Medicaid, and clients previously eligible for Medicaid enrolling due to increased outreach and publicity associated with the implementation of Medicaid expansion and the Affordable Care Act. All factors considered, the growth in this population is higher than previously anticipated. The Department believes that the majority of the surplus growth is related to MAGI implementation and previously eligible but not enrolled clients now enrolling.
- **Disabled Buy-in caseload and per capita cost revision** ($20M total funds, $11M cash funds) -- Caseload for this population began to surge in October. The Department has revised the caseload projection for this population from an estimate of 1,831 to 2,515, or an increase of 37 percent. Additionally, the Department has revised per capita expenditure estimates that were previously indexed to a proportion of other more established populations to reflect the actual expenditure patterns for this population; per capita expenditure for this population is significantly higher than the population to which it was previously indexed due to high utilization of hospital services. The Department is investigating why actual per capita expenditures are trending higher than expected and whether there are opportunities to reduce expenditures and improve health outcomes with coordinated care through the Accountable Care Collaborative.

For **FY 2014-15** the above changes continue to impact the projection and in addition the Department highlights the following:

Acute Care - $3.6 million reduction General Fund

- Children, low-income parents, and people with disabilities – The primary factor putting upward pressure on General Fund acute care expenses is enrollment growth. The Department is projecting 7.4 percent enrollment growth among children, 11.2 percent growth among the lowest income parents (AFDC-A), and 3.7 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 $44 million in total fund 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.
- Expiration of the Primary Care Physician Bump at the end of CY 2014 – the Department included approximately $750k General Fund savings as a result of the end of this program. Of note, the Department has submitted a budget action, FY 2014-15 BA-10 to continue this program through FY 2015-16.
- FY 2014-15 has 52 payment cycles compared to 53 payment cycles in FY 2013-14. This reduces expenditure by $38 million total in FY 2014-15 relative to FY 2013-14.
- 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 - $12.4 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 $13,711.

Long-term care and insurance - $11.6 million General Fund
- 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 14.1 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

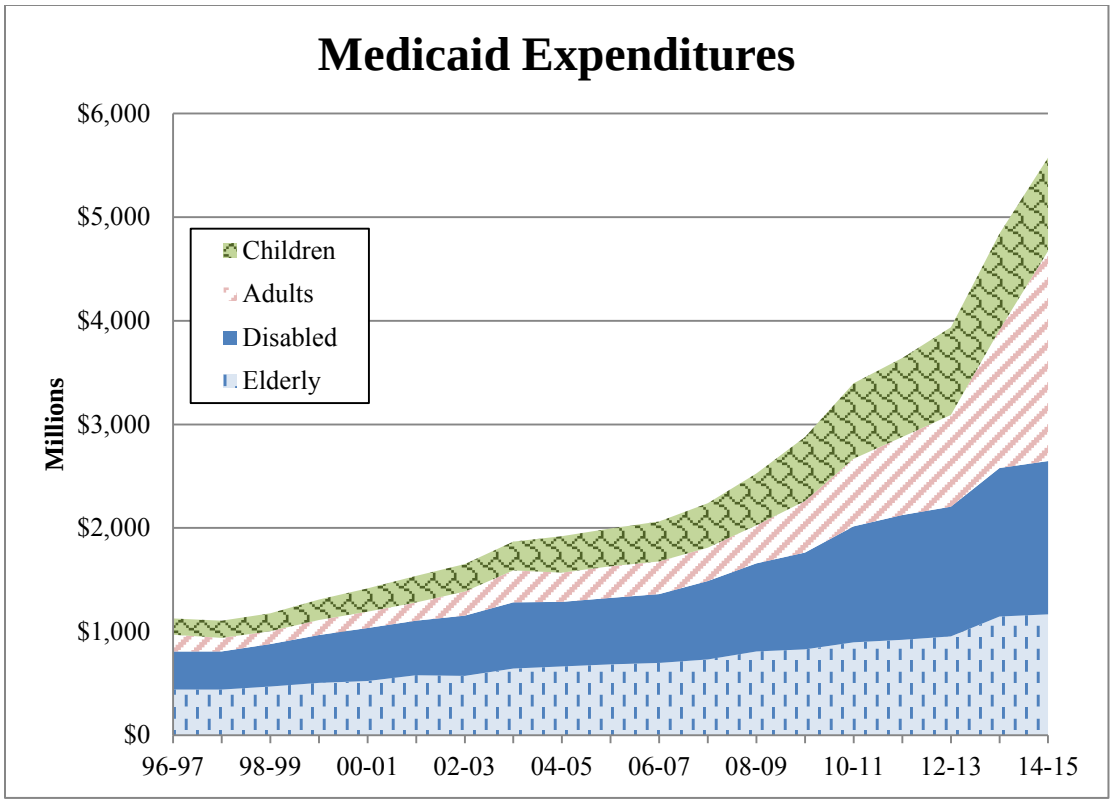
for private insurance, which the Department purchases for clients through the Health Insurance Buy-in when it is cost effective to do so.

Service management – $3.1 million General Fund

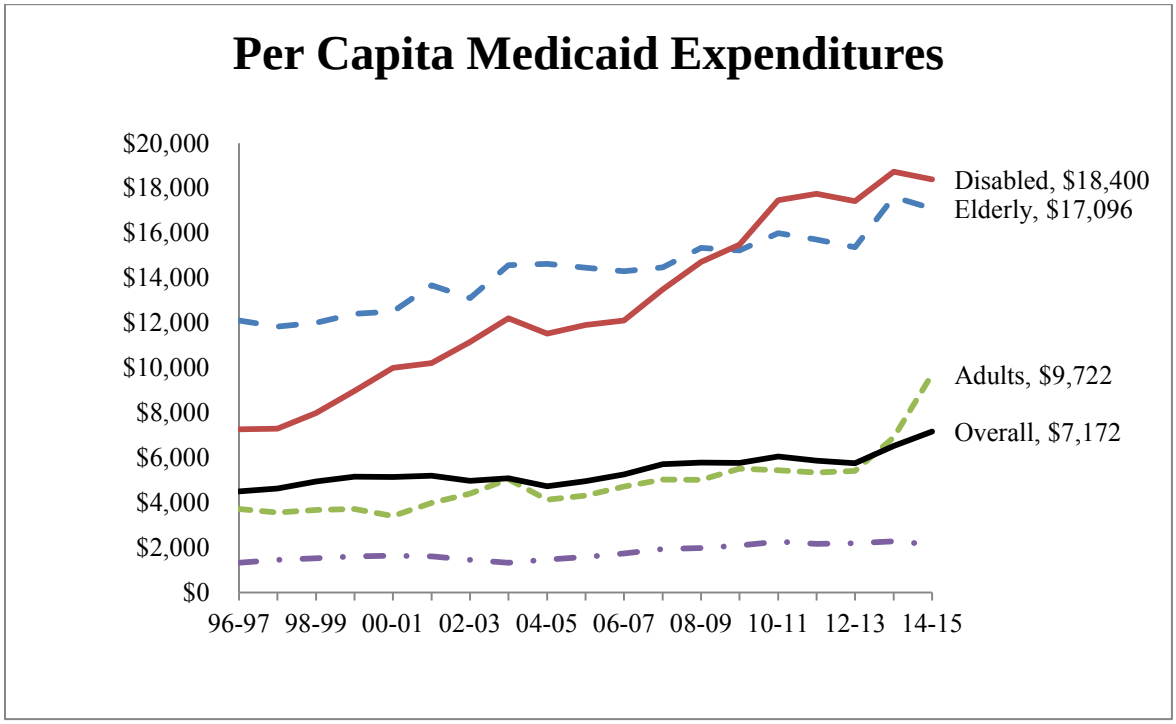
- The Department forecasts an increase in contracts with single entry point agencies that provide services for people needing long-term care based on increased utilization of community based long-term care services.

Recommendation: Staff recommends using the Department's February forecast of enrollment and expenditures to modify both the FY 2013-14 and FY 2014-15 appropriations. This is the best estimate available of what the actual costs will be for the Medicaid program based on current law and policy.

The graphs below show projected Medicaid enrollment and expenditures.



The next table provides projected changes in per capita expenditures, including allocated portions of financing payments.



➔ R10 Primary care specialty care collaboration

Request

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 addition to the amount requested for the Medical Service Premiums line item, the request includes $300,000 total funds, including $150,000 General Fund, for consulting services in the General Professional Services and Special Projects line item. Because the proposal involves changes to the way specialty care is reimbursed, the Department requests contract funds to assist in developing the plan, conducting actuarial analysis, promulgating rules, and getting approval from CMS.

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.

Recommendation
Staff recommends approval of the request. This technology would make it easier for Medicaid clients to receive the benefits of specialty consultations by reducing travel and difficulties associated with scheduling appointments. At the same time, the request reduces costs by replacing in-office visits with less expensive technology-assisted consults. The technology will also make specialists more efficient, allowing them to serve more patients and eliminating a perceived problem with high appointment cancelation rates among Medicaid clients.

➔ R11 Provider rate increase

Request
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 to be determined by the Department.

Not all services would be eligible for the across-the-board or targeted rate increases. For some services rates are set according to an external method governed by state statute or federal regulation. Examples include nursing home services where state statutes prescribe the rate setting method and capitated payments such as those to health maintenance organizations that must meet an actuarially sound standard pursuant to federal regulation. The costs to set these rates according to their external method are included in the Department's forecast requests R1 through R4 and BA5. Rates not eligible for the across-the-board or targeted increases include:

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

limit

The table below summarizes the Department's estimate of the cost of R11 by line item.

R11 Provider rate increase request				
	Estimated Eligible for Increase	Requested Increase 1.5%	Allocation Method	
			Across-the-board 1.0%	Targeted 0.5%
Medical Services Premiums				
Medical and Long-Term Care Services for Medicaid Eligible Individuals	$3,326,161,067	$49,892,416	$33,261,611	$16,630,805
Behavioral Health Community Programs				
Behavioral Health Fee-for-service Payments	6,125,200	91,878	61,252	30,626
Office of Community Living				
Adult Comprehensive Services	342,117,667	5,131,765	3,421,177	1,710,588
Adult Supported Living Services	57,308,467	859,627	573,085	286,542
Children's Extensive Support Services	18,785,200	281,778	187,852	93,926
Case Management	29,230,467	438,457	292,305	146,152
Family Support Services	6,662,133	99,932	66,621	33,311
Preventive Dental Hygiene	64,267	964	643	321
Eligibility Determination and Waiting List Management	2,987,400	44,811	29,874	14,937
TOTAL	$3,789,441,867	$56,841,628	$37,894,420	$18,947,208

The first thing to note about this table is that the total the Department proposed be reserved for targeted rate increases was $18.9 million. On February 26, 2014 the Department provided a list to the JBC of specific proposed targeted rate increases totaling $14,987,578. The Department did not detail how the remaining $3,959,630 would be allocated.

While the Department's February 26, 2014 proposal left $4.0 million of the originally contemplated $18.9 million for targeted rated increase unallocated, the majority of the unallocated money was in line item other than Medical Service Premiums. In the Department's February 26, 2014 presentation all of the specific rate increases identified by the Department were for providers paid from the Medical Services Premiums line item. The Department's specific rate increases left $1,643,227 unallocated in Medical Services Premiums and $2,316,403 unallocated in other line items spread throughout the Department.

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

The dramatic variations in the adequacy of rates occur when provider costs change more quickly than Medicaid rates. The Department goes through a detailed analysis to establish the initial Colorado Medicaid rate for each service, including a review of suggested guidance from the federal Centers for Medicare and Medicaid Services (CMS). According to the Department,

current practice usually results in new rates set at approximately 75 percent of the benchmark guidance from CMS. Once the Colorado Medicaid rate is set, it generally does not change without action by the General Assembly, unless federal or state laws and regulations require adjustments.

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

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

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

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

Recommendation

Staff recommends a 3.0 percent across-the-board increase consistent with the JBC's common policy for community provider rates, but in addition staff recommends an appropriation of $150,000 total funds, including $75,000 General Fund in the Executive Director's Office for consulting services to help the Department study options for correcting disparities in Medicaid rates that limit client access to cost-effective care. The appropriation for consulting services would be accompanied by the following footnote and legislative request for information:

Proposed footnote:

N **Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects –** This appropriation includes $150,000 for the purpose of consulting services and stakeholder outreach to assist the Department in developing a plan for addressing disparities in Medicaid rates that limit client access to cost-effective care.

Proposed Request for Information:

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

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

Staff believes the quality of the requested plan is likely to be higher if the Department has access to funding for consulting services and stakeholder engagement. Also, the recommended funding is intended to emphasize the importance of the request and forestall any potential reluctance from the executive branch to comply due to a lack of resources.

The Department's request highlights a critical problem with the current rate setting process that results in Colorado Medicaid rates not being responsive to changes in medical practice. Staff is unsure of the best way to improve the process. On the one hand, it would be infeasible for the General Assembly to regularly evaluate the more than 15,000 different Medicaid rates for adequacy. On the other hand, staff believes the Department's initial proposal to set aside money for targeted rate increases to be determined by the Department would have delegated too much legislative authority without sufficient accompanying policies or oversight to ensure the Department was doing a good job of prioritizing rate increases.

The Department's second attempt to propose targeted rate increases in the February 26, 2014 presentation represented a significant improvement over the initial request in that it detailed specific increases and provided a modicum of justification for each. Also, the Department used an interesting process to solicit stakeholder input. While these developments are promising, staff believes they fall short of what ought to be done on an ongoing basis.

Staff believes the Department successfully made a case that the specific rates identified in the February 26, 2014 presentation need attention in excess of what an across-the-board increase would provide. However, the Department's evidence is limited that the proposed increases are the right size to address the identified access issues and change provider behavior. Also, the Department's explanation of how the Department would measure whether the rate changes succeeded in changing provider behavior was vague. Furthermore, the Department's argument that these are the most urgent rate issues to address was not compelling, because the Department has very little in the way of standardized metrics to identify inadequate rates. Finally, the specific proposed rate increases were submitted well after the November 1 deadline for budget submissions, the January 2 deadline for budget amendments, or even the deadline exceptions for caseload-driven budgets. The late submission left inadequate time for the question and answer and refinement process typical of other budget requests. For these reasons, staff recommends holding off on implementing the targeted rate increases and focusing instead on developing a sustainable process for future years.

The JBC staff considered recommending the Department's proposed targeted rate increases on the basis that there is value in making an effort to address these rate inadequacies, even if questions remain about whether the increases have been sized appropriately and whether their

effectiveness will be measured adequately. Staff decided not to recommend the request, though, primarily because staff was unsure that these are the highest priority rate issues and capable of being defended as more important than some of the other rate concerns being brought to the attention of the JBC.

For the future, staff believes the Department needs to develop a more robust ongoing process that looks at the adequacy of rates. If the process is viewed as being based on objective criteria and providing adequate opportunity for stakeholder input, it could give the General Assembly more comfort in accepting the recommendations.

It is essential that the process be ongoing, because changes in medical practices that impact the adequacy of rates are ongoing. Also, staff believes it is worth considering looking at only a portion of the Department's rates every year, because trying to look at every rate every year might be too monumental a task. In this respect the Medicare rate setting model might serve as an example, where every rate is guaranteed a review at least once every five years, but some rates are prioritized for review more frequently than others within available resources.

As part of the response to the proposed request for information, staff would like the Department to provide a review of other rate setting models, and this might be difficult without funding for consulting services. The Department mentioned that Oregon has a system where rate changes are prioritized and a line is drawn based on available funding. This sounds promising, but staff wonders if there might be better options in other states or the private sector that would provide actions that could be taken in years where funding is flat or decreasing.

Staff would like to avoid setting up a system that only looks at rate adjustments when new money is available. This is a shortcoming in many state agency prioritization processes where existing resources are sacrosanct and change can only be achieved with new money. Staff suspects targeted rate adjustments could significantly improve or preserve client access and quality of care in years when state funding for rates is flat or declining.

Finally, staff believes the system must preserve a role for the legislature in reviewing rates. The legislature has a uniquely representative, transparent, and accessible process that serves as a check and balance to the executive branch. Staff is recommending a process for reviewing the adequacy of Medicaid rates that would improve the quality and defensibility of recommendations to the legislature, rather than a process that would remove decision making authority from the legislature and place it in the hands of an external rate-setting entity.

In addition to the recommendation that the Department develop a plan for addressing Medicaid rate disparities, staff recommends that the Department be requested to improve the metrics to identify when clients may be experiencing difficulty accessing cost-effective care. This recommendation is independent of the recommendation for a plan to address Medicaid rate disparities, although improved metrics would greatly benefit any such plan. Staff is concerned that most of the Department's information about access problems appears to be based on anecdotes and small-scale surveys. Staff would like to see the Department attempt develop more systematic ways to identify and quantify access issues. This could potentially result in interventions by providers in the Accountable Care Collaborative with the result of better

preventive care and health outcomes, as well as informing the rate setting process. Specifically, staff recommends the following request for information:

Proposed Request for Information:

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

An important technical note is that staff recommendation assumes the increase for Federally Qualified Health Centers (FQHCs) will be the lesser of 3.0 percent or the increase necessary to bring funding up to the rate called for in Colorado's Alternate Payment Method (APM). FQHCs receive an annually adjusted flat rate per encounter. The annual adjustment to the encounter rate is based on either federal requirements of the Benefits Improvement and Protection Act (BIPA) that include an annual inflation factor, or an alternate state formula. Colorado is currently using an alternate state formula that is based on allowable costs. During the recession, FQHC rates were reduced to the midpoint between Colorado's APM and the BIPA minimum. This impacted some FQHCs more than others. After the reduction, rates increased in subsequent years from the lower base according to the alternate state formula. The 3.0 percent across-the-board increase this year, combined with last year's rate increase, would cause some FQHC rates to exceed the APM. However, since the APM is based on allowable cost, staff assumes that increases that would cause rates to exceed the APM could not be implemented.

Alternatives

If the JBC would prefer to move forward with some form of targeted rate increases, then the first decision that needs to be made is whether the funding will come from within the previously approved 3.0 percent increase or be in addition to the 3.0 percent increase. The Department's original proposal was that money for targeted rate increases come from within the total, but this would mean that providers not benefiting from the targeted rate increases would receive a boost of less than the standard 3.0 percent applied in all other departments.

In a scenario where the JBC approves targeted rate increases, then staff would recommend that the 3.0 percent be treated as a baseline for all providers and any targeted rate increases be in addition to the 3.0 percent. It seems premature to begin undoing the 3.0 percent and attempting to balance the budget before the JBC knows if the budget is out of balance. If at a later date the JBC decides that the 3.0 percent needs to be reduced to accommodate targeted rate increases, then the reductions can be applied equitably to all providers statewide, rather than just to providers unlucky enough to be paid by the Department of Health Care Policy and Financing.

The second question the JBC needs to decide is whether targeted rate increases would be left to the discretion of the Department, as requested, or whether the General Assembly should give more specific direction on the targeted rate increases. Staff believes that more specific direction is preferable to preserve the authority of the General Assembly and avoid ambiguity about the

intent of the appropriation. However, the specific direction could be in the form of motions by the Joint Budget Committee and need not be as formal as spelling out the rate increases in a footnote. The Long Bill Narrative and Appropriations Report could provide detail to ensure that all members of the General Assembly are aware of the assumptions used for the appropriation.

Finally, the JBC would need to decide how much to spend for targeted rate increases. As noted previously, the Department proposed $18.9 million total funds for targeted rate increases, but in the February 26, 2014 presentation the Department detailed proposals totaling $15.0 million.

The table below summarizes the potential targeted rate increases described in the Department's February 26, 2014 presentation. A copy of the Department's entire presentation is included as an appendix at the end of this document. These specific rates were selected for targeted increases from among the ideas submitted through the Department's RFI process because the Department believes they meet the following criteria:

- Promote utilization of low-cost, high-value procedures that improve client outcomes and reduce expenditures
- Address inappropriate rates that create a barrier to access to cost-effective care
- Be implementable by July 1, 2014

Targeted Rate Increases Proposed by the Department February 26, 2014	Total Cost	JBC's 3%	Remaining Cost
Pediatric Hospice Services 20% rate increase	$246,878	($37,032)	$209,846
Extended Hours/After Hours Care 10% rate increase	641,597	NA	641,597
Transitional Living Program for Brain Injury Clients 191% rate increase	876,000	(13,693)	862,307
Pediatric/Developmental Assessment 50% rate increase	64,000	(3,841)	60,159
Single Entry Point Case Management 10% rate increase	1,229,790	(369,543)	860,247
Incentives to Use Ambulatory Surgery Centers	500,000	NA	500,000
High-Value Specialist Services to 80% of Medicare	11,312,435	(157,027)	11,155,408
Mammography Reimbursement to 80% of Medicare	94,841	(13,254)	81,587
Assistive Technology Reimbursement Rate to 80% of Medicare	22,037	(7,751)	14,286
	$14,987,578	($602,142)	$14,385,436

The Department did not estimate the cost of these rate increases by fund source, but a reasonable starting assumption would be that the General Fund cost will represent 33 percent of the total. The General Fund match will vary for proposals based on the financing for the specific populations and services most impacted. Staff estimates that for the JBC's proposed 3.0 percent across-the-board increase the General Fund share is approximately 33 percent, after taking into account enhanced matches available for populations such as the ACA expansion and financing from sources such as the Hospital Provider Fee. Depending on what targeted rate increases the JBC approves the General Fund share assumptions may need to be refined.

→ **Tobacco tax revenue:** Staff recommends an adjustment to both FY 2013-14 and FY 2014-15 to account for the December Legislative Council Staff forecast of tobacco tax revenues deposited in the Health Care Expansion Fund. The Health Care Expansion Fund offsets the need for General Fund, and so if tobacco tax revenues are lower the General Fund appropriation must increase and vice versa. If the LCS March forecast of tobacco tax revenues is significantly

different than the December forecast, then staff will recommend a comeback. The adjustment for FY 2014-15 is expressed as the difference between the assumptions in the Department's February 7, 2014 forecast and the LCS projection.

The purposes of the Health Care Expansion Fund, as described in Section 24-22-117 (2) (a), C.R.S., are to provide funding to expand eligibility in the Children's Basic Health Plan for children and pregnant women from 185% to 200% of federal poverty level, fund enrollment in the Children's Basic Health Plan above the FY 2003-04 level, to remove the asset test under the Medical Assistance Program for children and families, to expand the number of children that can be enrolled in the Children's Home and Community Based Service Program and the Children's Extensive Support Program, to increase eligibility in the Medical Assistance Program to at least 60% of the federal poverty level for a parent of a child who is eligible for the Medical Assistance Program or the Children's Basic Health Plan. Additionally, the fund provides funding to reinstate presumptive eligibility to pregnant women under Medicaid, fund Medicaid for certain legal immigrants, and expand Medicaid benefits to Foster Care children through age 20.

→ **Public Health transfer:** Staff recommends a fund source adjustment to account for the elimination of a transfer from the Department of Public Health and Environment that was offsetting the need for General Fund. The JBC-sponsored bill S.B. 14-109.

(3) Medicaid Mental Health Community Programs

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

(4) Indigent Care Program

This division contains funding for the following programs: (1) Colorado Indigent Care Program (CICP) which partially reimburses providers for medical services to uninsured individuals with incomes up to 250 percent of the federal poverty level; (2) Children's Basic Health Plan; and (3) the Primary Care Grant Program.

Indigent Care Program	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2013-14 Appropriation					
SB 13-230 (Long Bill)	$556,006,728	$31,529,213	$232,255,366	$292,222,149	0.0
Other legislation	2,007,812	694,706	22,938	1,290,168	0.0
HB 14-1236 (Supplemental)	(17,385,723)	(3,309,421)	(2,569,185)	(11,507,117)	0.0
14-15 Long Bill	16,835,119	(4,563,610)	25,562,896	(4,164,167)	0.0
TOTAL	**$557,463,936**	**$24,350,888**	**$255,272,015**	**$277,841,033**	**0.0**

Indigent Care Program	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2014-15 Recommended Appropriation					
FY 2013-14 Appropriation	$557,463,936	$24,350,888	$255,272,015	$277,841,033	0.0
Annualize SB 13-200 Expand Medicaid eligibility	10,868,376	3,761,947	119,957	6,986,472	0.0
Annualize prior year budget decisions	307,832	61,909	45,832	200,091	0.0
R3 Childrens Basic Health Plan	(15,696,420)	1,511,214	(21,857,884)	4,650,250	0.0
BA10 FMAP change	0	(1,027,591)	(2,340,619)	3,368,210	0.0
R12 Admin contract reprocurements	808,693	0	384,453	424,240	0.0
BA11 CHP+ oral health benefits	5,340,492	1,334,347	511,597	3,494,548	0.0
Tobacco tax forecast	(945,700)	(14,700)	(931,000)	0	0.0
TOTAL	**$558,147,209**	**$29,978,014**	**$231,204,351**	**$296,964,844**	**0.0**
Increase/(Decrease)	$683,273	$5,627,126	($24,067,664)	$19,123,811	0.0
Percentage Change	0.1%	23.1%	(9.4%)	6.9%	0.0%
FY 2014-15 Executive Request:	**$537,288,691**	**$26,948,062**	**$227,282,033**	**$283,058,596**	**0.0**
Request Above/(Below) Recommendation	($20,858,518)	($3,029,952)	($3,922,318)	($13,906,248)	0.0

Safety Net Provider Payments

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

Hospitals that participate in the CICP are eligible for reimbursement based on a share of the provider's estimated write-off costs for CICP clients equal to 70 percent for rural and Critical Access Hospitals, 53 percent for High Volume Medicaid and CICP Hospitals, and 54 percent for other participating CICP hospitals. High Volume Medicaid and CICP Hospitals are those that provide at least 35,000 Medicaid inpatient days per year and 30.0 percent of total inpatient days to Medicaid clients (Denver Health, University, Memorial, and Children's).

The source of cash funds is the Hospital Provider Fee and the federal match rate is at the standard Medicaid FMAP. Colorado draws the federal funds for Safety Net Provider Payments through two different methods. First, Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds, if the local match is provided. Although there are nuances to the calculation of the UPL, the additional federal funds the state can draw under the UPL are approximately equal to the difference between Colorado's Medicaid reimbursement rates and

what Medicare would have paid for the same services. Second, Colorado receives a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. DSH allotments are required to decrease with the implementation of the Affordable Care Act and the expected decrease in the uninsured population, but recent federal legislation delayed the decrease.

Request: The Department requests *BA10 Enhanced FMAP* to account for the increase in the federal match rate effective October 1, 2014. The Department estimates that 99.26 percent of the appropriation is eligible for the standard Medicaid FMAP, but the remainder must be reimbursed at the 50 percent rate for administration.

Recommendation: Staff recommends the requested funding. The outlook for the Safety Net Provider Payments is uncertain. Implementation of the Affordable Care Act and the Medicaid expansion is expected to reduce uncompensated care and DSH payments are scheduled to decrease. At the same time, an increase in Medicaid patients is likely to increase Colorado's room under the UPL. This is because the UPL is approximately the difference between what Medicare would have paid and what Medicaid actually pays. This makes it difficult to project the potential federal matching funds available. It is also difficult to project the net impact for providers of a reduction in uncompensated care but an increase in undercompensated care. The Department's current forecast of the Safety Net Provider Payments is within a margin of error of the appropriation, and so staff is recommending no change other than the adjustment for the FMAP.

Clinic Based Indigent Care

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

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

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

Unlike the Safety Net Provider Payments line item, the state participation for this line item comes from the General Fund. This line item existed prior to H.B. 09-1293, and so using the

Hospital Provider Fee to match the federal funds might be viewed as supplanting existing General Fund, which is prohibited in Section 25.5-4-402.3 (5) (a) (I), C.R.S. Also, these are not hospitals, and the hospitals are already giving up a share of their UPL to allow the clinics to receive these supplemental payments. The match rate is at the standard Medicaid FMAP.

Request: The Department requests *BA10 Enhanced FMAP* to account for the increase in the federal match rate effective October 1, 2014.

Recommendation: Staff recommends the requested funding. This program is discretionary, rather than a required component of Medicaid.

Health Care Services Fund Programs

The appropriation for this program in FY 2011-12 was part of a financing mechanism the JBC used to reduce the need for General Fund for Medical Service Premiums with minimal impact on providers. Senate Bill 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency. The Department did not request funding for FY 2014-15 and staff does not recommend funding.

Pediatric Specialty Hospital

The line item provides supplemental payments to The Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides $2.2 million ($1.1 million General Fund) for The Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

Request: The Department requests *BA10 Enhanced FMAP* to account for the increase in the federal match rate effective October 1, 2014.

Recommendation: Staff recommends the requested funding. This program is discretionary, rather than a required component of Medicaid.

Appropriation from Tobacco Tax Fund to General Fund

Section 24-22-117 (1) (c) (I) (A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-117 (1) (c) (I) (B.5) requires that 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

Request: The Department requests continuation funding.

Recommendation: Staff recommends an update based on the December forecast of tobacco tax revenues approved by the JBC during figure setting for the Department of Public Health and Environment and the statutory distribution formula for those funds. The staff recommendation is $14,700 lower than the Department's request.

Primary Care Fund

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The primary care fund receives 19 percent of tobacco tax collections annually.

In FY 2011-12 S.B. 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency.

Request: The Department requests continuation funding.

Recommendation: Staff recommends a reduction of $931,000 based on the Legislative Council Staff's December forecast of tobacco tax revenue. The projection for FY 2013-14 is lower, too, but because it is lower than the appropriation no supplemental adjustment is necessary.

Primary Care Fund		
	FY 13-14	FY 14-15
Appropriation	$27,759,000	NA
LCS December forecast	$26,391,000	$26,828,000
Difference	($1,368,000)	
Percent	-4.9%	

Primary Care Grant Program Special Distributions

This line item was funded in FY 2011-12 as part of the financing that occurred in S.B. 11-219 to minimize the adverse impacts on some providers. No funding is requested or recommended for FY 2013-14. The Department did not request, nor does staff recommend, funding in FY 2014-15.

Children's Basic Health Plan (CHP+) Administration

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System.

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee. The federal match rate for CHP+ is 65 percent, but much of the activities of the contractor are actually related to the Medicaid program, because children may not enroll in CHP+ unless determined ineligible for Medicaid. The portion of the line item funded at the 50 percent Medicaid match rate is based on a time allocation model approved by the federal government.

Request: The Department requests *R12 Admin contract reprocurements*.

Recommendation: Staff recommends the requested funding. For the recommendation on *R12 Admin contract reprocurements* please see the Personal Services line item in the Executive Director's Office.

Children's Basic Health Plan (CHP+) Medical and Dental Costs

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

If actual expenditures run higher than the forecast based on the eligibility criteria and plan benefits, the budget is usually adjusted. However, states have more options and flexibility under

CHP+ rules to keep costs within the budget than under Medicaid rules. Correspondingly, the statutes provide less overexpenditure authority for CHP+ than for Medicaid. Pursuant to Section 24-75-109 (1) (a.5), C.R.S. the Department can make unlimited overexpenditures from cash fund sources, including the CHP+ Trust Fund, but annual overexpenditures from the General Fund are capped at $250,000.

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid.

The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, and the Health Care Expansion Fund. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. For federal fiscal year 2013-14 the enhanced FMAP is 65 percent and for federal fiscal year 2014-15 it will increase to 65.71 percent.

Request: The Department requests

- *R3 Children's Basic Health Plan*
- *BA10 Enhanced FMAP*
- *BA11 Alignment of CHP+ oral health care benefits to CHIPRA*
- Annualization of S.B. 13-200 that expanded Medicaid eligibility
- Annualization of S.B. 13-079 that repealed a Department rule regarding prenatal clients in CHP+. The repeal of the rule means the Department will make payments to prenatal clients in CHP+ during the 45-day presumptive eligibility period when the Department subsequently determines that the client was ineligible for coverage. Before the repeal of the rule these costs were denied, and so the repeal increases expenditures for CHP+.

Recommendation: The staff recommendation is summarized in the table below and select components of the recommendation are detailed in the arrowed items below the table. For the recommendations on *BA10 Enhanced FMAP* see the State of Health Projects line item.

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
FY 2013-14 Appropriation					
SB 13-230 (Long Bill)	$194,274,465	$22,569,364	$46,390,391	$125,314,710	0.0
Other legislation	2,007,812	694,706	22,938	1,290,168	0.0
HB 14-1236 (Supplemental)	(17,385,723)	(3,309,421)	(2,569,185)	(11,507,117)	0.0
14-15 Long Bill	16,835,119	(4,563,610)	25,562,896	(4,164,167)	0.0
TOTAL	**$195,731,673**	**$15,391,039**	**$69,407,040**	**$110,933,594**	**0.0**
FY 2014-15 Recommended Appropriation					
FY 2013-14 Appropriation	$195,731,673	$15,391,039	$69,407,040	$110,933,594	0.0

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Annualize SB 13-200 Expand Medicaid eligibility	10,868,376	3,761,947	119,957	6,986,472	0.0
Annualize prior year budget decisions	307,832	61,909	45,832	200,091	0.0
R3 Children's Basic Health Plan	(15,696,420)	1,511,214	(21,857,884)	4,650,250	0.0
BA10 FMAP change	0	(891,849)	0	891,849	0.0
BA11 CHP+ oral health benefits	5,340,492	1,334,347	511,597	3,494,548	0.0
Tobacco tax forecast	0	0	0	0	0.0
TOTAL	**$196,551,953**	**$21,168,607**	**$48,226,542**	**$127,156,804**	**0.0**
Increase/(Decrease)	$820,280	$5,777,568	($21,180,498)	$16,223,210	0.0
Percentage Change	0.4%	37.5%	(30.5%)	14.6%	0.0%
FY 2014-15 Executive Request:	**$174,747,735**	**$18,123,955**	**$43,373,224**	**$113,250,556**	**0.0**
Request Above/(Below) Recommendation	($21,804,218)	($3,044,652)	($4,853,318)	($13,906,248)	0.0

➔ R3 Children's Basic Health Plan

Request: The Department requests a change to the appropriation based on a new forecast of caseload and expenditures under current law and policy. On February 7, 2014 the Department submitted an update to the forecast. Although the update is not an "official" request to change the appropriation and it was submitted after the General Assembly's budget request deadlines, it represents the most current forecast available. The November 1 request incorporated data through December 2013 while the February 7, 2014 update includes data through at least December 2013. The table below summarizes the changes in expenditure projected in the forecast.

Children's Basic Health Plan (CHP+) Forecast by Fiscal Year	Total	General Fund	Cash Funds	Federal Funds
FY 13-14 Appropriation	178,896,554	19,954,649	43,844,144	115,097,761
FY 13-14 Revised projection	195,731,674	15,391,039	69,407,040	110,933,594
Difference	**16,835,120**	**(4,563,610)**	**25,562,896**	**(4,164,167)**
Percent	9.4%	-22.9%	58.3%	-3.6%
FY 13-14 Revised projection	195,731,674	15,391,039	69,407,040	110,933,594
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	206,907,882	19,214,895	69,572,829	118,120,157
FY 14-15 Projection	191,211,461	20,044,358	47,390,923	123,776,180
Difference	**(15,696,421)**	**829,462**	**(22,181,906)**	**5,656,023**
Percent	-7.6%	4.3%	-31.9%	4.8%

The February forecast significantly changed the projected FY 2013-14 expenditures primarily due to three factors:

- The Department corrected an assumption about how recoveries from a prior year would be treated based on state accounting rules. In the original forecast, the Department assumed these would appear as an offset to expenditures, but this is only allowed when the expenditures and recoveries appear in the same fiscal year. When the recoveries are from a prior year the Department must have cash funds spending authority for those recoveries. As a result, the total forecast increased by approximately $6 million cash funds. These particular recoveries are from a computer error that generated duplicate payments. The Department expects the computer error to be corrected and does not project a similar level of recoveries in FY 2014-15.
- The Department added a new projection of recoveries due to rate setting errors. The Department recently changed the contract actuary for the CHP+ program and the new actuary identified some flaws in the rate setting method used in prior years. The Department estimates recoveries of $17 million. This didn't change the total funds forecast, but it significantly increased the cash funds and reduced the General Fund and federal funds.
- The Department increased caseload assumptions, particularly for the higher income clients financed from the Hospital Provider Fee. The Department attributes caseload growth to a combination of calculating income according to the new MAGI methodology and increased public awareness as a result of the implementation of the Affordable Care Act. Among the lower income eligibility categories financed with the General Fund, the Department believes that MAGI implementation may be causing a migration from CHP+ to Medicaid so that the growth trend is not as high as for Hospital Provider Fee-financed eligibility categories. The Department also changed per capita expenditure assumptions with slight decreases for most categories and an increase for pregnant women, but the net impact of these changes was not as great as the changes in the eligibility assumptions.

For FY 2014-15 the projected change is attributable to:

- The Department is not forecasting the same level of significant recoveries as in FY 2013-14 for the duplicate payments and rate setting errors. This reduces the projected total expenditures by approximately $6 million. It also significantly decreases the projected cash funds and increases the projected General Fund and federal funds.
- There was a one-time transfer of expenditures from FY 2012-13 to FY 2013-14 related to the timing of some system changes that will not recur in FY 2014-15. The end of the one one-time transfer reduces the projected expenditures by $13.1 million total funds.
- Caseload is expected to increase in all categories except low-income pregnant women, where the Department is expecting a migration from CHP+ to Medicaid due to the implementation of S.B. 11-008 Aligning Medicaid eligibility for children and the MAGI standard for income determination. Because the cost per capita for pregnant women is high, the decrease in caseload provides a significant, although not complete, offset of the cost from the caseload increases in other eligibility categories.

Recommendation: Staff recommends using the Department's February forecast of enrollment and expenditures to modify both the FY 2013-14 and FY 2014-15 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

➔ BA11 CHP+ oral health benefits

Request: The Department requests funding to ensure that CHP+ oral health benefits are aligned with federal requirements. The Department received notice in October 2009 detailing required oral health benefits under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), but due to state revenue shortfalls the Department did not request funding to implement the required benefits. The benefit changes needed to comply are in the areas of periodontic care, orthodontic care, prosthodontic care, and medically necessary oral health services. With the changes in covered services the Department proposes increasing the annual limit on expenditures from $600 to $1,000 to ensure that clients can access the covered services. This proposed $1,000 annual limit would be consistent with private insurance plans in Colorado and similar plans in Alabama, Iowa, Michigan, and Wyoming.

Recommendation: Staff recommends the request. These are federally required services and failing to provide them could result in penalties. With the expansion in covered services it is necessary to increase the annual limit on expenditures to ensure that clients can actually access the new benefits. The assumed federal funds match rate accounts for the enhanced FMAP effective October 1, 2014.

→ **Tobacco tax forecast:** Staff recommends reducing the General Fund Exempt and increasing the General Fund by $14,700 based on the December forecast of tobacco tax revenues approved by the JBC during figure setting for the Department of Public Health and Environment and the statutory distribution formula for those funds. See the line item Appropriation from Tobacco Tax Fund to General Fund for more detail.

(5) OTHER MEDICAL SERVICES

Other Medical Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$178,855,652	$84,910,914	$37,176,978	$2,491,722	$54,276,038	0.0
Other legislation	(745,639)	500,000	(1,745,639)	0	500,000	0.0
HB 14-1236 (Supplemental)	(4,917,552)	(16,805,357)	0	0	11,887,805	0.0
14-15 Long Bill	2,834,984	1,332,934	0	0	1,502,050	0.0
TOTAL	**$176,027,445**	**$69,938,491**	**$35,431,339**	**$2,491,722**	**$68,165,893**	**0.0**
FY 2014-15 Recommended Appropriation						
FY 2013-14 Appropriation	$176,027,445	$69,938,491	$35,431,339	$2,491,722	$68,165,893	0.0
Annualize SB 13-200 Expand Medicaid eligibility	(3,749,388)	0	(3,749,388)	0	0	0.0
BA10 FMAP change	0	(44,208)	(257,496)	0	301,704	0.0
R4 Medicare drug repayment	(1,083,796)	32,284,546	0	0	(33,368,342)	0.0
TOTAL	**$171,194,261**	**$102,178,829**	**$31,424,455**	**$2,491,722**	**$35,099,255**	**0.0**

Other Medical Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Increase/(Decrease)	($4,833,184)	$32,240,338	($4,006,884)	$0	($33,066,638)	0.0
Percentage Change	(2.7%)	46.1%	(11.3%)	0.0%	(48.5%)	0.0%
FY 2014-15 Executive Request:	**$167,993,809**	**$99,318,096**	**$31,424,455**	**$2,491,722**	**$34,759,536**	**0.0**
Request Above/(Below) Recommendation	($3,200,452)	($2,860,733)	$0	$0	($339,719)	0.0

Old Age Pension State Medical Program

The Old Age Pension (OAP) Health and Medical program was established through Article XXIV of the Colorado Constitution and by Section 25.5-2-101, C.R.S. to provide health care services to persons who qualify to receive old age pensions up to a maximum of $10.0 million. The funds are paid to providers based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation. The source of cash funds is a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund.

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility. With the expansion a significant portion of the Old Age Pension population is expected to be eligible for Medicaid, and so the funds are being used to offset the need for General Fund in the Medical Services Premiums line item.

Recommendation: Staff recommends the request with the annualization of S.B. 13-200.

Commission on Family Medicine

This line item provides payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). All of the funding in this line item goes directly to the residency programs. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

Request: The Department requests *BA10 Enhanced FMAP* to account for the higher federal match rate beginning October 1, 2014.

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

State University Teaching Hospitals -- Denver Health and Hospital Authority
State University Teaching Hospitals -- University of Colorado Hospital Authority

These two line items provide funding for the Denver Health and Hospital Authority and University of Colorado Hospital Authority respectively for Graduate Medical Education (GME).

Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helps to better track these costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in other line items, including Medical Service Premiums and the Indigent Care Program.

Request: The Department requests *BA10 Enhanced FMAP* to account for the higher federal match rate beginning October 1, 2014.

Recommendation: Staff recommends the requested continuation level of total funding with the fund source adjustment to account for the change in the federal match rate. Traditionally these line item have received periodic rate adjustments rather than the community provider rate increase. A 3.0 percent increase on both line items would cost $73,951 total funds including $36,415 General Fund.

Medicare Modernization Act

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, for the past several years the General Assembly has applied federal bonus payments for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

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

Recommendation: Staff recommends adjusting both the FY 2013-14 and FY 2014-15 appropriations based on an updated February 7, 2014 forecast discussed in more detail below.

➔ R4 Medicare Modernization Act

Request: The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation. Changes in the population dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices all impact the size of the state obligation. On February 7, 2014 the Department submitted an update to the forecast used for the November 1, 2013 budget request. Although the update is not an "official" request to change the appropriation and it was submitted after the General Assembly's budget request deadlines, it represents the most current forecast available. The November 1 request incorporated data through December 2013 while the February 7, 2014 update includes data through at least December 2013. The table below summarizes the changes in expenditure

projected in the updated forecast. These figures are different than those shown for the Department's "official" request in the numbers pages.

Medicare Modernization Act Forecast by Fiscal Year			
	Total	General Fund	Federal Funds
FY 13-14 Appropriation	102,256,317	65,687,505	36,568,812
FY 13-14 Revised projection	105,091,301	67,020,439	38,070,862
Difference	**2,834,984**	**1,332,934**	**1,502,050**
Percent	2.8%	2.0%	4.1%
FY 14-15 Base	105,091,301	67,020,439	38,070,862
FY 14-15 Projection	104,007,505	99,304,985	4,702,520
Difference	**(1,083,796)**	**32,284,546**	**(33,368,342)**
Percent	-1.0%	48.2%	-87.6%

The revised forecast for FY 2013-14 is primarily attributable to higher than expected federal retroactive adjustments. Federal rules allow a 24 month period for retroactive adjustments and historically the level of these adjustments has been very stable, but in December and January the adjustments were significantly higher than expected. The Department is investigating with the federal government why retroactivity has been higher than the historical trend.

For FY 2014-15 the Department is projecting a slight decrease in the total obligation, but a significant increase in the General Fund required. 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. 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 and the JBC took action last year to step down the cliff effect by putting $25 million General Fund into this line item and depositing $25 million of the federal bonus payments in the Controlled Maintenance Trust Fund.

Recommendation: Staff recommends using the Department's February forecast of enrollment and expenditures to modify both the FY 2013-14 and FY 2014-15 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

Public School Health Services Contract Administration; and
Public School Health Services

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under, or uninsured

children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts

Request: The Department requests *BA10 Enhanced FMAP* to reflect the additional federal match effective October 1, 2014. The Department estimates 62.54 percent of the funds are eligible for the standard Medicaid FMAP and the remainder must be reimbursed at the 50 percent match for administrative expenses. These reimbursements are based on actual allowable costs and certified public expenditures, and so no additional community provider rate increase was requested.

Recommendation: Staff recommends the requested funds. There have been dramatic increases in recent expenditures, but predicting the increases has proved difficult. The Department attributes the increases to a combination of outreach efforts by the Department, school districts needing to pursue new revenue streams due to the economy, and more students meeting the income thresholds for the program. The Department makes an initial payment during the fiscal year, but then makes a reconciliation payment in the next fiscal year. Some of the data points for that reconciliation payment are not available until the spring after the fiscal year when the service was provided, which is after the General Assembly's supplemental process. The staff recommendation for continuation funding is with the understanding that the actual certified public expenditures are not in the direct control of the Department and that the available data to forecast these certified public expenditures is limited, and so there may need to be a true-up at a later date.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID FUNDED PROGRAMS

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

Long Bill Footnotes and Requests for Information

LONG BILL FOOTNOTES

Staff recommends **CONTINUATION** of the following 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 explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions once all the JBC's decisions are made.

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.

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.

Comment: __

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 explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions.

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 explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions.

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.

Staff recommends **DISCONTINUATION** of the following footnotes:

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, 2013.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUATION** of the following requests for information:

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: This report provides useful information to the JBC staff and is a long-standing report that the Department has provided for many years.

2. **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, ~~2013~~ 2014, 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 Accountable Care Collaborative (ACC) continues to be one of the Department's primary initiatives to improve health outcomes and save money. The Department's Medicaid forecast assumes significant savings associated with the ACC. The program warrants continued close monitoring by the JBC.

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 provides useful information to the JBC staff and is a long-standing report that the Department has provided for many years.

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 significant supplemental requests for both FY 2011-12 and FY 2012-13. The report provides useful statistics about the program and why funding levels change.

Staff recommends **DISCONTINUING** the following footnotes:

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 and created an exhibit in the forecast to show the financing for the Colorado Choice Transitions Program, including the rebalancing funds.

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 submitted the report as requested and ongoing reporting would not likely provide additional information.

Appendix A: Number Pages

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
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						
Personal Services	20,609,604	22,338,943	24,725,133	28,588,051	25,874,674	*
FTE	293.4	315.9	358.1	395.1	359.6	
General Fund	7,727,247	8,062,731	8,410,879	10,292,289	8,747,250	
General Fund Exempt	0	0	0	0	0	
Cash Funds	1,371,016	1,922,374	2,599,615	2,693,382	2,676,189	
Reappropriated Funds	448,289	1,176,645	1,736,842	1,768,913	1,885,519	
Federal Funds	11,063,052	11,177,193	11,977,797	13,833,467	12,565,716	
Health, Life, and Dental	2,024,577	2,216,793	2,322,539	2,523,302	2,523,213	*
General Fund	627,749	796,479	748,152	920,169	920,169	
Cash Funds	255,164	174,652	227,912	166,111	166,067	
Reappropriated Funds	0	111,821	72,376	129,013	129,013	
Federal Funds	1,141,664	1,133,841	1,274,099	1,308,009	1,307,964	
Short-term Disability	32,188	33,497	42,151	64,785	64,854	
General Fund	12,334	12,334	13,671	21,323	21,425	
Cash Funds	2,503	2,503	3,764	5,047	4,951	
Reappropriated Funds	0	1,309	802	1,905	1,914	
Federal Funds	17,351	17,351	23,914	36,510	36,564	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
S.B. 04-257 Amortization Equalization Disbursement	532,854	730,633	850,598	1,242,758	1,246,928
General Fund	190,728	283,141	273,870	409,422	411,369
Cash Funds	53,148	53,468	76,148	96,742	96,323
Reappropriated Funds	0	37,574	16,232	36,619	36,796
Federal Funds	288,978	356,450	484,348	699,975	702,440
S.B. 06-235 Supplemental Amortization Equalization Disbursement	427,325	627,713	767,027	1,165,084	1,169,055
General Fund	151,785	242,160	246,370	383,833	385,658
Cash Funds	42,482	45,949	68,744	90,695	90,333
Reappropriated Funds	0	33,280	14,654	34,330	34,496
Federal Funds	233,058	306,324	437,259	656,226	658,568
Salary Survey	0	0	669,740	498,753	1,012,847
General Fund	0	0	199,437	163,365	333,368
Cash Funds	0	0	53,484	38,938	78,906
Reappropriated Funds	0	0	10,800	14,888	29,778
Federal Funds	0	0	406,019	281,562	570,795
Merit Pay	0	0	372,361	412,618	411,127
General Fund	0	0	119,442	147,216	147,180
Cash Funds	0	0	28,027	29,990	29,417
Reappropriated Funds	0	0	9,889	14,179	14,163
Federal Funds	0	0	215,003	221,233	220,367
Worker's Compensation	29,652	30,844	47,285	54,080	54,080
General Fund	14,826	15,422	23,643	27,040	27,040
Federal Funds	14,826	15,422	23,642	27,040	27,040

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
Operating Expenses	1,503,581	1,503,436	2,503,082	3,675,976	3,334,157 *
General Fund	677,693	663,213	1,097,532	1,751,174	1,576,996
Cash Funds	71,657	43,601	131,410	63,057	62,577
Reappropriated Funds	0	64,796	23,910	23,910	23,910
Federal Funds	754,231	731,826	1,250,230	1,837,835	1,670,674
Legal and Third Party Recovery Legal Services	903,975	896,802	1,262,869	1,300,844	1,300,844
General Fund	334,195	284,349	420,907	420,907	420,907
Cash Funds	123,284	162,313	210,528	229,516	229,516
Reappropriated Funds	0	0	0	0	0
Federal Funds	446,496	450,140	631,434	650,421	650,421
Administrative Law Judge Services	449,127	510,597	550,139	373,498	373,498
General Fund	199,865	211,949	224,892	145,128	145,128
Cash Funds	24,698	43,350	50,178	41,621	41,621
Federal Funds	224,564	255,298	275,069	186,749	186,749
Purchase of Services from Computer Center	835,844	1,001,906	882,219	0	0
General Fund	414,547	496,907	433,541	0	0
Reappropriated Funds	3,375	4,046	4,189	0	0
Federal Funds	417,922	500,953	444,489	0	0
Multiuse Network Payments	227,900	245,162	139,002	0	0
General Fund	113,950	122,581	69,500	0	0
Federal Funds	113,950	122,581	69,502	0	0

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
COFRS Modernization	0	569,048	504,639	504,639	504,639
General Fund	0	329,397	329,397	329,397	329,397
Cash Funds	0	173,190	173,190	173,190	173,190
Reappropriated Funds	0	2,052	2,052	2,052	2,052
Federal Funds	0	64,409	0	0	0
Information Technology Security	0	0	11,374	0	0
General Fund	0	0	5,607	0	0
Reappropriated Funds	0	0	44	0	0
Federal Funds	0	0	5,723	0	0
Management and Administration of OIT	631,234	0	72,129	0	0
General Fund	315,617	0	36,065	0	0
Federal Funds	315,617	0	36,064	0	0
Payment to Risk Management and Property Funds	77,888	123,841	263,208	164,260	164,260
General Fund	38,944	61,921	131,604	82,130	82,130
Federal Funds	38,944	61,920	131,604	82,130	82,130
Vehicle Lease Payments	0	0	0	3,291	3,291
General Fund	0	0	0	3,291	3,291
Leased Space	628,141	659,770	757,651	1,121,384	1,121,384
General Fund	197,846	216,966	238,009	417,938	417,938
Cash Funds	116,224	99,625	140,818	142,754	142,754
Federal Funds	314,071	343,179	378,824	560,692	560,692

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Capitol Complex Leased Space	397,925	394,599	496,658	442,846	442,846	
General Fund	198,962	197,300	248,329	221,423	221,423	
Federal Funds	198,963	197,299	248,329	221,423	221,423	
General Professional Services and Special Projects	3,971,819	3,350,149	8,598,752	5,501,079	5,686,920	*
General Fund	1,094,416	1,353,401	2,507,418	1,978,419	2,039,127	
Cash Funds	449,206	354,610	568,500	562,500	562,500	
Federal Funds	2,428,197	1,642,138	5,522,834	2,960,160	3,085,293	
Payments to OIT	0	0	201,447	1,523,605	1,725,052	*
General Fund	0	0	100,723	750,852	851,575	
Reappropriated Funds	0	0	0	6,061	6,061	
Federal Funds	0	0	100,724	766,692	867,416	
SUBTOTAL - (A) General Administration	33,283,634	35,233,733	46,040,003	49,160,853	47,013,669	
FTE	293.4	315.9	358.1	395.1	359.6	
General Fund	12,310,704	13,350,251	15,878,988	18,465,316	17,081,371	
General Fund Exempt	0	0	0	0	0	
Cash Funds	2,509,382	3,075,635	4,332,318	4,333,543	4,354,344	
Reappropriated Funds	451,664	1,431,523	1,891,790	2,031,870	2,163,702	
Federal Funds	18,011,884	17,376,324	23,936,907	24,330,124	23,414,252	
(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	5,296,042	5,296,042	
General Fund	1,438,076	1,383,261	1,651,255	1,650,874	1,650,874	
Federal Funds	3,233,922	3,288,928	3,646,510	3,645,168	3,645,168	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	0	0	
General Fund	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Nurse Home Visitor Program, Transfer from the Department of Human Services	1,001,532	964,536	3,010,000	3,010,000	3,010,000	*
Reappropriated Funds	500,766	481,337	1,505,000	1,482,199	1,482,199	
Federal Funds	500,766	483,199	1,505,000	1,527,801	1,527,801	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	0	5,887	5,887	5,887	5,887	
General Fund	0	2,943	2,944	2,944	2,944	
Federal Funds	0	2,944	2,943	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,041	324,041	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652	
Federal Funds	162,020	162,020	162,020	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	0	4,818	4,160	10,000	10,000	
General Fund	0	2,409	2,080	5,000	5,000	
Federal Funds	0	2,409	2,080	5,000	5,000	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
Public School Health Services Administration, Transfer to the Department of Education	139,649	145,640	149,999	149,999	149,999
Reappropriated Funds	0	0	149,999	149,999	149,999
Federal Funds	139,649	145,640	0	0	0
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	0	0	272,099	205,146 *
General Fund	0	0	0	136,049	102,573
Federal Funds	0	0	0	136,050	102,573
SUBTOTAL - (B) Transfers to Other Departments	6,137,220	6,117,111	8,791,852	9,068,068	9,001,115
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,585,445	1,535,982	1,803,648	1,942,236	1,908,760
Reappropriated Funds	515,418	495,989	1,669,651	1,646,850	1,646,850
Federal Funds	4,036,357	4,085,140	5,318,553	5,478,982	5,445,505

(C) Information Technology Contracts and Projects

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

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

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
SUBTOTAL - (C) Information Technology Contracts and Projects	32,037,565	32,954,691	60,270,089	81,036,809	81,036,809	
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	10,511,027	
Cash Funds	2,532,625	3,589,565	6,047,998	5,357,522	5,357,522	
Reappropriated Funds	92,163	100,328	1,443,350	1,443,350	1,443,350	
Federal Funds	23,304,000	22,955,018	44,447,265	63,724,910	63,724,910	
(D) Eligibility Determinations and Client Services						
Medical Identification Cards	115,591	117,011	140,257	158,247	158,247	
General Fund	52,867	53,532	59,400	60,370	60,370	
Cash Funds	4,132	4,177	9,932	17,957	17,957	
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593	
Federal Funds	56,999	57,709	69,332	78,327	78,327	
Contracts for Special Eligibility Determinations	3,509,989	3,800,160	9,865,097	11,695,703	11,695,703	
General Fund	828,091	826,993	969,756	1,116,459	1,116,459	
Cash Funds	661,117	827,925	3,574,868	4,343,468	4,343,468	
Federal Funds	2,020,781	2,145,242	5,320,473	6,235,776	6,235,776	
County Administration	30,602,852	25,338,161	39,560,955	41,718,342	41,718,342	*
General Fund	10,157,979	9,894,404	10,145,834	10,572,620	10,572,620	
Cash Funds	5,299,296	0	5,604,460	5,707,810	5,707,810	
Federal Funds	15,145,577	15,443,757	23,810,661	25,437,912	25,437,912	
Hospital Provider Fee County Administration	1,939,544	2,029,164	4,361,206	9,723,802	10,454,674	*
Cash Funds	969,772	1,014,582	1,755,168	3,208,371	3,208,371	
Federal Funds	969,772	1,014,582	2,606,038	6,515,431	7,246,303	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Administrative Case Management	1,391,668	1,866,788	869,744	869,744	869,744	
General Fund	695,834	933,394	434,872	434,872	434,872	
Federal Funds	695,834	933,394	434,872	434,872	434,872	
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	0	0	2,449,793	986,436	986,436	*
General Fund	0	0	585,870	314,109	314,109	
Federal Funds	0	0	1,863,923	672,327	672,327	
Medical Assistance Sites	0	0	0	1,152,000	1,152,000	*
Cash Funds	0	0	0	288,000	288,000	
Federal Funds	0	0	0	864,000	864,000	
Customer Outreach	4,694,853	4,917,340	5,904,730	6,321,050	6,542,986	*
General Fund	2,259,497	2,371,809	2,575,246	2,860,895	2,860,895	
Cash Funds	101,362	86,861	186,338	336,621	336,621	
Federal Funds	2,333,994	2,458,670	3,143,146	3,123,534	3,345,470	
SUBTOTAL - (D) Eligibility Determinations and Client Services	42,254,497	38,068,624	63,151,782	72,625,324	73,578,132	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	13,994,268	14,080,132	14,770,978	15,359,325	15,359,325	
Cash Funds	7,035,679	1,933,545	11,130,766	13,902,227	13,902,227	
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593	
Federal Funds	21,222,957	22,053,354	37,248,445	43,362,179	44,314,987	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	6,384,617	6,435,636	9,432,809	11,757,587	11,795,087 *
General Fund	1,806,527	1,799,872	2,279,886	3,149,524	3,149,524
Cash Funds	57,620	103,638	305,844	461,089	461,089
Federal Funds	4,520,470	4,532,126	6,847,079	8,146,974	8,184,474
SUBTOTAL - (E) Utilization and Quality Review Contracts	6,384,617	6,435,636	9,432,809	11,757,587	11,795,087
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,806,527	1,799,872	2,279,886	3,149,524	3,149,524
Cash Funds	57,620	103,638	305,844	461,089	461,089
Federal Funds	4,520,470	4,532,126	6,847,079	8,146,974	8,184,474
(F) Provider Audits and Services					
Professional Audit Contracts	1,841,190	2,207,726	3,051,907	2,463,406	2,463,406
General Fund	908,175	891,703	1,116,408	969,283	969,283
Cash Funds	12,420	0	365,408	262,420	262,420
Reappropriated Funds	0	212,160	0	0	0
Federal Funds	920,595	1,103,863	1,570,091	1,231,703	1,231,703
SUBTOTAL - (F) Provider Audits and Services	1,841,190	2,207,726	3,051,907	2,463,406	2,463,406
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	908,175	891,703	1,116,408	969,283	969,283
Cash Funds	12,420	0	365,408	262,420	262,420
Reappropriated Funds	0	212,160	0	0	0
Federal Funds	920,595	1,103,863	1,570,091	1,231,703	1,231,703

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(G) Recoveries and Recoupment Contract Costs						
Estate Recovery	315,578	531,346	700,000	700,000	700,000	
Cash Funds	157,789	265,673	350,000	350,000	350,000	
Federal Funds	157,789	265,673	350,000	350,000	350,000	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	315,578	531,346	700,000	700,000	700,000	
FTE	0.0	0.0	0.0	0.0	0.0	
Cash Funds	157,789	265,673	350,000	350,000	350,000	
Federal Funds	157,789	265,673	350,000	350,000	350,000	
State of Health Projects						
Transfer from General Fund to State of Health Cash Fund	0	0	0	17,089,710	0	*
General Fund	0	0	0	17,089,710	0	
State of Health Projects	0	0	0	17,089,710	0	*
Cash Funds	0	0	0	17,089,710	0	
Pain Management Capacity Program	0	0	0	0	500,000	
General Fund	0	0	0	0	246,212	
Federal Funds	0	0	0	0	253,788	
SUBTOTAL - State of Health Projects	0	0	0	34,179,420	500,000	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	0	17,089,710	246,212	
Cash Funds	0	0	0	17,089,710	0	
Federal Funds	0	0	0	0	253,788	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
(H) Indirect Cost Assessment					
Indirect Cost Assessment	0	0	545,140	663,489	663,489
Cash Funds	0	0	121,193	122,479	122,479
Reappropriated Funds	0	0	29,596	21,941	21,941
Federal Funds	0	0	394,351	519,069	519,069
SUBTOTAL - (H) Indirect Cost Assessment	0	0	545,140	663,489	663,489
FTE	0.0	0.0	0.0	0.0	0.0
Cash Funds	0	0	121,193	122,479	122,479
Reappropriated Funds	0	0	29,596	21,941	21,941
Federal Funds	0	0	394,351	519,069	519,069
TOTAL - (1) Executive Director's Office	122,254,301	121,548,867	191,983,582	261,654,956	226,751,707
FTE	293.4	315.9	358.1	395.1	359.6
General Fund	36,713,896	37,967,720	44,181,384	67,486,421	49,225,502
General Fund Exempt	0	0	0	0	0
Cash Funds	12,305,515	8,968,056	22,653,527	41,878,990	24,810,081
Reappropriated Funds	1,060,838	2,241,593	5,035,980	5,145,604	5,277,436
Federal Funds	72,174,052	72,371,498	120,112,691	147,143,941	147,438,688

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,642,032,762	3,937,400,734	4,841,422,684	5,602,533,355	5,736,522,818 *
General Fund	833,239,176	847,647,042	1,069,570,964	1,109,543,542	1,138,752,104
General Fund Exempt	373,508,751	507,235,957	469,842,084	469,842,084	469,842,084
Cash Funds	629,762,743	639,607,454	655,296,441	614,787,554	636,595,945
Reappropriated Funds	6,445,828	2,936,892	2,936,892	2,000,000	0
Federal Funds	1,799,076,264	1,939,973,389	2,643,776,303	3,406,360,175	3,491,332,685
TOTAL - (2) Medical Services Premiums	3,642,032,762	3,937,400,734	4,841,422,684	5,602,533,355	5,736,522,818
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	833,239,176	847,647,042	1,069,570,964	1,109,543,542	1,138,752,104
General Fund Exempt	373,508,751	507,235,957	469,842,084	469,842,084	469,842,084
Cash Funds	629,762,743	639,607,454	655,296,441	614,787,554	636,595,945
Reappropriated Funds	6,445,828	2,936,892	2,936,892	2,000,000	0
Federal Funds	1,799,076,264	1,939,973,389	2,643,776,303	3,406,360,175	3,491,332,685

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(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.						
Behavioral Health Capitation Payments	273,376,614	301,303,046	397,171,674	483,334,936	544,053,019	*
General Fund	131,782,602	136,833,502	149,923,432	159,772,908	169,074,553	
Cash Funds	5,791,948	13,513,748	11,020,649	3,569,852	4,489,831	
Reappropriated Funds	25,046	0	0	0	0	
Federal Funds	135,777,018	150,955,796	236,227,593	319,992,176	370,488,635	
Behavioral Health Fee-for-service Payments	3,894,039	4,569,198	5,842,623	6,334,887	7,176,726	*
General Fund	1,917,565	2,253,518	2,921,311	3,167,443	3,533,999	
Federal Funds	1,976,474	2,315,680	2,921,312	3,167,444	3,642,727	
Contract Reprocurement	0	0	1,000,000	0	0	
General Fund	0	0	500,000	0	0	
Federal Funds	0	0	500,000	0	0	
TOTAL - (3) Behavioral Health Community Programs	277,270,653	305,872,244	404,014,297	489,669,823	551,229,745	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	133,700,167	139,087,020	153,344,743	162,940,351	172,608,552	
Cash Funds	5,791,948	13,513,748	11,020,649	3,569,852	4,489,831	
Reappropriated Funds	25,046	0	0	0	0	
Federal Funds	137,753,492	153,271,476	239,648,905	323,159,620	374,131,362	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	0	0	0	0	2,927,116 *
FTE	0.0	0.0	0.0	0.0	35.5
General Fund	0	0	0	0	1,563,221
Federal Funds	0	0	0	0	1,363,895
Operating Expenses	0	0	0	0	296,786 *
General Fund	0	0	0	0	146,145
Federal Funds	0	0	0	0	150,641
Community and Contract Management System	0	0	0	137,480	137,480
General Fund	0	0	0	89,362	88,633
Federal Funds	0	0	0	48,118	48,847
Support Level Administration	0	0	0	57,368	57,368
General Fund	0	0	0	28,684	28,250
Federal Funds	0	0	0	28,684	29,118
SUBTOTAL - (i) Administrative Costs	0	0	0	194,848	3,418,750
FTE	0.0	0.0	0.0	0.0	35.5
General Fund	0	0	0	118,046	1,826,249
Federal Funds	0	0	0	76,802	1,592,501

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(ii) Program Costs						
Adult Comprehensive Services	0	0	0	338,580,732	346,132,357	*
General Fund	0	0	0	151,052,881	155,280,869	
Cash Funds	0	0	0	31,254,275	30,798,715	
Federal Funds	0	0	0	156,273,576	160,052,773	
Adult Supported Living Services	0	0	0	60,677,175	69,689,818	*
General Fund	0	0	0	33,818,237	38,128,550	
Federal Funds	0	0	0	26,858,938	31,561,268	
Children's Extensive Support Services	0	0	0	24,292,404	25,018,317	*
General Fund	0	0	0	11,961,381	12,305,751	
Federal Funds	0	0	0	12,331,023	12,712,566	
Case Management	0	0	0	28,237,881	29,610,763	*
General Fund	0	0	0	15,050,072	15,742,627	
Federal Funds	0	0	0	13,187,809	13,868,136	
Family Support Services	0	0	0	6,762,095	6,862,028	*
General Fund	0	0	0	6,762,095	6,862,028	
Preventive Dental Hygiene	0	0	0	65,203	66,057	*
General Fund	0	0	0	61,506	62,415	
Cash Funds	0	0	0	3,697	0	
Eligibility Determination and Waiting List Management	0	0	0	3,032,242	3,077,054	*
General Fund	0	0	0	3,012,587	3,056,806	
Federal Funds	0	0	0	19,655	20,248	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
SUBTOTAL - (ii) Program Costs	0	0	0	461,647,732	480,456,394
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	221,718,759	231,439,046
Cash Funds	0	0	0	31,257,972	30,802,357
Federal Funds	0	0	0	208,671,001	218,214,991
TOTAL - Office of Community Living	0	0	0	461,842,580	483,875,144
FTE	0.0	0.0	0.0	0.0	35.5
General Fund	0	0	0	221,836,805	233,265,295
Cash Funds	0	0	0	31,257,972	30,802,357
Federal Funds	0	0	0	208,747,803	219,807,492

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(4) INDIGENT CARE PROGRAM						
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.						
Safety Net Provider Payments	288,633,447	299,175,424	311,296,186	311,296,186	311,296,186	*
Cash Funds	144,316,724	149,587,712	155,648,093	153,307,474	153,307,474	
Federal Funds	144,316,723	149,587,712	155,648,093	157,988,712	157,988,712	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760	*
General Fund	3,059,880	3,059,880	3,059,880	3,013,523	3,013,523	
Federal Funds	3,059,880	3,059,880	3,059,880	3,106,237	3,106,237	
Health Care Services Fund Programs	23,510,000	0	0	0	0	
Cash Funds	11,755,000	0	0	0	0	
Federal Funds	11,755,000	0	0	0	0	
Pediatric Specialty Hospital	11,799,938	11,799,938	11,799,938	11,799,938	11,799,938	*
General Fund	5,899,969	5,899,969	5,899,969	5,810,584	5,810,584	
Federal Funds	5,899,969	5,899,969	5,899,969	5,989,354	5,989,354	
General Fund Appropriation to Pediatric Specialty Hospital	0	0	0	0	0	
General Fund Exempt	0	0	0	0	0	
Appropriation from Tobacco Tax Fund to the General Fund	445,214	429,812	438,300	438,300	423,600	
General Fund	0	0	0	0	(14,700)	
Cash Funds	445,214	429,812	438,300	438,300	438,300	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Primary Care Fund	0	27,258,545	27,759,000	27,759,000	26,828,000	
Cash Funds	0	27,258,545	27,759,000	27,759,000	26,828,000	
Primary Care Grant Program Special Distribution	2,135,830	0	0	0	0	
Cash Funds	2,135,830	0	0	0	0	
Children's Basic Health Plan Administration	4,759,499	4,245,129	4,319,079	5,127,772	5,127,772	
General Fund	272,494	0	0	0	0	
Cash Funds	1,941,946	1,883,715	2,019,582	2,404,035	2,404,035	
Federal Funds	2,545,059	2,361,414	2,299,497	2,723,737	2,723,737	
Children's Basic Health Plan Medical and Dental Costs	182,454,122	191,570,458	195,731,673	174,747,735	196,551,953	*
General Fund	29,413,207	29,398,182	14,952,739	17,688,955	20,748,307	
General Fund Exempt	446,100	441,600	438,300	435,000	420,300	
Cash Funds	35,148,096	37,761,085	69,407,040	43,373,224	48,226,542	
Federal Funds	117,446,719	123,969,591	110,933,594	113,250,556	127,156,804	
Comprehensive Primary and Preventive Care Grants	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Hospice Supplemental Payment	0	0	0	0	0	
General Fund	0	0	0	0	0	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
TOTAL - (4) Indigent Care Program	519,857,810	540,599,066	557,463,936	537,288,691	558,147,209
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	38,645,550	38,358,031	23,912,588	26,513,062	29,557,714
General Fund Exempt	446,100	441,600	438,300	435,000	420,300
Cash Funds	195,742,810	216,920,869	255,272,015	227,282,033	231,204,351
Federal Funds	285,023,350	284,878,566	277,841,033	283,058,596	296,964,844

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(5) OTHER MEDICAL SERVICES						
Primary functions: This division provides funding for the following three state-only Medical programs: (1) Old Age Pension Medical Program, (2) the Medicare Modernization Act State Contribution Payment, and (3) the Colorado Cares RX Program. This division also contains funding for programs that eligible for Medicaid funding but are not part of the Medical Services Premiums or Mental Health Programs.						
Old Age Pension State Medical	9,148,285	9,675,508	8,254,361	4,504,973	4,504,973	
General Fund	0	0	0	0	0	
Cash Funds	9,148,285	9,675,508	8,254,361	4,504,973	4,504,973	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Commission on Family Medicine Residency Training Programs	1,741,077	1,741,077	3,371,077	3,371,077	3,371,077	*
General Fund	870,538	870,538	1,685,538	1,660,002	1,660,002	
Federal Funds	870,539	870,539	1,685,539	1,711,075	1,711,075	
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	1,831,714	1,831,714	1,831,714	1,831,714	*
General Fund	915,857	915,857	915,857	901,982	901,982	
Federal Funds	915,857	915,857	915,857	929,732	929,732	
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	633,314	633,314	633,314	*
General Fund	316,657	316,657	316,657	311,860	311,860	
Federal Funds	316,657	316,657	316,657	321,454	321,454	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
Medicare Modernization Act State Contribution Payment	93,582,494	101,817,855	105,091,301	100,807,053	104,007,505
General Fund	62,939,212	52,136,848	67,020,439	96,444,252	99,304,985
Reappropriated Funds	0	0	0	0	0
Federal Funds	30,643,282	49,681,007	38,070,862	4,362,801	4,702,520
Public School Health Services Contract Administration	824,064	811,941	2,491,722	2,491,722	2,491,722
Reappropriated Funds	0	0	2,491,722	2,491,722	2,491,722
Federal Funds	824,064	811,941	0	0	0
Public School Health Services	46,873,870	49,784,091	54,353,956	54,353,956	54,353,956 *
Cash Funds	22,390,960	24,887,311	27,176,978	26,919,482	26,919,482
Federal Funds	24,482,910	24,896,780	27,176,978	27,434,474	27,434,474
TOTAL - (5) Other Medical Services	154,634,818	166,295,500	176,027,445	167,993,809	171,194,261
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	65,042,264	54,239,900	69,938,491	99,318,096	102,178,829
Cash Funds	31,539,245	34,562,819	35,431,339	31,424,455	31,424,455
Reappropriated Funds	0	0	2,491,722	2,491,722	2,491,722
Federal Funds	58,053,309	77,492,781	68,165,893	34,759,536	35,099,255

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(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						
Executive Director's Office - Medicaid Funding	11,608,558	4,169,886	17,535,090	17,268,349	17,268,349	*
General Fund	5,804,279	2,084,943	8,767,545	8,504,451	8,504,451	
Federal Funds	5,804,279	2,084,943	8,767,545	8,763,898	8,763,898	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	11,608,558	4,169,886	17,535,090	17,268,349	17,268,349	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	5,804,279	2,084,943	8,767,545	8,504,451	8,504,451	
Federal Funds	5,804,279	2,084,943	8,767,545	8,763,898	8,763,898	
(B) Office of Information Technology Services - Medicaid Funding						
Colorado Benefits Management System	9,447,008	10,006,971	8,405,843	8,408,583	8,408,583	
General Fund	4,147,409	4,249,653	4,173,836	4,175,198	4,175,198	
Cash Funds	550,920	8,092	13,660	13,671	13,671	
Reappropriated Funds	25,562	37,834	18,809	18,809	18,809	
Federal Funds	4,723,117	5,711,392	4,199,538	4,200,905	4,200,905	
CBMS SAS-70 Audit	50,850	46,554	55,204	55,204	55,204	
General Fund	25,294	23,164	27,416	27,416	27,416	
Cash Funds	53	25	89	89	89	
Reappropriated Funds	112	155	119	119	119	
Federal Funds	25,391	23,210	27,580	27,580	27,580	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Colorado Benefits Management System, HCPF Only	812,400	0	611,520	611,520	611,520	
General Fund	107,460	0	0	0	0	
Cash Funds	298,740	0	305,760	305,760	305,760	
Federal Funds	406,200	0	305,760	305,760	305,760	
CBMS Modernization	0	0	13,466,086	27,334,919	28,131,316	
General Fund	0	0	2,274,072	7,384,602	7,772,615	
Cash Funds	0	0	55,915	1,286,032	1,293,162	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	11,136,099	18,664,285	19,065,539	
Other Office of Information Technology Services line items	555,484	500,820	572,374	591,113	591,113	*
General Fund	277,742	250,410	286,187	291,079	291,079	
Federal Funds	277,742	250,410	286,187	300,034	300,034	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	10,865,742	10,554,345	23,111,027	37,001,339	37,797,736	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	4,557,905	4,523,227	6,761,511	11,878,295	12,266,308	
Cash Funds	849,713	8,117	375,424	1,605,552	1,612,682	
Reappropriated Funds	25,674	37,989	18,928	18,928	18,928	
Federal Funds	5,432,450	5,985,012	15,955,164	23,498,564	23,899,818	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
(C) Office of Operations - Medicaid Funding						
Office of Operations - Medicaid Funding	4,082,810	4,069,739	4,786,843	4,974,114	4,974,114	*
General Fund	2,041,406	2,034,870	2,393,422	2,449,378	2,449,378	
Federal Funds	2,041,404	2,034,869	2,393,421	2,524,736	2,524,736	
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,082,810	4,069,739	4,786,843	4,974,114	4,974,114	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,041,406	2,034,870	2,393,422	2,449,378	2,449,378	
Federal Funds	2,041,404	2,034,869	2,393,421	2,524,736	2,524,736	
(D) Division of Child Welfare - Medicaid Funding						
Administration	130,938	132,899	133,070	137,306	137,306	
General Fund	65,470	66,449	66,535	68,653	68,653	
Federal Funds	65,468	66,450	66,535	68,653	68,653	
Child Welfare Services	10,935,479	8,428,490	14,579,137	14,797,824	14,797,824	*
General Fund	5,467,740	4,214,245	7,289,569	7,286,818	7,286,818	
Federal Funds	5,467,739	4,214,245	7,289,568	7,511,006	7,511,006	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	11,066,417	8,561,389	14,712,207	14,935,130	14,935,130	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	5,533,210	4,280,694	7,356,104	7,355,471	7,355,471	
Federal Funds	5,533,207	4,280,695	7,356,103	7,579,659	7,579,659	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
(D.5) Office of Early Childhood - Medicaid Funding					
Division of Community and Family Support, Early Intervention Services	4,582,485	4,994,334	4,994,334	*	
General Fund	2,291,243	2,459,335	2,459,335		
Federal Funds	2,291,242	2,534,999	2,534,999		
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	4,582,485	4,994,334	4,994,334		
FTE	0.0	0.0	0.0		
General Fund	2,291,243	2,459,335	2,459,335		
Federal Funds	2,291,242	2,534,999	2,534,999		
(E) Office of Self Sufficiency - Medicaid Funding					
Systematic Alien Verification for Eligibility	33,211	25,550	33,951	33,951	33,951
General Fund	27	(394)	0	0	0
Federal Funds	33,184	25,944	33,951	33,951	33,951
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	33,211	25,550	33,951	33,951	33,951
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	27	(394)	0	0	0
Federal Funds	33,184	25,944	33,951	33,951	33,951
(F) Behavioral Health Services - Medicaid Funding					
Administration	287,245	293,274	388,784	404,350	404,350
General Fund	143,623	146,637	194,392	202,175	202,175
Federal Funds	143,622	146,637	194,392	202,175	202,175

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
Residential Treatment for Youth (H.B. 99-1116)	201,542	44,226	118,593	120,372	120,372 *
General Fund	100,771	22,113	59,297	59,275	59,275
Federal Funds	100,771	22,113	59,296	61,097	61,097
Mental Health Institutes	4,755,640	5,217,448	4,997,745	4,997,745	5,219,739 *
General Fund	2,377,820	2,606,566	2,498,873	2,461,014	2,572,011
Federal Funds	2,377,820	2,610,882	2,498,872	2,536,731	2,647,728
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	1,126,310	1,052,270	1,429,133	1,450,570	1,450,570 *
General Fund	563,155	526,135	714,567	714,297	714,297
Federal Funds	563,155	526,135	714,566	736,273	736,273
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	6,370,737	6,607,218	6,934,255	6,973,037	7,195,031
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	3,185,369	3,301,451	3,467,129	3,436,761	3,547,758
Federal Funds	3,185,368	3,305,767	3,467,126	3,536,276	3,647,273
(G) Services for People with Disabilities - Medicaid Funding					
Community Services for People with Developmental Disabilities, Administration	2,705,995	2,356,594	2,897,037	0	0
General Fund	1,352,998	1,178,297	1,448,519	0	0
Federal Funds	1,352,997	1,178,297	1,448,518	0	0

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
Community Services for People with Developmental Disabilities, Program Costs	329,836,283	327,987,037	374,575,651	0	0	
General Fund	164,927,548	163,993,519	187,287,826	0	0	
Cash Funds	1	0	1	0	0	
Federal Funds	164,908,734	163,993,518	187,287,824	0	0	
Community Services for People with Developmental Disabilities, Early Intervention Services	0	0	0	0	0	
General Fund	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Regional Centers	43,301,047	54,035,040	47,499,561	49,010,457	49,010,457	*
General Fund	22,340,689	23,231,667	21,883,639	22,231,796	22,231,796	
Cash Funds	0	3,785,853	1,866,142	1,866,142	1,866,142	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	20,960,358	27,017,520	23,749,780	24,912,519	24,912,519	
Regional Center Depreciation and Annual Adjustments	1,187,825	1,187,826	1,187,825	1,187,825	0	*
General Fund	593,913	593,913	593,913	584,915	0	
Federal Funds	593,912	593,913	593,912	602,910	0	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	377,031,150	385,566,497	426,160,074	50,198,282	49,010,457	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	189,215,148	188,997,396	211,213,897	22,816,711	22,231,796	
Cash Funds	1	3,785,853	1,866,143	1,866,142	1,866,142	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	187,816,001	192,783,248	213,080,034	25,515,429	24,912,519	
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding						
Community Services for the Elderly	1,800	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	900	
Federal Funds	900	900	900	900	900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	1,800	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	900	900	900	900	900	
Federal Funds	900	900	900	900	900	
(I) Division of Youth Corrections - Medicaid Funding						
Division of Youth Corrections - Medicaid Funding	1,501,271	1,503,985	1,630,924	1,389,674	1,655,209	*
General Fund	750,636	751,992	815,463	684,605	817,373	
Federal Funds	750,635	751,993	815,461	705,069	837,836	

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,501,271	1,503,985	1,630,924	1,389,674	1,655,209
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	750,636	751,992	815,463	684,605	817,373
Federal Funds	750,635	751,993	815,461	705,069	837,836
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	500,000	500,000	500,000	500,000	
Federal Funds	500,000	500,000	500,000	500,000	
SUBTOTAL - (J) Other	500,000	500,000	500,000	500,000	
FTE	0.0	0.0	0.0	0.0	
Federal Funds	500,000	500,000	500,000	500,000	
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	423,061,696	421,060,409	499,988,656	138,270,010	138,366,111
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	211,088,880	205,975,079	243,067,214	59,585,907	59,632,770
Cash Funds	849,714	3,793,970	2,241,567	3,471,694	3,478,824
Reappropriated Funds	25,674	37,989	18,928	18,928	18,928
Federal Funds	211,097,428	211,253,371	254,660,947	75,193,481	75,235,589

	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2014-15 Request	FY 2014-15 Recommendation
TOTAL - Department of Health Care Policy and Financing	5,139,112,040	5,492,776,820	6,670,900,600	7,659,253,224	7,866,086,995
FTE	293.4	315.9	358.1	395.1	395.1
General Fund	1,318,429,933	1,323,274,792	1,604,015,384	1,747,224,184	1,785,220,766
General Fund Exempt	373,954,851	507,677,557	470,280,384	470,277,084	470,262,384
Cash Funds	875,991,975	917,366,916	981,915,538	953,672,550	962,805,844
Reappropriated Funds	7,557,386	5,216,474	10,483,522	9,656,254	7,788,086
Federal Funds	2,563,177,895	2,739,241,081	3,604,205,772	4,478,423,152	4,640,009,915

Department of Health Care Policy and Financing Targeted Rate Increase Recommendations			
Row	**Item**	**Amounts (TF)**	**Notes**
A	Increase Reimbursement Rate for Pediatric Hospice Services	$246,878	20% rate increase to increase provider participation for critical pediatric hospice services
B	Increase Reimbursement Rate for Extended Hours/After Hours Care	$641, 597	Increase evaluation and management codes associated with after-hours care by 10%
C	Fund the Transitional Living Program for Brain Injury Clients	$876,000	191% rate increase; currently zero provider participation at current rate, will facilitate transitioning clients back into their home and community
D	Increase Reimbursement for Pediatric/Developmental Assessment	$64,000	50% rate increase to increase provider participation for critical pediatric developmental assessments
E	Increase Funding for Single Entry Point Case Management	$1,229,790	Increase funding by 10% to deal with significant increases in case management services for long term care clients
F	Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers	$500,000	Increase Ambulatory Surgery Centers utilization by incentivizing surgeons to perform surgeries in lower cost setting
G	Increase Reimbursement Rates for High-Value Specialist Services to 80% of Medicare	$11,312,435	Increase specific high-value specialist rates to 80% of Medicare to increase specialty care access for clients and result in better health outcomes
H	Increase Mammography Reimbursement Rate to 80% of Medicare	$94,841	Increase specific mammography rates to 80% of Medicare to increase access for clients and increase provider participation
I	Increase Assistive Technology Reimbursement Rate to 80% of Medicare	$22,037	Increase specific assistive technology rates to 80% of Medicare to increase access for clients and increase provider participation
	Total Department of Health Care Policy and Financing Targeted Rate Increase Recommendations	**$14,987,578**	

1. Increase Reimbursement for Pediatric Hospice Services

Rationale: The Children with Life Limiting Illness (CLLI) program provides services to critically ill children in the home, allowing clients to receive care in a more comfortable, less expensive setting. Increasingly providers are either capping the amount of CLLI services they provide or are unable to provide the services altogether due to low reimbursement rates. This option would increase provider reimbursement for CCLI services to ensure these children can continue to receive medical care in their home. The option also reduces costs by providing care in less expensive settings.

Projected Total Cost per Year: $246,878 TF; a 20% increase in the reimbursement rate.

Federal Authority: The Department will need to amend the current federally approved waiver.

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Stakeholder Feedback: Support from The Butterfly Program, Children's Hospital Colorado, Colorado Centers for Hospice and Palliative Care, Colorado Community Health Alliance, Community Connections and Denver Health

2. Increase Reimbursement Rates for Extended Hours/After Hours Care

Rationale: Often times Medicaid clients seek care after physician offices are closed for the day or on the weekends. Although the client may only require basic primary care, they must go to the emergency room (ER) to receive that care. This option provides a financial incentive for physicians to keep their offices open later and on the weekend by increasing reimbursement for care that is provide after normal business hours and on weekends. Clients will be able to receive the care they need in a less expensive setting, saving money for the state and improving health care outcomes for clients. The Department estimates there will be savings associated with this increased reimbursement based on a reduction in ER visits.

Projected Total Cost per Year: Evaluation and management codes associated with after-hours care are increased by 10% at a cost of $641,597 TF. The Department anticipates savings may be achieved with this investment by avoiding ER visit costs because those services would be delivered in a physician's office. The Department would account for any savings achieved through the regular budget process.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder Feedback: Support from Children's Hospital Colorado, Colorado Academy of Family Physicians, Colorado Community Health Alliance, Colorado Community Health Network, Colorado Medical Society, Community Connections, Denver Health, Kaiser Permanente Colorado**,** Planned

Parenthood of Rocky Mountains, Primary Care Partners, Regional Care Collaborative Organizations (RCCOs), Rocky Mountain Health Care Services, University of Colorado Denver School of Medicine

3. Fund the Transitional Living Program for Brain Injury Clients

Rationale: The Transitional Living Program (TLP) assists clients with critical injuries in returning home and integrating back into their community. The program provides both rehabilitative and habilitative care. Due to rates, there are currently no providers for this integral service within the care spectrum for individuals who have suffered a brain injury. The lack of services requires these patients to remain in the hospital for longer periods of time with eventual discharge to a more costly service option. In some cases the lack of provider participation for this service is causing incarceration and homelessness. This option would fund TLP for brain injury patients. Extending TLP to brain injury clients should serve to reduce costs by shortening hospitals stays and avoiding nursing facility admissions.

Projected Total Cost per Year: $876,000 TF; 191.28% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Stakeholder Feedback: Support from Aurora Residential Alternatives, Brain Injury Alliance of Colorado, Brain Injury Program within Division of Vocational Rehab, Colorado Cross Disability Coalition, Community Connections, Craig Hospital, Denver Health, Rocky Mountain Health Care Services

4. Increase Reimbursement for Pediatric Developmental Assessments

Rationale: If a physician determines that a child may have a developmental delay, that child must undergo a comprehensive developmental assessment prior to receiving additional health care interventions. Currently only three entities are providing these assessments to Medicaid clients. Each of these entities currently has a 6-9 month waitlist to provide the full developmental assessment. As a result, many children are not receiving the services they need in a timely fashion, resulting in missed windows of opportunity for development. This option increases the reimbursement rate for providing developmental assessments to children which will maximize the success of the interventions by increasing capacity.

Projected Total Cost per Year: $64,000 TF; a 50% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Children's Hospital Colorado, Colorado Community Health Network, Community Connections, Denver Health, Guardian Angels Health Center, Primary Care Partners

5. Increase Funding for Single Entry Point Case Management

Rationale: Single Entry Point (SEP) providers administer case management services for long term care clients throughout the state. SEP caseloads have grown significantly, reducing the ability of case managers to provide comprehensive and effective case management services for all clients. This option increases funding for SEPs to hire additional qualified case management staff. As the number of these staff increase, caseloads will fall enabling case managers to provide more person-centered service including: better assessment of need; better alignment of services; and better and more thoughtful care coordination. These service enhancements will improve the client experience, increase their quality of life, and reduce Medicaid costs.

Projected Total Cost per Year: $1,229,790 TF; a 10% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No.

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Colorado Cross Disability Coalition Community Connections, Conejos County Nursing Service, Guardian Angels Health center, Rocky Mountain Health Care Services

6. Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers

Rationale: Ambulatory Surgery Centers (ASC) can provide certain services at a lower cost and similar quality to hospitals. In an attempt to shift some volume from hospitals to ASCs, the Department previously conducted a pilot program with ASCs. The pilot increased the ASC payment rate, but the pilot did not result in a significant shift in care to ASCs. Rather than increasing payments to the ASC, this option instead creates a financial incentive to surgeons—who decide the setting of surgery—to provide the same level of care but in an ASC rather than a hospital. The Department would establish target ratios of ASC vs. outpatient hospital utilization for services that can be provided at a lower cost without compromising quality, and surgeons would be eligible to receive an incentive payment for reaching ASC targets.

Projected Total Cost per Year: $500,000 TF

Federal Authority: (SPA or Waiver required?) No.

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Colorado Medical Society, Community Connections, Primary Care Partners

7. Increase Reimbursement Rates for High-Value Specialist Services

Rationale: Department analysis reveals that reimbursement rates for some specialty care are significantly lower than Medicare reimbursement rates. The analysis reveals Medicaid reimbursement rates for individual codes range from 3 to 99 percent of Medicare rates and 21 to 94 percent of Medicare rates for aggregated codes by specialties. Targeted increases for certain, high-value specialty care may

serve to increase specialty care access for clients and result in better health outcomes. The Department recommends the following list of codes—which were chosen from specialties who had aggregate reimbursement of 50% of Medicare rates or below—be increased to 80% of Medicare rates.

Projected Total Cost per Year: $11,312,435 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from over 95 Optometry and Ophthalmology practices across the state, Assistive Technology Partners, Children's Hospital Colorado, Colorado Community Health Network, Colorado Medical Society, Colorado Society of Eye Physicians and Surgeons, Community Connections, Denver Health, Denver Nephrology, Kaiser Permanente Colorado, Rocky Mountain Health Care Services, University of Colorado Denver School of Medicine

List of Potential Codes to Increase

Code	Description	CO Medicaid Fee as % of Medicare Fee
92002	EYE EXAM, NEW PATIENT	23%
92004	EYE EXAM, NEW PATIENT	18%
92012	EYE EXAM ESTABLISHED PAT	21%
92014	EYE EXAM & TREATMENT	21%
92018	NEW EYE EXAM & TREATMENT	18%
92019	EYE EXAM & TREATMENT	32%
92020	SPECIAL EYE EVALUATION	52%
92060	SPECIAL EYE EVALUATION	39%
92502	EAR AND THROAT EXAMINATION	22%
92506	SPEECH/HEARING EVALUATION	14%
92511	NASOPHARYNGOSCOPY	28%
92520	Laryngeal function studies	77%
92545	OSCILLATING TRACKING TEST	17%
92553	AUDIOMETRY, AIR & BONE	33%
92555	SPEECH THRESHOLD AUDIOMETRY	27%
92556	SPEECH AUDIOMETRY, COMPLETE	34%
92563	TONE DECAY HEARING TEST	16%
92565	Stenger test, pure tone	30%
92567	TYMPANOMETRY	57%
92579	VISUAL AUDIOMETRY (VRA)	42%
92585	AUDITOR EVOKE POTENT, COMPRE	65%
92601	COCHLEAR IMPLT F/UP EXAM < 7	65%
92607	EX FOR SPEECH DEVICE RX, 1HR	60%

92609	USE OF SPEECH DEVICE SERVICE	39%
92625	Tinnitus assessment	43%
93922	EXTREMITY STUDY	43%
93923	EXTREMITY STUDY	53%
93924	EXTREMITY STUDY	46%
93925	LOWER EXTREMITY STUDY	41%
93926	LOWER EXTREMITY STUDY	63%
93930	Upper extremity study	42%
93931	UPPER EXTREMITY STUDY	48%
93965	Extremity study	37%
93970	EXTREMITY STUDY	31%
93975	VASCULAR STUDY	38%
93976	VASCULAR STUDY	51%
93978	VASCULAR STUDY	46%
93979	VASCULAR STUDY	47%
93990	DOPPLER FLOW TESTING	33%
95812	EEG, 41-60 MINUTES	16%
95813	EEG, OVER 1 HOUR	17%
95873	GUIDE NERV DESTR, ELEC STIM	24%
95874	GUIDE NERV DESTR, NEEDLE EMG	25%
95928	C MOTOR EVOKED, UPPR LIMBS	39%
95929	C MOTOR EVOKED, LWR LIMBS	41%
95953	EEG MONITORING/COMPUTER	57%
95954	EEG monitoring/giving drugs	24%
95956	Eeg monitoring, cable/radio	16%
95958	EEG monitoring/function test	25%
96111	DEVELOPMENTAL TEST, EXTEND	76%
96440	CHEMOTHERAPY, INTRACAVITARY	3%
96450	CHEMOTHERAPY, INTO CNS	16%
97001	PT EVALUATION	46%
97002	PT RE-EVALUATION	55%
97003	OT EVALUATION	41%
97004	OT RE-EVALUATION	43%
97597	ACTIVE WOUND CARE/20 CM OR <	41%
G0365	VESSEL MAPPING HEMODIALYSIS ACSS	60%
G0389	Ultrasound exam AAA screen	65%

8. Increase Reimbursement for Digital Breast Cancer Screening Exams

Rationale: The American Cancer Society has identified breast cancer as the most prevalent cancer in Colorado. Advanced digital mammography offers the opportunity to identify and diagnose breast

cancers at the earliest stages before they spread into the surrounding tissue. Early stage cancers are often highly treatable, improving the chances for a cure. Raising the rates for digital mammography will likely increase the number of providers in the state who offer these services, increase Medicaid client access to these services, and ultimately improve health outcomes. We recommend three mammography codes be increase to 80% of Medicare rates.

Projected Total Cost per Year: $94,841 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Code	Description	CO Medicaid Fee as % of Medicare Fee
G0202	Screening mammography, producing direct digital image, bilateral, all views	74%
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views	64%
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views	65%

9. Increase Reimbursement Rates for Assistive Technology

Rationale: Clients with complex, chronic disabilities sometimes require assistive technology devices, such as speech generating devices, custom configured power wheelchairs, and complex positioning systems, to improve health and functional outcomes. Specialized technology assessments and trainings are needed to ensure that clients receive the most appropriate devices and learn how to use them. Medicaid clients currently have limited access to these services as very few therapists offer them; and those providers that do offer these services have restricted Medicaid appointments with long wait lists. Increasing reimbursement will remove a number of the barriers for providers and improve client access by reducing the wait time. We recommend increasing these codes to 80% of Medicare rates.

Projected Total Cost per Year: $22,037 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Code	Description	CO Medicaid Fee as % of Medicare Fee
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient	26%
97542	Wheelchair management (eg, assessment, fitting, training)	53%
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report	52%

Notice: The Colorado Department for Health Care Policy and Financing (Department) is seeking stakeholder input regarding potential targeted rate increases using funds that may be appropriated. Approximately $19 million may be available for targeted rate increases in FY 2014-2015.

The ultimate decision on moving forward with a 0.5% increase is dependent upon Joint Budget Committee (JBC) approval. Even if we do not receive JBC approval to move forward with this request, we do plan to use the information you submit to us to help inform future budget and policy requests.

It is our intention for this to reach all interested stakeholders. Please distribute this to anyone who may be interested in submitting a proposal to the Department or interested in participating in this process.

Any rate increase(s) MUST be implemented no later than July 1, 2014**. Stakeholders are asked to submit their input on or before 5pm, Friday, January 31, 2014 to allow the Department sufficient time to review their input.**

Below please find the intended purpose of the rate increase and guidelines for submitting input.

Purpose: Targeted rate increases should:

- promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or
- address inappropriate provider reimbursement rates to improve client access to cost-effective care.

The Department has identified an initial list of rate increase options intended to promote high-value, cost effective care and/or serve to alleviate some access to care issues related to inappropriate reimbursement rates. This initial list is based on client and provider feedback as well as Department analysis.

The Department requests your input on the list of options attached to this notice. Additionally, the Department welcomes your suggestions for rate increases that will result in high-value, cost effective care and/or will address access to care issues that stem from low reimbursement rates.

Guidelines for Submitting Input:

The attached list of rate increase options contains information regarding the rationale, cost, projected timeline for implementation, and related information.

A. Please consider each option on the list and respond to the following questions <u>for each option</u>:

    1. Do you support or oppose the option?

a. If you support the option, please explain how the proposed increase will accomplish the following goals:
    i. Ensure or improve client access to care
    ii. Incentivize more providers to deliver the service(s)
    iii. Improve quality health outcomes for Medicaid clients
    iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

2. If you do not support the option, please explain why.

B. Please provide your recommendations for a rate increase(s) that:

a. promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or

b. address inappropriate provider reimbursement rates to improve client access to cost-effective quality care.

Each rate increase recommendation should be limited to 2 pages and should include the following information.

a. Specific service or units of service recommended for an increase

b. Percentage and dollar amount of the recommended rate increase

c. Known challenges and barriers to implementation, including the need for state legislative or regulatory changes and/or federal approval.

d. Explain how the proposed increase will likely:
    i. Ensure or improve client access to care
    ii. Incentivize more providers to deliver the service(s)
    iii. Improve quality health outcomes for Medicaid clients
    iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

e. Would the Department be able to implement the increase by July 1, 2014?

f. Is the proposed increase operationally and programmatically feasible and sustainable?

Please note the Department must select rate increase option(s) that comply with legal requirements and are operationally feasible. When selecting options, the Department must consider whether major system changes would be required and the associated cost and timeline for those changes. Only rate increases that are able to be implemented on or before July 1, 2014 can be selected.

The 0.5% increase is dependent upon Joint Budget Committee (JBC) approval. Even if we do not receive JBC approval to move forward with this request, we do plan to use the information submitted to help inform future budget and policy requests.

Please submit feedback to: Medicaid2015@state.co.us

Input must be received by the Department by 5pm, Friday, January 31st.