COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

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

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

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

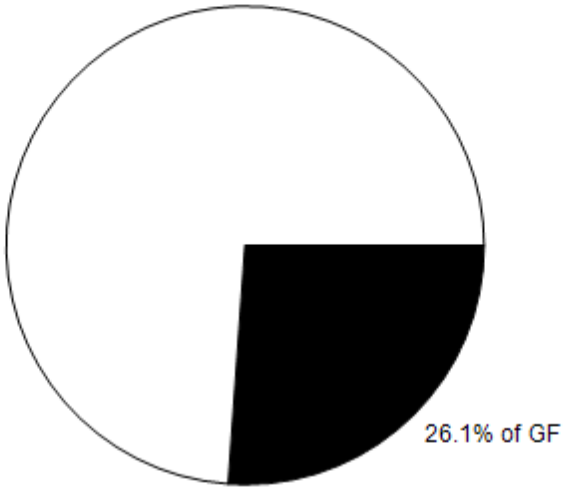
Department Budget: Recent Appropriations

Funding Source	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 *
General Fund	$2,067,258,413	$2,352,444,300	$2,507,080,610	$2,642,647,613
Cash Funds	986,463,698	899,805,052	1,031,847,224	991,324,107
Reappropriated Funds	10,483,522	6,104,791	7,805,549	7,059,407
Federal Funds	3,592,923,500	4,673,350,937	5,343,721,014	5,252,128,000
Total Funds	**$6,657,129,133**	**$7,931,705,080**	**$8,890,454,397**	**$8,893,159,127**
Full Time Equiv. Staff	358.3	390.9	421.2	424.5

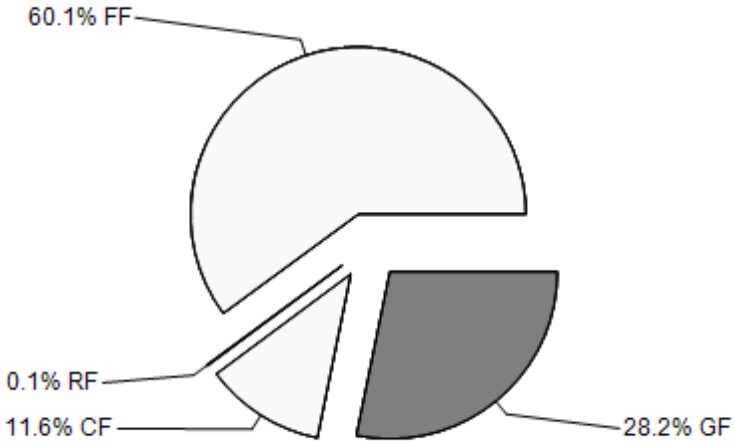
*Requested appropriation.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

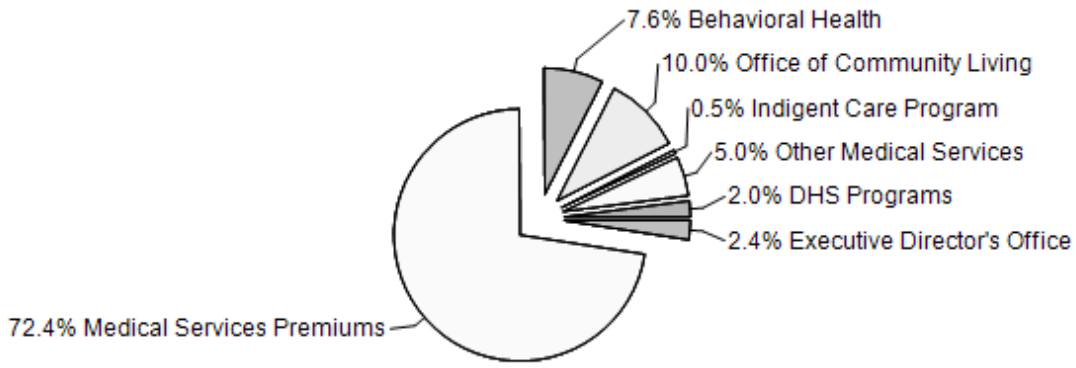


Department Funding Sources

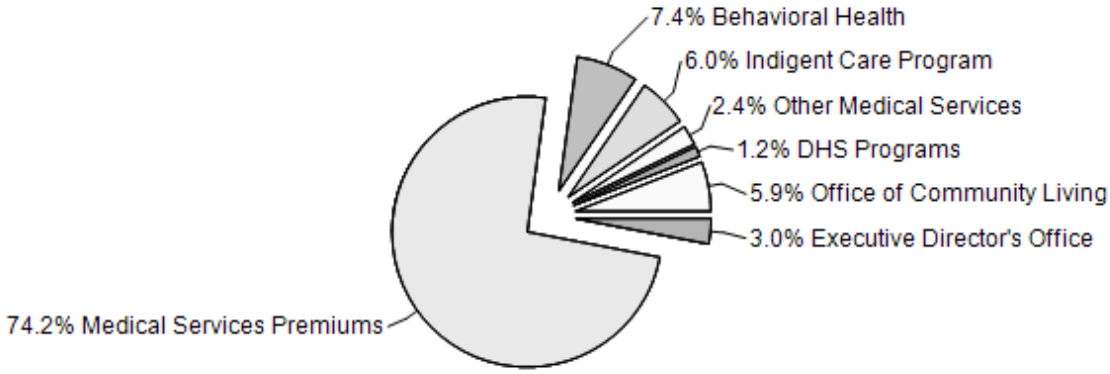


All charts are based on the FY 2015-16 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2015-16 appropriation.

General Factors Driving the Budget

Funding for this department consists of 28.2 percent General Fund, 11.6 percent cash funds, 0.1 percent reappropriated funds, and 60.1 percent federal funds. Some of the major factors driving the Department's budget are discussed below. The major sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; and (5) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

MEDICAID

Medicaid provides health insurance to people with low income and to people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. Administration and policy making responsibilities for the program are shared between the federal and state governments. The federal government matches state expenditures for the program. The federal match rate, called the Federal Medical Assistance Percentage (FMAP), can vary based on economic conditions in the state, the type of service being provided, and the population receiving services. For federal fiscal year 2014-15 the FMAP for the majority of Colorado Medicaid expenditures is 51.01 percent and the Department projects it will be 50.72 for federal fiscal year 2015-16.

Medi**caid** should not be confused with the similarly named Medi**care** that provides insurance for people who are elderly or have a specific eligible diagnosis regardless of income. Medicare is federally administered and financed with a combination of federal funds and annual premiums charged to participants. While the two programs are distinct, they do interact with each other as some people are eligible for both Medicaid, due to their income, and Medicare, due to their age. For these people (called "dual eligible"), Medicaid pays the Medicare premiums and may assist with copayments, depending on the person's income. Also, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term services and supports (LTSS) while Medicare coverage for LTSS is limited to post-acute care.

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

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

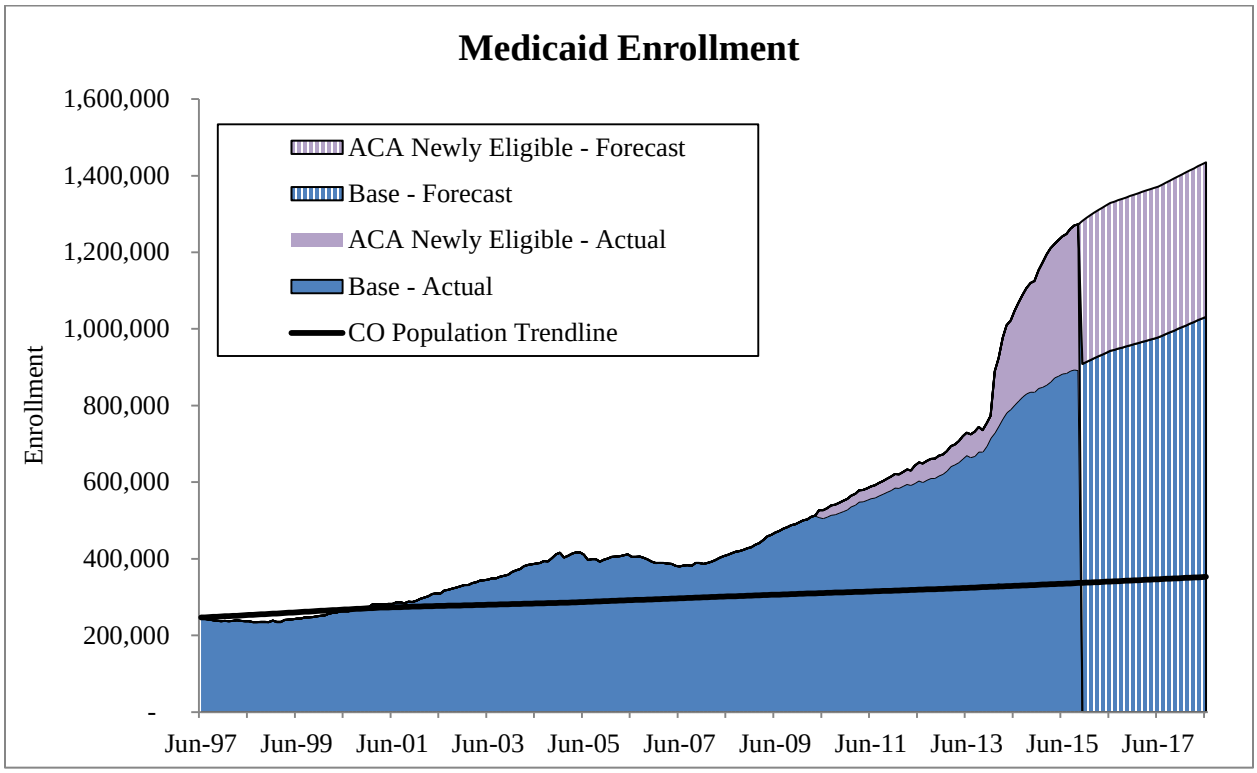
event that the State's Medicaid obligation is greater than anticipated, the Department has statutory authority[2] to overexpend the Medicaid appropriation.

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

(1) Medical Service Premiums

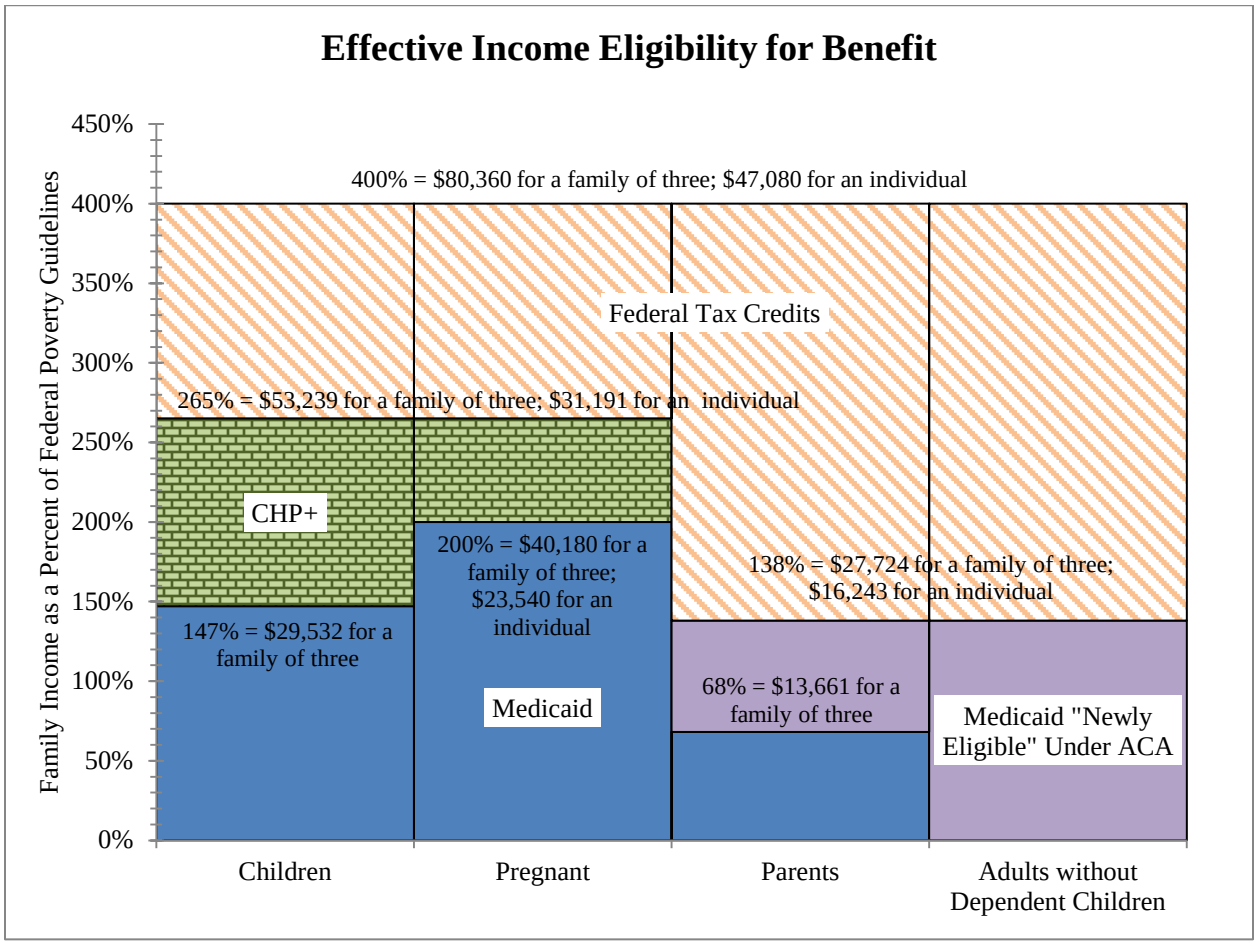
Medical Service Premiums pay for physical health care and long-term services and supports. Expenditures for Medical Service Premiums are driven by the number of clients, the amount of services each client uses, and the cost per unit of service.

Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. The federal Affordable Care Act provides an enhanced match for newly eligible adults. In calendar year 2016 the federal match is 100 percent, but beginning in calendar year 2017 it decreases to 95 percent and it continues to decrease annually in increments until it reaches 90 percent in 2020. The following chart shows the actual and forecasted Colorado Medicaid population with the newly eligible adults highlighted in purple. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 1997.



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

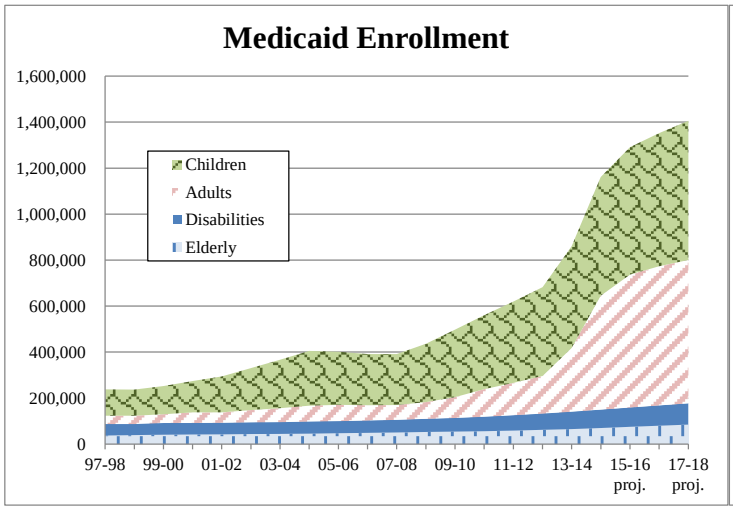
The next table summarizes the effective income eligibility criteria for Medicaid and other publicly-financed health care programs for people with low income. The eligibility for these programs is usually expressed as a percentage of the federal poverty level (FPL) guidelines, but some populations qualify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

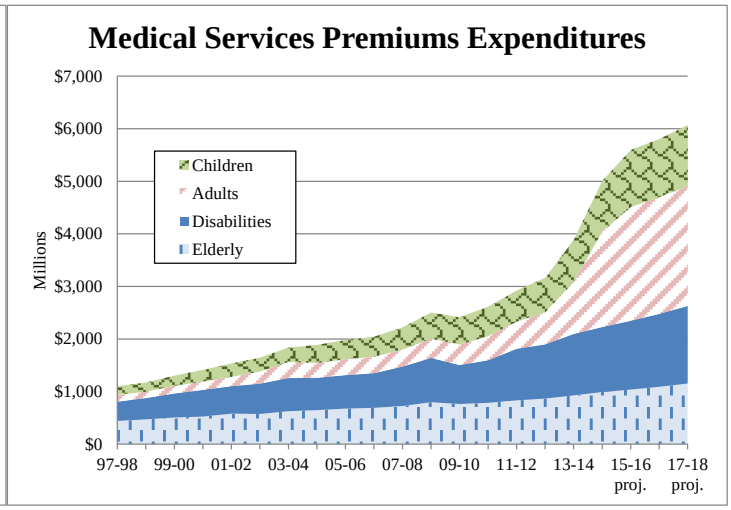


Special Medicaid Eligibility Categories	
Category	**Eligibility Standard**
Elderly 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities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

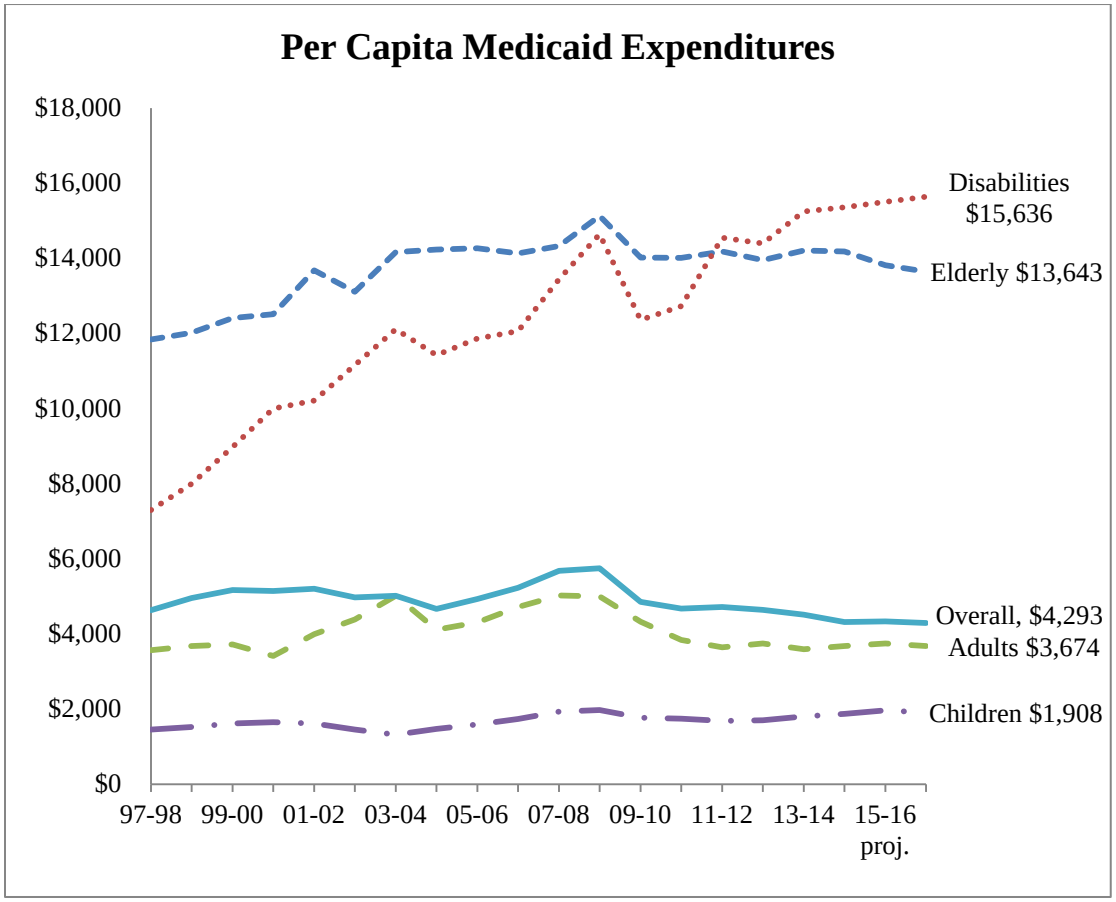
Family Size	Federal Poverty Guideline - 2015	SSI Annual Income Limit
1	$11,770	$8,796
2	$15,930	$13,200
3	$20,090	
4	$24,250	
5	$28,410	
6	$32,570	
7	$36,730	
8	$40,890	

In addition to costs due to Medicaid enrollment growth, the Medicaid budget also fluctuates as a result of changes in medical costs and utilization of medical services. The two charts below illustrate recent changes in Medicaid enrollment and expenditures by eligibility category. The enrollment includes clients eligible for behavioral health services and services for people with intellectual disabilities, but the expenditures are for Medical Services Premiums only. Also, the expenditures don't include special financing for hospital reimbursements and nursing reimbursements. In FY 2015-16, the elderly and people with disabilities are projected to account for approximately 12.5 percent of enrollment, but 42.7 percent of Medical Services Premiums medical expenditures.





As illustrated in the following chart, per capita costs for the elderly and people with disabilities are much higher than for children and adults. Changes in per capita costs for the elderly are dampened by Medicare absorbing a portion of the costs for the subset of the population that is dually eligible for both Medicare and Medicaid.



(2) Behavioral Health Community Programs

Behavioral health services will be covered in more detail during the December 9 briefing.

Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with regional entities, known as behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are eligible for and enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary.

The enrollment changes that are described in detail above for the Medical Services Premiums section also apply to services that are funded in this section, with two exceptions. Two Medicaid populations that are eligible for certain medical benefits are not eligible for behavioral health services: (1) non-citizens; and (2) adults who are eligible for both Medicaid and Medicare but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments.

Each BHO receives a pre-determined monthly amount for each Medicaid client who is *eligible* for behavioral health services within its geographic area. The "per-member-per-month" rates

paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on client utilization and BHO expenditures.

Capitated behavioral health program expenditures are thus affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories. The following table details recent expenditure and caseload trends for Medicaid Behavioral Health Capitation Payments.

Medicaid Behavioral Health Capitation Payments						
	FY 2010-11	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15 [/1]**	**FY 2015-16 [/2]**
	Actual	**Actual**	**Actual**	**Actual**	**Adjusted Appropriation**	**Appropriation**
Capitation Payments	**$249,352,665**	**$273,376,614**	**$301,303,046**	**$415,933,333**	**$553,659,183**	**$646,025,263**
Annual Dollar Change	$22,731,847	$24,023,949	$27,926,432	$114,630,287	$137,725,850	$92,366,080
Annual Dollar % Change	*10.0%*	*9.6%*	*10.2%*	*38.0%*	*33.1%*	*16.7%*
Caseload (eligible clients)	**540,456**	**598,322**	**659,104**	**835,098**	**1,130,436**	**1,255,060**
Annual Caseload Change	61,271	57,866	60,782	175,994	295,338	124,624
Annual Caseload % Change	*12.8%*	*10.7%*	*10.2%*	*26.7%*	*35.4%*	*11.0%*
Expenditures per capita	**$461**	**$457**	**$457**	**$498**	**$490**	**$515**

[/1] The "Capitation Payments" figures for FY 2014-15 exclude amounts appropriated for BHOs' school-based substance abuse prevention and intervention programs (S.B. 14-215).

[/2] The "Capitation Payments" figures for FY 2015-16 include $295,672 and an additional 151 Medicaid-eligible children for the projected impact of the Department's request (R8) to expand services for children with autism. This request was approved and enacted through H.B. 15-1186.

Please note that in addition to capitation payments to BHOs, the Department makes fee-for-service payments for behavioral health services provided to Medicaid clients who are not enrolled in a BHO and for the provision of behavioral health services that are not covered by the BHO contract. In FY 2013-14, the Department made fee-for-service payments totaling $5.3 million; $8.4 million is appropriated for this purpose for FY 2015-16.

(3) Office of Community Living

The Office of Community Living will be covered in more detail during the December 14 briefing.

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. As part of the waiver, Colorado is allowed to limit the number of waiver program participants which has resulted in a large number of individuals being unable to immediately access the services they need. The General Assembly is not required to appropriate funds for services for individuals waiting for services, but has made the policy decision to provide additional funds for waiver services in past years. Those decisions include:

- Funding for youth transition to adult services;
- Funding for individuals requiring services resulting from emergency situations and funding to eliminate the Supported Living Services(SLS) and Children's Extensive Services (CES) waiting lists; and
- Provider rate increases.

Youth with intellectual and developmental disabilities (IDD) receive services through the Children's Extensive Support waiver (CES), or the child welfare system. Funding for adult services for these youth when they age out of children's services is not required, but the General Assembly has regularly made the decision that once an individual receives services, they should continue to receive those services regardless of age. The following table summarizes the number of new enrollments funded each year for youth transitioning to adult services.

Funding for Youth Transitions				
	CES Transitions to Adult Services		Youth Aging out of Foster Care Transitions to the CES Waiver	
	New Enrollments	Full Year Cost	New Enrollments	Full Year Cost
FY 2008-09	28	584,752	45	$4,211,460
FY 2009-10	29	578,318	37	3,425,127
FY 2010-11	0	0	0	0
FY 2011-12	35	433,615	66	4,167,900
FY 2012-13	50	868,950	46	3,734,004
FY 2013-14	38	619,134	50	3,635,500
FY 2014-15 Long Bill	61	907,131	55	3,744,895
FY 2014-15 H.B. 14-1368	n/a	n/a	186	5,746,227
FY 2015-16	61	1,310,472	55	3,682,108

In FY 2013-14 the General Assembly approved funding to enable all children who qualify for services through the children's extensive support waiver to receive services. For FY 2014-15 the General Assembly appropriated funding sufficient to provide services to all adults seeking support living services (i.e. non-residential community-based services for adults). The table on the following page shows how many enrollments, since FY 2008-09, have been funded for individuals who are either waiting for services or required services due to an emergency situation.

Number of New Emergency and Waiting List Enrollments			
Fiscal Year	Adult Comprehensive	Supported Living Services	Children's Extensive Support
FY 2008-09	260	200	0
FY 2009-10	0	0	0
FY 2010-11	0	0	0
FY 2011-12	30	0	0
FY 2012-13	47	30	0

Number of New Emergency and Waiting List Enrollments			
Fiscal Year	**Adult Comprehensive**	**Supported Living Services**	**Children's Extensive Support**
FY 2013-14	267	7	811
FY 2014-15	40	2,040	0
FY 2015-16	40	92	49

Two primary factors driving the Division's budget are the amount of services consumed and the cost of those services. As more individuals are served the total cost of services will increase. This increase is compounded either positively or negatively by adjustments made to provider rates through both the annual budget process and as a budgeting mechanism by the Department. The following table summarizes the percent changes to the provider service reimbursement rates since FY 2008-09.

Community Provider Rate Changes							
FY 06-07	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 13-14**	**FY 14-15**	**FY 15-16**
3.25%	1.50%	1.50%	(2.50%)	(2.00%)	4.00%	2.50%	1.70%
$4,149,332	$2,257,019	$2,594,770	($4,343,556)	($4,427,894)	$7,446,715	$5,788,375	$8,461,129

There was no provider rate increase in FY 2011-12 and FY 2012-13.

The Family Support Services Program (FSSP) is General Fund dollars provided directly to Community-Centered Boards for distribution to individuals and families for services and supports. Individuals and families use this funding to purchase assistive technology, make home and vehicle modifications, pay for medical and dental expenses, respite care, and transportation. Community-Centered Boards manage the eligibility determinations for FSSP and ensure that services and supports are targeted towards families that are most in need. Funding for FSSP has fluctuated over the years as cuts were made due to the economic downturn. The following table summarizes the funding for FSSP over the past four years.

Family Support Services Program				
	FY 2012-13 Actual	**FY 2013-14 Actual**	**FY 2014-15 Appropriation**	**FY 2015-16 Appropriation**
General Fund Appropriation	$2,173,467	$3,065,802	$6,828,718	$6,960,204
Change from Prior Year	n/a	892,335	3,762,916	131,486

(4) Indigent Care Program

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from the Hospital Provider Fee, certifying

public expenditures at hospitals, and the General Fund. Providers that participate agree to accept reduced payments for medical services on a sliding scale based on income up to 250 percent of the federal poverty guidelines. The following table summarizes recent expenditures for this program.

Colorado Indigent Care Program					
	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request
Safety Net Provider Payments	$299,175,424	$309,976,756	$309,470,584	$311,296,186	311,296,186
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Pediatric Specialty Hospital	11,799,938	11,799,938	13,455,012	13,455,012	13,455,012
TOTAL	$317,095,122	$327,896,454	$329,045,356	$330,870,958	$330,870,958
General Fund	8,959,849	8,959,849	9,639,107	9,639,107	9,705,172
Cash Funds	149,587,712	154,988,378	152,391,319	153,307,474	153,236,591
Federal Funds	158,547,561	163,948,227	167,014,930	167,924,377	167,929,195
Total Funds Change		$10,801,332	$1,148,902	$1,825,602	$0
Percent Change		3.41%	0.35%	0.55%	0.00%

(5) Programs Administered by Other Departments

The Department of Health Care Policy and Financing (HCPF) transfers Medicaid money to several other departments. The Medicaid funds are first appropriated to HCPF and then transferred to the administering departments to comply with federal regulations that one state agency receives all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments, but the table below summarizes some of the larger transfers. In FY 2014-15 the administration of community-based services for people with IDD was transferred from the Department of Human Services to the HCPF, and so the transfer of Medicaid funds to the Department of Human Services is now limited to the amount necessary for the state-operated Regional Centers for people with IDD.

Major Medicaid-funded Programs Administered by Other Departments					
Program	Department	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Approp.	FY 2016-17 Request
Information Technology, Maintenance, and Administration	Human Services	$50,635,936	$42,785,233	$23,512,571	$21,982,134
Child Welfare	Human Services	8,069,034	6,943,426	15,363,412	15,188,116
Office of Early Childhood	Human Services	3,407,528	4,002,321	5,928,683	6,500,962
Behavioral Health Services	Human Services	2,527,843	7,379,092	8,139,680	8,127,750
People with Disabilities	Human Services	402,400,310	40,468,778	53,818,572	54,558,042
Youth Corrections	Human Services	1,682,431	1,413,139	1,670,305	1,656,659
Regulation of long-term care facilities	Public Health and Environment	4,426,141	4,776,959	6,130,010	6,130,010
	TOTAL	**$473,149,223**	**$107,768,948**	**$114,563,233**	**$114,143,673**

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than the Medicaid eligibility criteria allows. Annual membership premiums are variable based on income, with an example being $75 to enroll one child in a family earning 206 percent of the federal poverty level (FPL) guidelines. Coinsurance costs are nominal. In federal fiscal year 2015-16, federal funds pay 88.50 percent of the program costs not covered by member contributions and state funds pay the remaining 11.5 percent. For federal fiscal year 2016-17 the Department projects a federal match rate of 88.22 percent. CHP+ typically receives approximately $28 million in revenue from the tobacco master settlement agreement and the remaining state match comes from the General Fund.

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

Children's Basic Health Plan					
	FY 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY 15-16 Proj.	FY 16-17 Proj.
Expenditures					
Children Medical	$156,801,423	$156,926,336	$114,964,361	$118,469,422	$121,233,395
Children Dental	$13,335,076	$13,817,690	$11,657,211	$13,141,616	$14,420,045
Prenatal	$21,433,958	$12,009,028	$9,580,452	$9,831,723	$10,965,454
TOTAL	$191,570,458	$182,753,054	$136,202,023	$141,442,761	$146,618,894
Enrollment					
Children	77,835	61,554	53,699	57,693	61,382
Prenatal	1,611	953	687	778	846
TOTAL	79,446	62,507	54,386	58,471	62,228
Per Capita					
Children Medical	$2,014.54	$2,549.41	$2,140.89	$2,053.45	$1,975.06
Children Dental	$171.32	$224.48	$217.08	$227.79	$234.92
Prenatal	$13,304.75	$12,601.29	$13,945.34	$12,637.18	$12,961.53

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION

The federal Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what

states would have paid for this population in Medicaid, as estimated by a federal formula. This payment is sometimes referred to as the "clawback." In recent years, in order to offset General Fund costs, Colorado has applied bonus payments received from the federal government for meeting performance goals in CHP+ toward this obligation. The table below summarizes Colorado's payments to the federal government.

	Medicare Modernization Act				
	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request
State Contribution	$101,817,855	$106,376,992	$107,776,447	$116,816,749	$133,682,247
General Fund	52,136,848	68,306,130	107,360,512	116,816,749	133,682,247
Federal Funds	49,681,007	38,070,862	415,935	0	0
State Contribution change		4,559,137	1,399,455	9,040,302	16,865,498
Percent		4.48%	1.32%	8.39%	14.44%
General Fund change		16,169,282	39,054,382	9,456,237	16,865,498
Percent		31.01%	57.18%	8.81%	14.44%

Summary: FY 2015-16 Appropriation & FY 2016-17 Request

Department of Health Care Policy and Financing

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	$8,873,331,056	$2,506,252,972	$1,024,522,841	$6,110,549	$5,336,444,694	413.7
Other legislation	17,123,341	827,638	7,324,383	1,695,000	7,276,320	7.5
TOTAL	**$8,890,454,397**	**$2,507,080,610**	**$1,031,847,224**	**$7,805,549**	**$5,343,721,014**	**421.2**
FY 2016-17 Requested Appropriation						
FY 2015-16 Appropriation	$8,890,454,397	2,507,080,610	$1,031,847,224	$7,805,549	$5,343,721,014	421.2
R1 Medical Services Premiums						
Services	207,501,363	132,879,795	32,852,420	0	41,769,148	0.0
Booster Payments/Financing	(147,220,545)	8,822,624	(63,834,743)	0	(92,208,426)	0.0
Subtotal - R1	*60,280,818*	*141,702,419*	*(30,982,323)*	*0*	*(50,439,278)*	*0.0*
R2 Behavioral Health Programs	13,430,867	(3,793,986)	7,447,782	0	9,777,071	0.0
R3 Children's Basic Health Plan	(17,605,016)	(25,277)	(11,208,331)	0	(6,371,408)	0.0
R4 Medicare Modernization Act	16,865,498	16,865,498	0	0	0	0.0
R5 Office of Community Living	11,910,323	6,969,260	0	0	4,941,063	0.0
R7 County administration funding	7,105,769	0	0	0	7,105,769	0.0
R9 Old Age Pension State Medical Program	(3,939,225)	0	(3,939,225)	0	0	0.0
R11 Federal match rate	0	103,915	0	8,930	(112,845)	0.0
R12 Provider rates	(35,753,121)	(12,886,073)	(945,958)	0	(21,921,090)	0.0
NP CO Benefits Management System	11,363,637	3,618,325	1,590,106	0	6,155,206	0.0
NP Cervical cancer eligibility	291,528	0	107,119	0	184,409	0.0
NP Administrative law judges	40,765	15,840	4,543	0	20,382	0.0
NP Secure Colorado	13,851	6,884	42	0	6,925	0.0
Annualize prior year budget decisions	16,682,905	9,534,693	1,689,762	(847,793)	6,306,243	3.3
Annualize HB 15-1186 children with autism	8,426,145	8,463,025	(4,331,637)	0	4,294,757	0.0
Annualize primary care rate bump	(85,234,565)	(34,860,937)	0	0	(50,373,628)	0.0
Indirect cost adjustment	59,489	(59,489)	46,187	60,710	12,081	0.0
Centrally appropriated line items	(815,378)	(500,483)	73,441	32,011	(420,347)	0.0
Human Services programs	(419,560)	413,389	(74,625)	0	(758,324)	0.0
TOTAL	**$8,893,159,127**	**$2,642,647,613**	**$991,324,107**	**$7,059,407**	**$5,252,128,000**	**424.5**

Legislation to restrict revenue from the Hospital Provider Fee by $100 million	0	0	0	0	0	0.0
Placeholder for potential increase in Medicare premiums paid by Medicaid	0	0	0	0	0	0.0
TOTAL	**$8,893,159,127**	**$2,642,647,613**	**$991,324,107**	**$7,059,407**	**$5,252,128,000**	**424.5**
Increase/(Decrease)	$2,704,730	$135,567,003	($40,523,117)	($746,142)	($91,593,014)	3.3
Percentage Change	0.0%	5.4%	(3.9%)	(9.6%)	(1.7%)	0.8%

DESCRIPTION OF REQUESTED CHANGES

R1 Medical Service Premiums: The Department requests a net increase of $60.3 million total funds, including $141.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the medical services, long-term services and supports, and booster payments paid from the Medical Services Premiums line item. The JBC staff subdivided the request in the table into projected changes in expenditures for services and for booster payments/financing. The booster payments/financing are composed primarily of increased reimbursements to hospitals and nursing facilities that are subsidized with provider fees and matching federal funds, but also include some miscellaneous other financing adjustments such as General Fund offsets from the Health Care Expansion Fund and from certified public expenditures by hospitals with local government funding. The component of the request for booster payments/financing assumes a decrease in hospital reimbursements associated with a proposal from the Governor to restrict revenue from the Hospital Provider Fee by $100 million.

R2 Behavioral Health Programs: The Department requests a net increase of $13.4 million total funds, including a decrease of $3.8 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services. *See the 12/9/15 briefing on Behavioral Health Community Programs for more information.*

R3 Children's Basic Health Plan: The Department requests a decrease of $17.6 million total funds, including $25,277 General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan.

R4 Medicare Modernization Act: The Department requests an increase of $16.9 million General Fund for the projected state obligation pursuant to the Medicare Modernization Act to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

R5 Office of Community Living: The Department requests an increase of $11.9 million total funds, including $7.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the 12/14/15 briefing on the Office of Community Living for more information.*

R7 County administration funding: The Department requests an increase of $7.1 million federal funds to increase reimbursements for county eligibility determination services. A higher-

than-anticipated portion of county activities are eligible for an enhanced federal match rate for populations newly eligible for Medicaid. In addition, the Department requests removing the "(M)" headnote on the line item to allow increased funding if additional federal funds are available. The Department also requests moving money between line items to reflect changes in the contract with the centralized eligibility vendor and the duties performed by this provider versus the duties performed by counties and medical assistance sites. Finally, the Department requests the federal funding to provide additional flexibility in the county incentive and grant program to allow incentives for activities other than eligibility determinations that may help improve health outcomes. Examples of the non-eligibility determination activities cited by the Department that would be encouraged through grant funding include: using shared Customer Relationship Management and Interactive Voice Response systems so counties use the same knowledge library; increasing training on programs and new policies; connecting clients with the Regional Care Collaborative Organizations and Behavioral Health Organizations; implementing the Colorado Opportunity Project; and collaborating with the No Wrong Door Long Term Support Services redesign project.

R9 Old Age Pension State Medical Program: The Department requests a $3.9 million cash funds reduction for the Old Age Pension State Medical Program to better match the projected caseload. Article XXIV, Section 7 of the Colorado Constitution sets aside $10.0 million annually from sales tax revenues to provide health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases. The Old Age Pension State Medical Program serves old age pensioners who do not qualify for Medicaid and the remainder of the $10.0 million is used in the Medical Services Premiums line item to offset General Fund costs for old age pensioners who do qualify for Medicaid. With the expansion of Medicaid eligibility, there are fewer old age pensioners who do not qualify for Medicaid.

R11 Federal match rate: The Department requests an increase in General Fund and cash funds and a corresponding decrease in federal funds based on a projected decrease in the federal match rate for Medicaid. The Department expects per capita income in Colorado will grow faster than the national average, leading to a formula decrease in the Federal Medical Assistance Percentage (FMAP) for Medicaid. This request is just for the line items where the Department did not submit a forecast adjustment. For Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, and the Office of Community Living the effect of the change in the FMAP is included in the requested forecast adjustment. The table below summarizes the historic and projected FMAP rates.

Medicaid Federal Medical Assistance Percentage (FMAP)					
State	Ave.	FMAP by Quarter (of state fiscal year)			
Fiscal Year	FMAP	Q1-July	Q2-October	Q3-January	Q4-April
FY 12-13	50.00	50.00	50.00	50.00	50.00
FY 13-14	50.00	50.00	50.00	50.00	50.00
FY 14-15	50.76	50.00	51.01	51.01	51.01
FY 15-16	50.79	51.01	50.72	50.72	50.72
FY 16-17	*50.42*	50.72	*50.32*	*50.32*	*50.32*
FY 17-18	*50.24*	*50.32*	*50.21*	*50.21*	*50.21*

Italicized figures are projections.

R12 Provider rates: The Department requests a decrease of $35.8 million total funds, including $12.9 million General Fund, for a 1.0 percent across-the-board decrease in discretionary provider rates. The Governor proposes an exception for physician services and early, periodic, screening, detection and treatment services (EPSDT), because the providers of these services will be significantly affected by the scheduled expiration of the primary care rate bump. Also, the proposed reduction does not apply to non-discretionary rates traditionally excluded from across-the-board adjustments because they are capitated rates, cost-based rates, or rates that are based on a methodology defined in statute. The traditionally excluded rates are for pharmacy reimbursements, rural health centers, federally qualified health centers, home- and community-based services for children with autism, hospice care in nursing facilities, nursing reimbursements, disease management, and administrative contracts.

NP CO Benefits Management System: The request includes an increase of $11.4 million total funds, including $3.6 million General Fund, for FY 2016-17 for the base level operation of the Colorado Benefits Management System (CBMS) and the Program Eligibility Application Kit (PEAK) and for future enhancements of the integrated systems and tools. *See the 12/11/15 briefing on the Office of Information Technology in the Department of Human Services for more information.*

NP Cervical cancer eligibility: The Department requests $291,528 additional funds, including $107,119 cash funds, for the Breast and Cervical Cancer Treatment Program in conjunction with the Department of Public Health and Environment's proposal to expand the age of women eligible for publicly-funded screening for cervical cancer from the current ages of 40 to 64 to include women ages 21 to 39. The Department of Public Health and Environment already has adequate spending authority and revenue to support the cost of the increased screenings, but increased screenings are expected to result in additional women requiring treatment through the Department of Health Care Policy and Financing's Breast and Cervical Cancer Treatment Program.

NP Administrative law judges: The request includes $40,765 total funds, including $15,840 General Fund, for the Department's share of the adjustment for the Resources for Administrative Courts request.

NP Secure Colorado: The request seeks an increase of $13,851 total funds, including $6,884 General Fund, for FY 2016-17 to cover the Department's share of the Office of Information Technology's implementation of advanced information security event analytics capabilities.

Annualize prior year budget decisions: The Department requests a net increase of $16.7 million total funds, including $9.5 million General Fund, for the annualization of the following prior year budget decisions:

Annualize Prior Year Budget Decisions	TOTAL	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 15-16 R12 Rate increases	$19,170,823	$7,013,018	$442,815	$0	$11,714,990	0.0
FY 15-16 R6 CHP+ enrollment	16,223,773	1,774,662	45,663	0	14,403,448	0.0
FY 15-16 R19 Public school funding	3,966,785	0	1,943,328	0	2,023,457	0.0
FY 15-16 R7 Participant directed services	948,585	492,557	0	0	456,028	0.1
FY 15-16 R9 Public health records	712,709	230,271	0	0	482,438	0.0
FY 07-08 S5 Revised PERM	588,501	147,125	102,988	0	338,388	0.0
HB 15-1367 Retail marijuana (Prop BB)	500,000	500,000	0	0	0	0.0
FY 15-16 S12/BA12 Leased space	300,671	121,179	29,157	0	150,335	0.0
FY 15-16 R12 Rate increases	295,247	134,246	16,695	0	144,306	0.0
FY 15-16 R15 Primary care	109,808	54,904	0	0	54,904	0.0
FY 15-16 R10 Customer services	97,610	35,277	13,529	0	48,804	4.2
SB 15-011 Spinal cord pilot	27,071	13,574	0	0	13,497	0.2
FY 15-16 BA13 Predictive analytics	11,259	1,126	0	0	10,133	0.1
FY 15-16 BA17 FMAP adjustment	0	3,642,962	966,113	2,207	(4,611,282)	0.0
FY 15-16 BA16 Public school funding	0	0	28,026	0	(28,026)	0.0
FY 15-16 R5 MMIS Reprocurement	(8,151,765)	(737,351)	(149,015)	0	(7,265,399)	0.0
FY 14-15 S7/BA7 MMIS Adjustment	(4,595,621)	(828,692)	(153,259)	0	(3,613,670)	0.0
FY 14-15 BA12 Medicare-Medicaid enrollees	(4,576,085)	(2,103,141)	0	0	(2,472,944)	0.0
FY 14-15 R5 Medicaid Health Information Exchange	(3,059,000)	(5,900)	0	0	(3,053,100)	0.0
HB 15-1318 Waiver redesign	(1,941,909)	0	(670,954)	0	(1,270,955)	0.3
HB 15-1368 IDD-BHO pilots	(1,700,000)	0	(850,000)	(850,000)	0	0.0
HB 12-1281 Medicaid payment reform	(592,703)	(245,639)	0	0	(347,064)	(1.0)
FY 15-16 S9/BA9 CLAG & HCBS	(512,475)	(206,238)	(50,000)	0	(256,237)	0.0
FY 14-15 BA10 Enhanced FMAP	(500,000)	(244,950)	0	0	(255,050)	0.0
SB 11-177 Teen pregnancy	(214,958)	16,960	(25,022)	0	(206,896)	(0.6)
FY 15-16 R13 ACC Reprocurement	(150,000)	(75,000)	0	0	(75,000)	0.0
SB 14-159 Medical clean claims	(128,688)	(128,688)	0	0	0	0.0
FY 15-16 R18 DDDWeb	(109,018)	(54,508)	0	0	(54,510)	0.0
SB 15-228 Provider rate review	(18,812)	(9,406)	0	0	(9,406)	0.0
HB 15-1309 Restoration by hygienists	(11,253)	(1,140)	850	0	(10,963)	0.0
Merit base pay	(7,650)	(2,515)	(1,152)	0	(3,983)	0.0
TOTAL	$16,682,905	$9,534,693	$1,689,762	($847,793)	$6,306,243	3.3

Annualize HB 15-1186 children with autism: The Department requests a net increase of $8.4 million total funds, including $8.5 million General Fund, for annualizing the cost of expanding and modifying the children with autism waiver, based on the assumptions in the fiscal note for H.B. 15-1186. The federal Centers for Medicare and Medicaid Services (CMS) rejected the Department's waiver amendment to implement the bill, indicating that most of the services should be covered under the mandatory early, periodic, screening, detection and treatment (EPSDT) benefit. The Department is working with CMS to determine how the EPSDT benefit needs to be modified and to prepare a revised estimate of the cost. In the meantime, the annualization of H.B. 15-1186 can be viewed as a placeholder for the expected cost.

Annualize primary care rate bump: The Department requests a reduction of $85.2 million total funds, including a decrease of $34.9 million General Fund, for the scheduled end of a bump in primary care rates. The amount of the annualization is based on assumptions that were included in the Department's FY 14-15 BA10, when General Fund for the primary care rate

bump was approved. However, this dollar amount for the annualization is misleading, because there is also an adjustment built into the forecast in R1 Medical Services Premiums to update the projected fiscal impact of the scheduled end to the primary care rate bump. The current forecast is that to continue the primary care rate bump in FY 2016-17 would cost $130.4 million total funds, including $44.6 million General Fund. *See the issue brief on Primary Care Rates for more information.*

Indirect cost adjustment: The Department requests a net increase of $59,489 total funds, including a decrease of $59,489 General Fund, based on an increase in statewide indirect cost collections used to offset the need for General Fund.

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

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

Legislation to restrict revenue from the Hospital Provider Fee by $100 million: The Governor proposes legislation to restrict revenue from the Hospital Provider Fee by $100 million in order to reduce the General Fund obligation for a TABOR refund by a like amount. The General Fund obligation for a TABOR refund is statutory and not appropriated, so the change to appropriations is shown as $0 in the table. In addition to changing the TABOR refund, reducing Hospital Provider Fee revenues would reduce expenditures for hospital reimbursements by a total of $202.2 million, including $100 million from the Hospital Provider Fee and $102.2 million matching federal funds, but in the Governor's request these expenditure adjustments were included in R1 Medical Services Premiums, rather than with the request for legislation.

Placeholder for potential increase in Medicare premiums paid by Medicaid: The Governor's budget transmittal letter identified that $25 million General Fund was set aside for a potential increase in Medicare premiums and deductibles paid by Medicaid and "opportunities presented by the update to the prison utilization study and the findings from the Results First project." The change to appropriations shown in the table is $0, because the Governor did not specify the portion of the total for the Department of Health Care Policy and Financing versus the other "opportunities." In R1 the Department included a projected increase in expenditures for Medicare premiums and deductibles based on utilization and rate trends from prior years. In addition, the Department submitted an "informational" request for additional funds that would be needed if Congress decided to raise Medicare premiums consistent with the July 22, 2015 recommendations of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance. The informational request was a worst-case scenario for what the Department thought could happen. Since the request was submitted, Congress has acted and the Department has a new projection of the increased costs for Medicare premiums and

deductibles above what was forecast in R1. The revised estimate is significantly less than the worst-case scenario presented in the "informational" request submitted with the budget, but it is unknown how it compares to what the Governor anticipated when creating the $25 million set aside, so it is unclear whether the revised estimate represents a savings from the Governor's request. The Governor's set aside was for FY 2016-17 and there was no discussion of how potential increased costs in FY 2015-16 would be addressed.

Increase in Medicare Premiums and Deductibles Above R1			
	"Informational" Nov 2 Request	Revised for Actual Rates	Difference
FY 2015-16			
Medicare Premiums	$33,821,832	$8,559,845	($25,261,987)
Deductibles	1,546,022	406,848	(1,139,174)
TOTAL	$35,367,854	$8,966,693	($26,401,161)
General Fund	*20,067,127*	*5,086,379*	*(14,980,748)*
Federal Funds	*15,300,727*	*3,880,314*	*(11,420,413)*
FY 2016-17			
Medicare Premiums	$71,313,580	$18,048,496	($53,265,084)
Deductibles	3,123,235	821,904	(2,301,331)
TOTAL	$74,436,815	$18,870,400	($55,566,415)
General Fund	*42,479,001*	*10,766,452*	*(31,712,549)*
Federal Funds	*31,957,814*	*8,103,948*	*(23,853,866)*

Issue: Forecast Trends (R1, R3, R4)

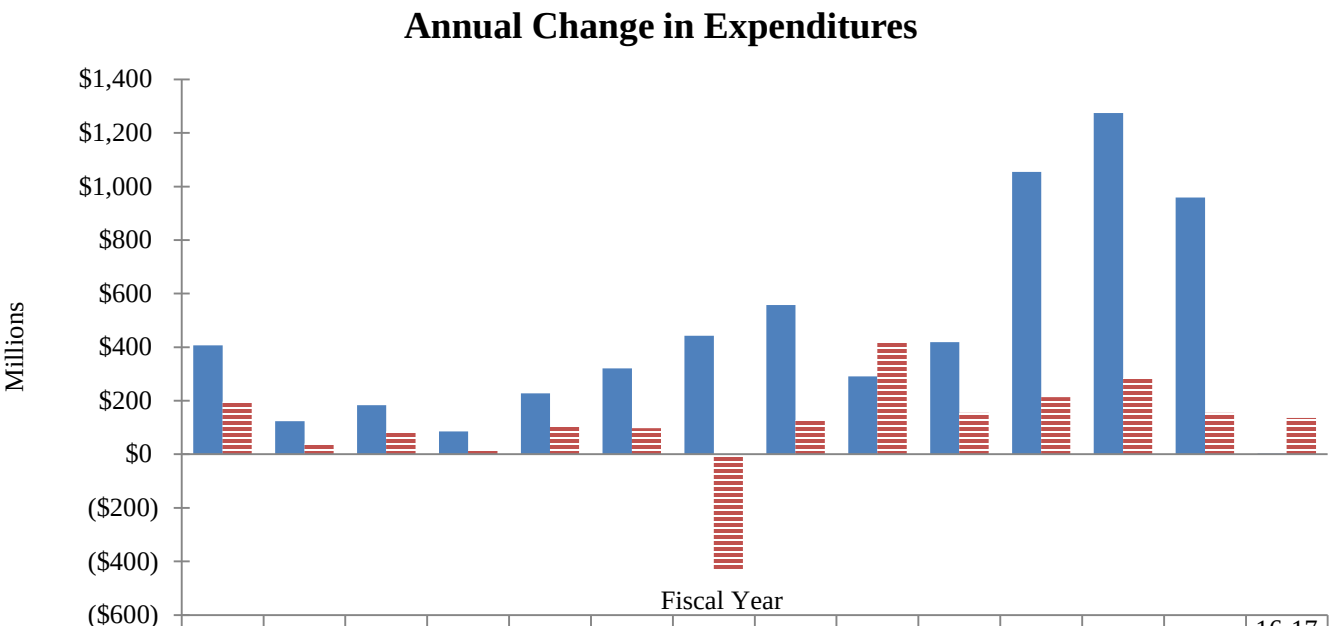
This issue brief provides a brief overview of forecast trends in enrollment and expenditures for Medical Service Premiums, the Children's Basic Health Plan, and the Medicare Modernization Act State Contribution Payment.

SUMMARY:

- Medicaid covers an estimated 1 in 5 Colorado residents, but the proportion of the population covered by Medicaid varies significantly by county.
- Medicaid covers 43 percent of births in Colorado.
- Nationally Medicaid covers about 51 percent of the cost of long term supports and services.
- Services for the "newly eligible" population under the ACA are projected to cost $1.442 billion in FY 2016-17. The state share of costs for this population when the enhanced federal match is fully phased down will be 10%, or $144.2 million. The state share of cost will be paid by the Hospital Provider Fee.
- Key trends behind the forecasted changes are discussed.

DISCUSSION:

The requested change for the Department in total funds is strikingly low compared to prior years. To put the request in context, the table below shows the annual change in total funds and General Fund for the Department for the last several fiscal years. Most of the changes in expenditures for the Department each year are due to trends in enrollment and utilization of services.

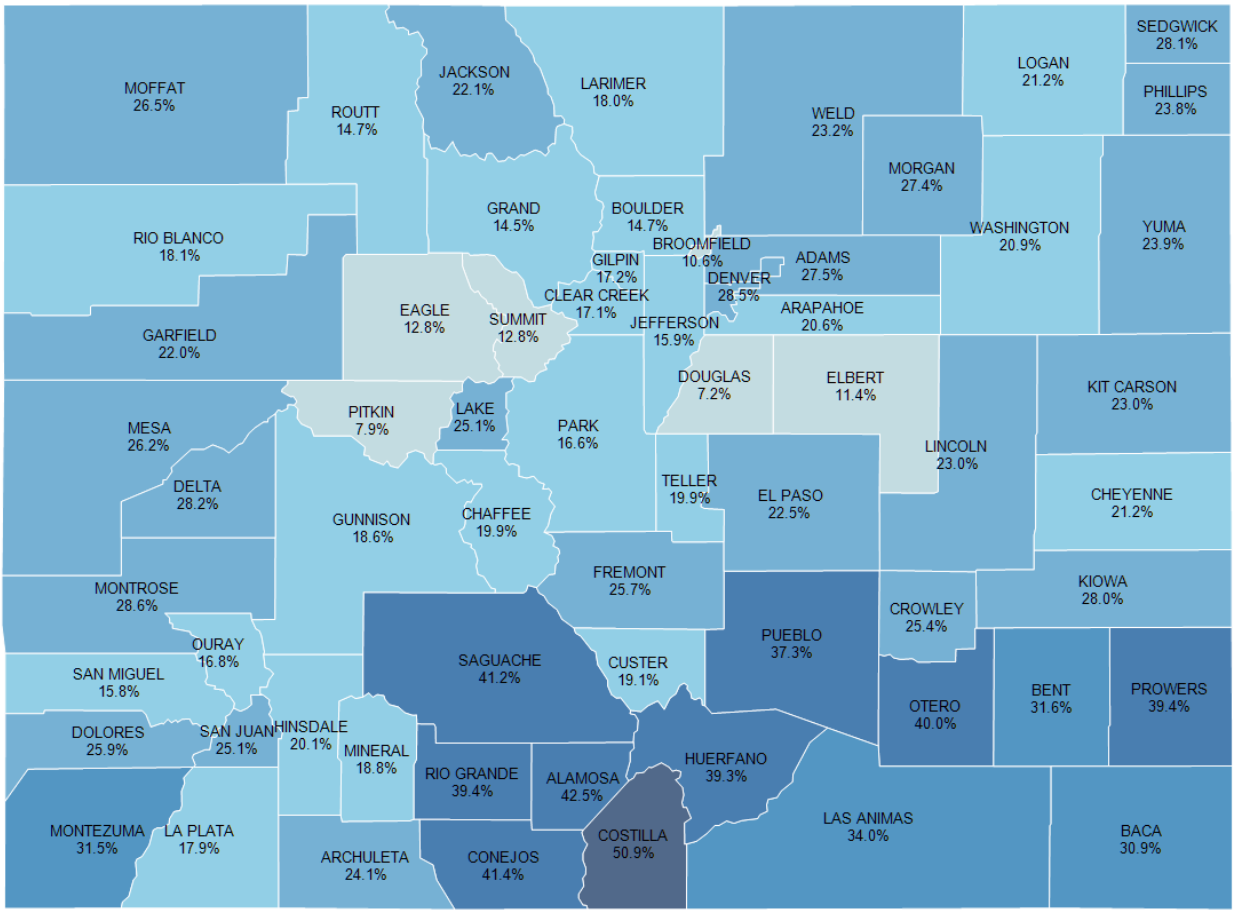


	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17 Req.
TOTAL Funds	$407	$123	$183	$86	$227	$321	$443	$558	$291	$418	$1,055	$1,275	$959	$3
General Fund	$197	$40	$85	$14	$102	$98	($428)	$128	$420	$154	$214	$285	$155	$136

Medicaid highlights

Medicaid is the largest health insurer in Colorado, covering an estimated 1 in 5 residents. This is up from 1 in 7 just prior to the S.B. 13-200 expansion that took effect in January 2014. However, the proportion of the population insured by Medicaid varies considerably by county from approximately 7 percent in Douglas County to more than 50 percent in Costilla County.

Percentage of Population Enrolled in Medicaid, FY 2014-15



Sources:
Health Care Policy and Financing Medicaid Caseload Report for FY 2014-15
Colorado Population Estimate from State Demographer for CY 2014

While Medicaid covers 20 percent of the population statewide, it covers a higher proportion of pregnancy care, paying for 43 percent of calendar year 2014 births in Colorado. In part this is due to a higher income qualifying threshold for pregnant women (an effective limit of 200 percent of FPL).

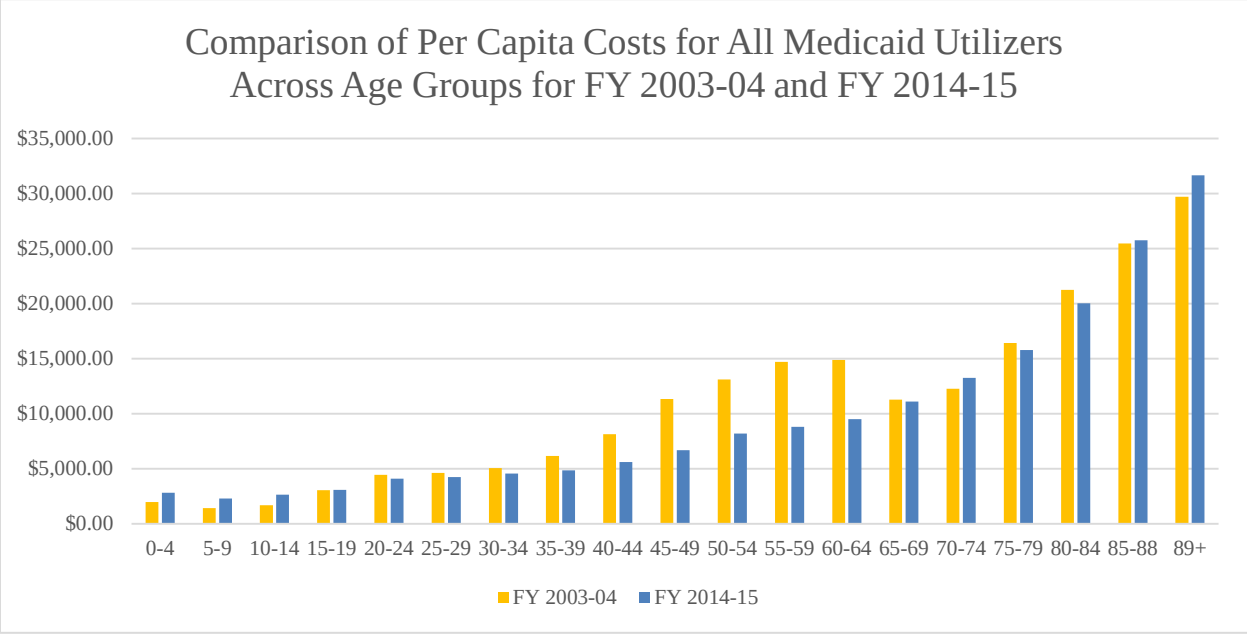
Nationally Medicaid consistently ranks as the largest payer for long term services and supports (LTSS), representing an estimated 51 percent of national expenditures in 2013.[3] The next largest payer is Medicare, but Medicare coverage of LTSS is limited, generally to post-acute services such as surgery recovery and home health for qualifying beneficiaries who are home bound.

The Colorado Health Institute estimates that when Medicare and CHP+ coverage are added to Medicaid, the result is that approximately 1 in 3 Coloradoans are covered by publicly-funded insurance.[4]

[3] http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
[4] http://coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/colorado-health-access-survey-1

Costs for Medicaid, as with private insurance, are driven by a relatively small number of very expensive cases. The top 20 percent of utilizers accounted for 79 percent of costs in FY 2014-15. The top 1 percent of utilizers accounted for 23 percent of expenditures. Pharmacy and hospitalization expenditures are particularly concentrated among a few high cost clients.

Medicaid costs tend to increase as clients get older. The chart below shows per capita medical costs paid from the Medical Services Premiums line item by age. The difference between FY 2003-04 and FY 2014-15 is attributable to the Medicaid expansion. Prior to the expansion a large portion of the Medicaid eligible adults 40-64 was composed of people with disabilities. The expansion increased the eligible adults without disabilities, lowering the average per capita. At age 65 Medicare begins covering a large portion of medical costs, but there are still Medicaid costs for paying Medicare premiums and for long-term services and supports.



The federal Affordable Care Act (ACA) provides an enhanced federal match for populations defined as "newly eligible" as a result of the ACA. For Colorado, the "newly eligible" include adults without dependent children to an effective income eligibility limit of 138 percent of the federal poverty guidelines and parents and caretakers with income from 69 percent to 138 percent of the federal poverty guidelines. The enhanced match is 100 percent in calendar year 2016 and decreases to 95 percent in calendar year 2017. It continues to decrease each year in increments until it reaches 90 percent in 2020.

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

The state share of costs for the "newly eligible" is paid from the Hospital Provider Fee. In FY 2016-17 the Department projects to spend a total of $1,441,979,895 for the "newly eligible" and $40,754,393 will be from the Hospital Provider Fee. If the federal match were phased down to the lowest level of 90 percent for the entire fiscal year, the cost from the Hospital Provider Fee would be roughly $144.2 million.

Medical Service Premiums forecast

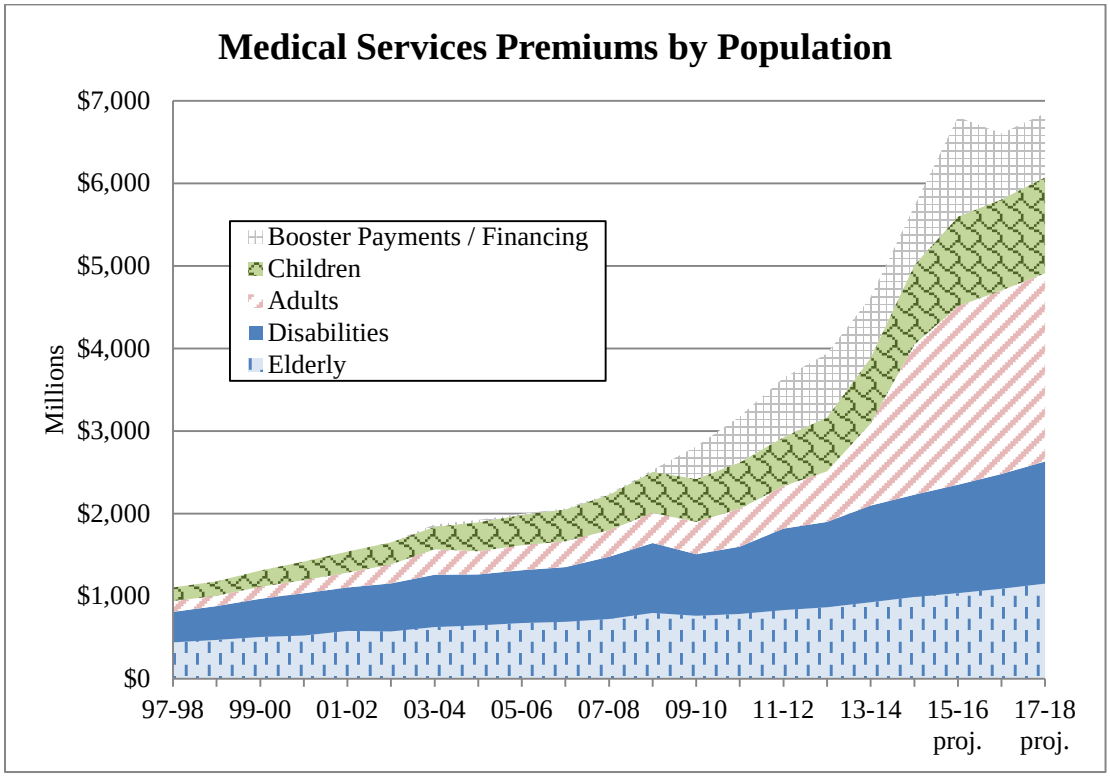
The Department's R1 provides the forecast of expenditures for Medical Service Premiums. The Request is expressed in terms of the change from the FY 2015-16 appropriation, but a portion of the increase will actually occur in FY 2016-17, for which the Department will submit a supplemental request in January. The table below shows the portion of R1 attributable to reforecasting FY 2015-16 and the portion attributable to FY 2016-17.

Medical Services Premiums				
	Total	General Fund	Cash Funds	Federal Funds
FY 15-16				
FY 15-16 Approp	$6,594,830,484	$1,816,359,768	$703,597,288	$4,074,873,428
FY 15-16 Forecast	$6,801,990,609	$1,854,229,521	$819,261,032	$4,128,500,056
$ Difference	**$207,160,125**	**$37,869,753**	**$115,663,744**	**$53,626,628**
% Difference	3.1%	2.1%	16.4%	1.3%
FY 16-17				
FY 15-16 Forecast	$6,801,990,609	$1,854,229,521	$819,261,032	$4,128,500,056
Annualizations	($51,383,746)	($18,082,260)	($3,092,501)	($30,208,985)
FY 16-17 Base	$6,750,606,863	$1,836,147,261	$816,168,531	$4,098,291,071
FY 16-17 Forecast	$6,603,727,556	$1,939,979,927	$669,522,464	$3,994,225,165
$ Difference	**($146,879,307)**	**$103,832,666**	**($146,646,067)**	**($104,065,906)**
% Difference	-2.2%	5.6%	-17.9%	-2.5%
TOTAL R1	$60,280,818	$141,702,419	($30,982,323)	($50,439,278)

The changes shown in the table are attributable to hundreds of little changes, many offsetting each other, that compound to result in the net change. To make sense of what is happening, the JBC staff finds it easier to subdivide the forecast further into the components related to services and to booster payments/financing. Otherwise, changes in booster payments/financing obscure the trends in service expenditures. The booster payments/financing are composed primarily of increased reimbursements to hospitals and nursing facilities that are subsidized with provider fees and matching federal funds, but also include some miscellaneous other financing

adjustments such as General Fund offsets from the Health Care Expansion Fund and from certified public expenditures by hospitals with local government funding.

The graph below illustrates the Department's forecast in R1 and how changes in booster payments/financing result in changes to total expenditures that don't match the trends in service expenditures. Note that the graph goes to FY 2017-18 and so the request year is the penultimate year illustrated, rather than the last year.



Services

The table below shows the change in the forecast for the component of R1 related to service expenditures by fiscal year. The FY 15-16 Approp is the portion of the total appropriation for Medical Services Premiums estimated to pay for physical health services and for long-term services and supports. Note that in FY 2016-17 the total difference from the FY 2015-16 forecast is $206.4 million, including $84.7 million General Fund, but in the Governor's request $257.8 million total funds, including $102.8 million General Fund is attributed to R1 and the remainder is attributed to annualizations of policies previously approved by the General Assembly. This is important because some of the later tables blur the distinction between annualizations and what is requested in R1.

	R1-Services			
	Total	General Fund	Cash Funds	Federal Funds
FY 15-16				
FY 15-16 Approp	$5,648,340,622	$1,958,346,824	$75,535,542	$3,614,458,256
FY 15-16 Forecast	$5,598,029,703	$1,988,426,066	$66,110,711	$3,543,492,926
$ Difference	**($50,310,919)**	**$30,079,242**	**($9,424,831)**	**($70,965,330)**
% Difference	-0.9%	1.5%	-12.5%	-2.0%
FY 16-17				
FY 15-16 Forecast	$5,598,029,703	$1,988,426,066	$66,110,711	$3,543,492,926
Annualizations	($51,383,746)	($18,082,260)	($3,092,501)	($30,208,985)
FY 16-17 Base	$5,546,645,957	$1,970,343,806	$63,018,210	$3,513,283,941
FY 16-17 Forecast	$5,804,458,239	$2,073,144,359	$105,295,461	$3,626,018,419
$ Difference	**$257,812,282**	**$102,800,553**	**$42,277,251**	**$112,734,478**
% Difference	4.6%	5.2%	63.9%	3.2%
TOTAL R1-Services	$207,501,363	$132,879,795	$32,852,420	$41,769,148

FY 2015-16 Services

For FY 2015-16 the Department lowered the total funds forecast by $50.3 million, or 0.9 percent, and increased the General Fund forecast by $30.1 million, or 1.5 percent. There are lots of little stories that compound to explain this change, but there are two big stories responsible for the lion's share of the difference:

- The Department increased projected base acute care expenditures by $79.3 million total funds, including $47.9 million General Fund. In this context, base acute care expenses are those acute care expenses without special financing. Most of the change is due to increasing assumptions about per capita costs for children. Last year, the Department assumed that a rapid increase in enrollment, attributable to secondary effects of outreach efforts related to the Medicaid expansion, would put downward pressure on per capita expenditures, with new enrollees needing time to connect with providers and new enrollees generally being healthier than the base population. However, actual per capita costs for kids have been higher than anticipated. For example, for acute care the Department previously projected FY 14-15 per capita expenditures for children to 106% percent of the FPL would be $1,617.93 and that would remain unchanged in FY 15-16 before policy adjustments approved by the General Assembly. The actual per capita for this population in FY 14-15 was $1,637.29 and the Department has raised the forecast for FY 15-16 before policy changes to $1,645.48. Children are one of the largest enrollment categories and the financing for children comes from the General Fund, so the $27.55 difference in the base per capita assumption, or 1.7 percent difference, makes a large dollar difference in both the total funds and General Fund forecast. The Department also increased cost assumptions for policies approved by the General Assembly that affect per capita expenditures for children, most notably for the primary care rate bump, where utilization has been higher than expected. This adjustment should be interpreted as a correction of a forecast error, and not necessarily an indicator that utilization has increased. The data the Department pulled to make the original forecast of the primary care rate bump did not capture all the eligible codes.
- The Department decreased projected acute care expenditures for adults without dependent children by $112.2 million total funds, all from federal funds. This is again primarily due to

a change in per capita cost assumptions based on actual utilization in FY 2014-15, but in this case the Department lowered the per capita estimate. This is an expansion population that the Department had very little experience serving. There are many potential causes of the lower-than-expected per capita expenditures in FY 2014-15, including potentially the population being healthier than expected, the new clients having trouble connecting with providers, the new clients being served primarily by less-costly providers, or some combination of many factors.

FY 2016-17 Services

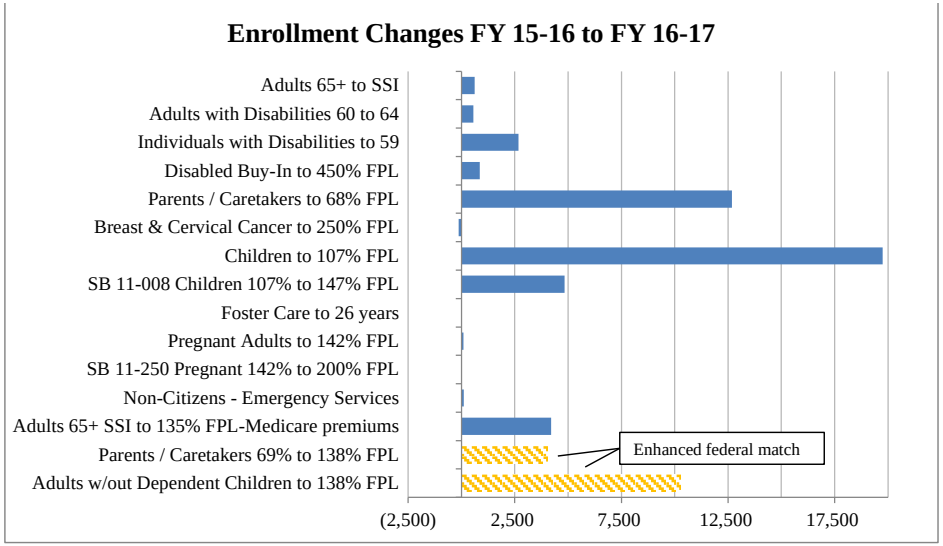
Of the FY 2016-17 projected increase in total service expenditures, 62.4 percent is for services to the elderly and people with disabilities and 22.4 percent is for adults without dependent children. Increases in expenditures for services to the elderly and people with disabilities account for roughly 82.4 percent of the projected FY 2016-17 General Fund increase.

For adults and children the Department is expecting the rate of enrollment growth to taper off significantly compared to prior years, as the state moves past the ramp-up period for the Medicaid expansion. The Department's enrollment expectations for these populations are also informed by new data suggesting the pool of people potentially eligible for Medicaid who have not enrolled is shrinking. The data comes from the Colorado Health Access Survey performed by the Colorado Health Institute and it shows record lows in the uninsured. For example, the report estimates only 6.7 percent of Coloradoans were uninsured in 2015, compared to 14.3 percent in the last survey in 2013. The report estimates only 2.5 percent of children, or approximately 33,000 children, were uninsured in 2015. If all 33,000 uninsured children were eligible for Medicaid, it would only be a 6.4 percent increase over the children actually enrolled in Medicaid in FY 2014-15.

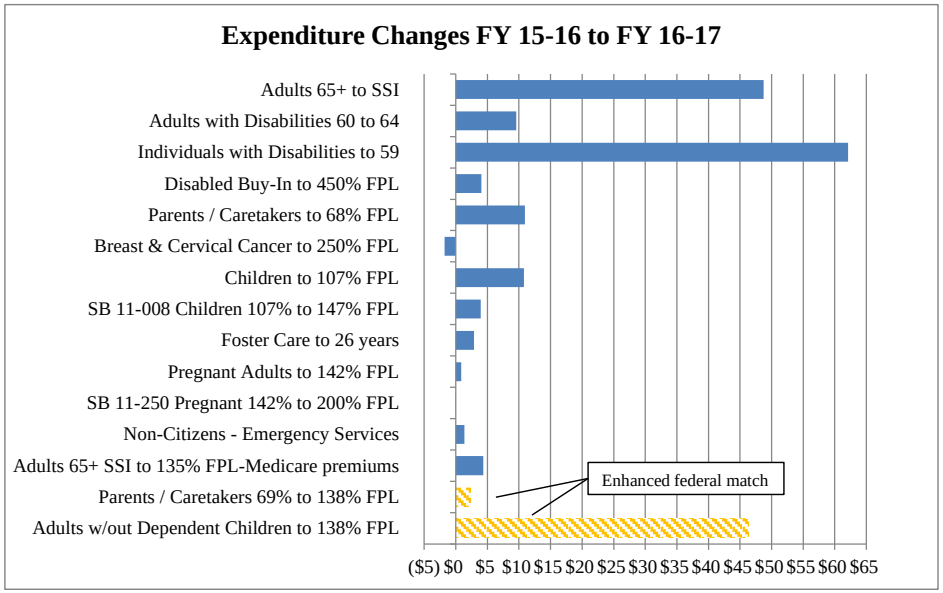
The effect on expenditures of the enrollment growth the Department is forecasting for adults and children is dampened by lower per capita cost estimates, including the scheduled end of the primary care rate bump. This helps to explain why the greatest portion of forecasted cost increases is attributable to the elderly and people with disabilities.

The tables and charts below summarize the projected changes from FY 2015-16 to FY 2016-17 in enrollment, expenditures, and per capita costs by forecasted population.

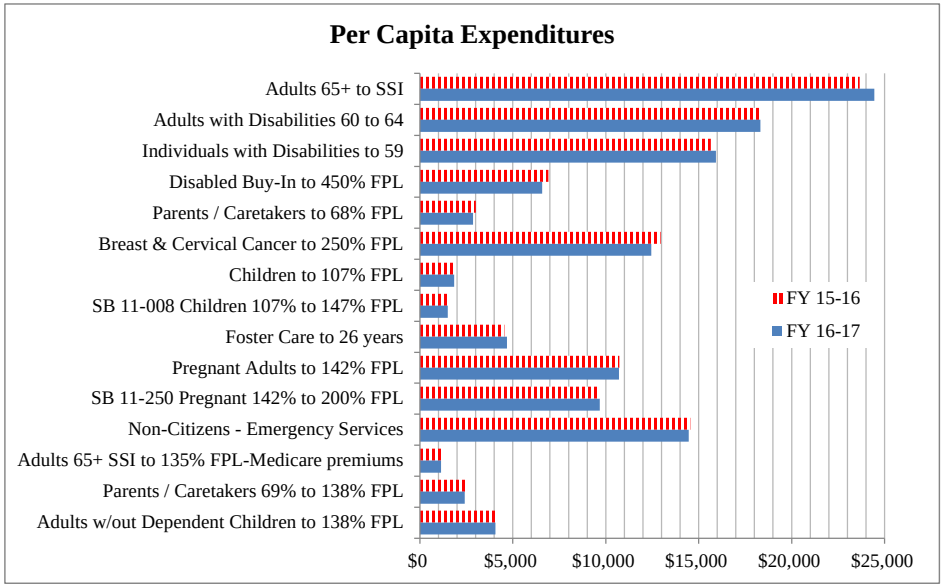
Enrollment				
Category	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	42,218	42,830	612	1.4%
Adults with Disabilities 60 to 64	11,035	11,585	550	5.0%
Individuals with Disabilities to 59	68,897	71,569	2,672	3.9%
Disabled Buy-In to 450% FPL	4,859	5,721	862	17.7%
Parents / Caretakers to 68% FPL	181,652	194,331	12,679	7.0%
Breast & Cervical Cancer to 250% FPL	283	153	(130)	-45.9%
Children to 107% FPL	474,429	494,175	19,746	4.2%
SB 11-008 Children 107% to 147% FPL	59,802	64,629	4,827	8.1%
Foster Care to 26 years	19,923	19,943	20	0.1%
Pregnant Adults to 142% FPL	14,830	14,916	86	0.6%
SB 11-250 Pregnant 142% to 200% FPL	1,728	1,725	(3)	-0.2%
Non-Citizens - Emergency Services	2,992	3,104	112	3.7%
Adults 65+ SSI to 135% FPL-Medicare premiums	32,835	37,035	4,200	12.8%
Subtotal - Traditional Medicaid	**915,483**	**961,716**	**46,233**	**5.1%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	82,897	86,948	4,051	4.9%
Adults w/out Dependent Children to 138% FPL	293,091	303,341	10,250	3.5%
Subtotal - ACA "Newly Eligible"	**375,988**	**390,289**	**14,301**	**3.8%**
TOTAL	**1,291,471**	**1,352,005**	**60,534**	**4.7%**



Expenditures				
Category	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	$998,530,810	$1,047,283,770	$48,752,960	4.9%
Adults with Disabilities 60 to 64	202,637,667	212,214,445	9,576,778	4.7%
Individuals with Disabilities to 59	1,077,767,607	1,139,847,336	62,079,729	5.8%
Disabled Buy-In to 450% FPL	33,553,204	37,597,723	4,044,519	12.1%
Parents / Caretakers to 68% FPL	544,932,830	555,889,325	10,956,495	2.0%
Breast & Cervical Cancer to 250% FPL	3,662,496	1,905,909	(1,756,587)	-48.0%
Children to 107% FPL	903,421,795	914,202,251	10,780,456	1.2%
SB 11-008 Children 107% to 147% FPL	92,546,263	96,502,681	3,956,418	4.3%
Foster Care to 26 years	90,391,388	93,292,338	2,900,950	3.2%
Pregnant Adults to 142% FPL	159,049,590	159,887,508	837,918	0.5%
SB 11-250 Pregnant 142% to 200% FPL	16,693,559	16,681,175	(12,384)	-0.1%
Non-Citizens - Emergency Services	43,515,454	44,869,095	1,353,641	3.1%
Adults 65+ SSI to 135% FPL-Medicare premiums	37,963,773	42,304,788	4,341,015	11.4%
Subtotal - Traditional Medicaid	**$4,204,666,436**	**$4,362,478,344**	**$157,811,908**	**3.8%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	208,071,733	210,364,476	2,292,743	1.1%
Adults w/out Dependent Children to 138% FPL	1,185,291,534	1,231,615,419	46,323,885	3.9%
Subtotal - ACA "Newly Eligible"	**$1,393,363,267**	**$1,441,979,895**	**$48,616,628**	**3.5%**
Services Subtotal	**$5,598,029,703**	**$5,804,458,239**	**$206,428,536**	**3.7%**
Booster Payments / Financing	1,203,960,906	799,269,317	(404,691,589)	-33.6%
TOTAL	**$6,801,990,609**	**$6,603,727,556**	**($198,263,053)**	**-2.9%**



Per Capita Expenditures				
Category	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	$23,651.78	$24,452.11	$800.33	3.4%
Adults with Disabilities 60 to 64	$18,363.18	$18,318.04	($45.14)	-0.2%
Individuals with Disabilities to 59	$15,643.17	$15,926.55	$283.38	1.8%
Disabled Buy-In to 450% FPL	$6,905.37	$6,571.88	($333.49)	-4.8%
Parents / Caretakers to 68% FPL	$2,999.87	$2,860.53	($139.34)	-4.6%
Breast & Cervical Cancer to 250% FPL	$12,941.68	$12,456.92	($484.76)	-3.7%
Children to 107% FPL	$1,904.23	$1,849.96	($54.27)	-2.8%
SB 11-008 Children 107% to 147% FPL	$1,547.54	$1,493.18	($54.36)	-3.5%
Foster Care to 26 years	$4,537.04	$4,677.95	$140.91	3.1%
Pregnant Adults to 142% FPL	$10,724.85	$10,719.19	($5.66)	-0.1%
SB 11-250 Pregnant 142% to 200% FPL	$9,660.62	$9,670.25	$9.63	0.1%
Non-Citizens - Emergency Services	$14,543.94	$14,455.25	($88.69)	-0.6%
Adults 65+ SSI to 135% FPL-Medicare premiums	$1,156.20	$1,142.29	($13.91)	-1.2%
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	$2,510.00	$2,419.43	($90.57)	-3.6%
Adults w/out Dependent Children to 138% FPL	$4,044.11	$4,060.17	$16.06	0.4%
TOTAL (without booster payments/financing)	**$4,334.62**	**$4,293.22**	**($41.40)**	**-1.0%**



For the elderly and people with disabilities there are several important stories explaining the projected increase in expenditures in FY 2016-17 that are detailed in the bullets below. Most services for the elderly and people with disabilities will earn an average federal match in FY 2016-17 of 50.42 percent.

- The Department is projecting a $56.6 million increase in base Community Based Long-term Care expenses, mostly due to an expected 5.6 percent increase in enrollment in home- and community-based service (HCBS) waivers and a 7.9 percent increase in per capita costs for HCBS before policy adjustments. The Department also revised the expected implementation date of the large targeted rate increase in personal care and homemaker rates approved by the JBC, pushing roughly half of the projected increase in costs from FY 2015-16 into FY 2016-17. The projected increase also reflects annualization of the Colorado Choice Transitions program.
- The Department is projecting a $27.5 million increase in expenditures for private duty nursing and long-term home health, mostly due to large expected increases in utilization of 18.1 percent and 15.7 percent respectively.
- The Department is projecting a $23.0 million increase, or 17.2 percent, for the Program for All-inclusive Care for the Elderly (PACE). This is a function of projected strong growth in both utilization and per capita costs. PACE providers are paid a capitated rate per client and accept the risk if actual costs are higher than anticipated. Because of the capitated and risk-based nature of the payment, federal Medicaid rules require that the rates meet a standard of actuarial soundness. The Department changes rates annually based on the actuarial analysis rather than discretionary policies of the General Assembly.
- The Department is projecting a $17.8 million increase in nursing home expenditures, mostly based on the statutory formula for increasing provider rates.
- The Department projects a $14.3 million increase in Medicaid payments to purchase third party insurance. This is mostly for clients who meet income qualifications for assistance with their Medicare premiums. This is the forecast based on prior year trends. It assumes that Medicare premiums would increase from $104.90 to $110.70. As noted previously, the Governor included a placeholder in the budget for an expected increase in expenditures for Medicare premiums and deductibles on top of the base trend. The actual Medicare premium increased to $123.00 and the incremental difference in cost above the previously estimated premium of $110.70 will need to be covered by the placeholder. Also, not accounted for in R1 was an increase in the Medicare deductible from $147.00 to $167.00 that will need to be covered by the placeholder.
- These increases are partially offset by a projected $19.3 million decrease in acute care expenses, largely attributable to the end of the primary care rate bump.

Projected Medical Services Premiums Expenditures for the Elderly and People with Disabilities				
	FY 15-16	FY 16-17	Difference	% of Dif.
Acute Care	$722,273,534	$702,976,198	($19,297,336)	-15.0%
Community Based Long-Term Care (CBLTC)				
Base CBLTC	408,017,322	464,660,369	56,643,047	44.0%
Hospice	45,686,214	47,669,126	1,982,912	1.5%
Private Duty Nursing & Long-Term Home Health	247,488,940	274,939,166	27,450,226	21.3%
Subtotal CBLTC	*701,192,476*	*787,268,661*	*86,076,185*	*66.8%*
Long-Term Care				
Class I Nursing Facilities	592,864,316	610,703,089	17,838,773	13.9%
Class II Nursing Facilities	4,764,670	5,035,779	271,109	0.2%
Program for All-inclusive Care for the Elderly (PACE)	133,853,042	156,900,991	23,047,949	17.9%
Subtotal Long-Term Care	*731,482,028*	*772,639,859*	*41,157,831*	*32.0%*
Insurance				
Supplemental Medicare Insurance Benefit	148,169,400	162,125,765	13,956,365	10.8%
Heath Insurance Buy-In	1,381,364	1,736,982	355,618	0.3%
Subtotal Insurance	*149,550,764*	*163,862,747*	*14,311,983*	*11.1%*
Service Management				
Single Entry Points	31,461,008	33,238,452	1,777,444	1.4%
Disease Management	184,233	192,497	8,264	0.0%
ACC and PIHP Administration	14,309,018	19,069,648	4,760,630	3.7%
Subtotal Service Management	*45,954,259*	*52,500,597*	*6,546,338*	*5.1%*
Medical Services Total	$2,350,453,061	$2,479,248,062	$128,795,001	

The projected increase for adults without dependent children is primarily a function of projected enrollment growth. This population receives a 100 percent federal match through calendar year 2016 and a 95 percent federal match for calendar year 2017. In calendar year 2017 the 5 percent state match comes from the Hospital Provider Fee. As described above, acute care per capita expenditures for adults without dependent children were lower than expected in FY 2014-15, causing a reduction in FY 2015-16 assumptions. For FY 2016-17 the Department carried forward the lower per capita growth trend, and then reduced per capita assumptions for the end of the primary care rate bump, resulting in an almost flat projection of per capita costs. The Department is not seeing an increase in utilization by the clients in this category who have been covered the longest. This suggests that the lower per capita trend is real, rather than due to a ramp up period where clients work to get connected with providers.

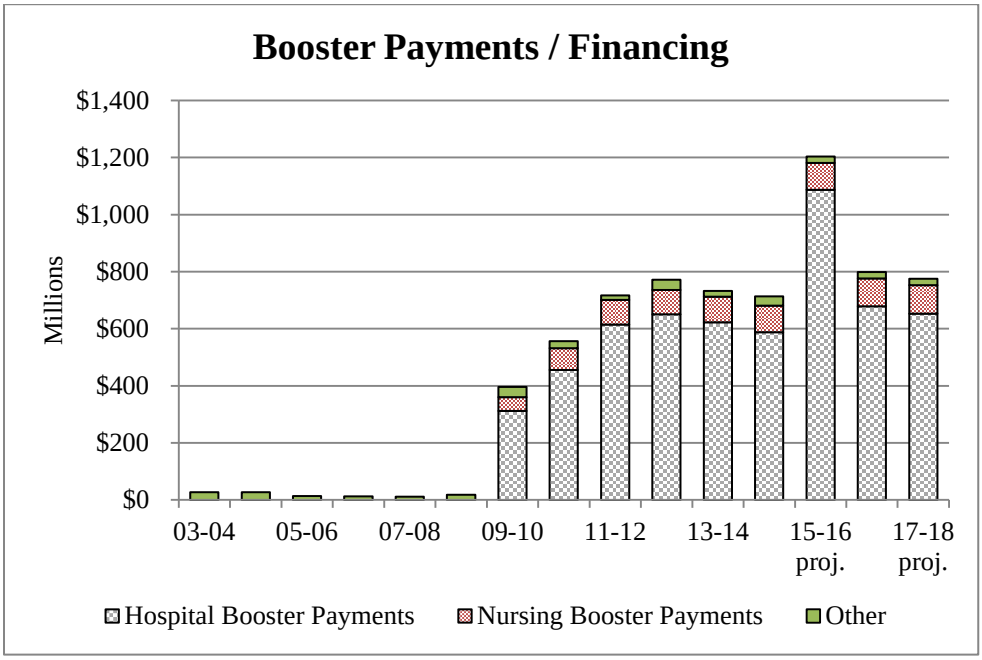
Booster Payments/Financing

The table below shows the change in the forecast for the component of R1 related to booster payments and financing. The FY 15-16 Approp is the portion of the total appropriation for Medical Services Premiums estimated to pay for booster payments and financing. Booster payments are increased reimbursements to hospitals and nursing facilities that are subsidized with provider fees and matching federal funds. Financing includes several miscellaneous ways the Department uses cash funds to offset the need for General Fund or increase federal fund reimbursements. Examples of financing include tobacco settlement funds deposited in the Health Care Expansion Fund that are used to offset the need for General Fund, certified public expenditures by hospitals with local government funding, and recoveries of overpayments.

R1-Booster Payments/Financing	Total	General Fund	Cash Funds	Federal Funds
FY 15-16				
FY 15-16 Approp	$946,489,862	($141,987,056)	$628,061,746	$460,415,172
FY 15-16 Forecast	$1,203,960,906	($134,196,545)	$753,150,321	$585,007,130
$ Difference	**$257,471,044**	**$7,790,511**	**$125,088,575**	**$124,591,958**
% Difference	27.2%	-5.5%	19.9%	27.1%
FY 16-17				
FY 15-16 Forecast	$1,203,960,906	($134,196,545)	$753,150,321	$585,007,130
FY 16-17 Forecast	$799,269,317	($133,164,432)	$564,227,003	$368,206,746
$ Difference	**($404,691,589)**	**$1,032,113**	**($188,923,318)**	**($216,800,384)**
% Difference	-33.6%	-0.8%	-25.1%	-37.1%
TOTAL R1-Financing	($147,220,545)	$8,822,624	($63,834,743)	($92,208,426)

Almost all the variance in the booster payments/financing is attributable to changes in the Hospital Provider Fee. For FY 2015-16 delays in approval from the Centers for Medicare and Medicaid Services (CMS) caused payments the Department expected to occur in FY 2014-15 to move to FY 2015-16. For FY 2016-17 the decrease in expenditures is partially attributable to removing the one-time shift in expenditures between fiscal years that occurred in FY 2015-16. It also reflects restricting revenues from the Hospital Provider Fee by $100 million as proposed by the Governor. *For more information about trends in Hospital Provider Fee expenditures see the Hospital Provider Fee issue brief below.*

The following graph shows actual and projected Booster Payments / Financing over time. The figures are total funds, including the matching federal funds, and reflect the Governor's proposed $100 million reduction in Hospital Provider Fee revenues.



Children's Basic Health Plan (CHP+) forecast

The Department's R3 provides the forecast of expenditures for the Children's Basic Health Plan (CHP+). The table below summarizes the portions of the request attributable to FY 2015-16 and FY 2016-17. The main source of cash funds for CHP+ is an annual transfer from the tobacco master settlement agreement to the CHP+ Trust. The CHP+ Trust also receives payments for premiums and interest. A small portion of the cash funds are from the Hospital Provider Fee, the Colorado Immunization Fund, and the Health Care Expansion Fund. The requested General Fund is to pay federal recoupments related to expenditures in prior years for prenatal costs that are not eligible for payment from the CHP+ Trust.

R3 Children's Basic Health Plan				
	Total	General Fund	Cash Funds	Federal Funds
FY 15-16				
FY 15-16 Approp	$166,723,024	$2,525,718	$29,111,476	$135,085,830
FY 15-16 Forecast	$143,968,479	$2,525,719	$25,326,308	$116,116,452
$ Difference	**($22,754,545)**	**$1**	**($3,785,168)**	**($18,969,378)**
% Difference	-13.6%	0.0%	-13.0%	-14.0%
FY 16-17				
FY 15-16 Forecast	$143,968,479	$2,525,719	$25,326,308	$116,116,452
Annualizations	$1,327	$0	$108,403	($107,076)
FY 16-17 Base	$143,969,806	$2,525,719	$25,434,711	$116,009,376
FY 16-17 Forecast	$149,119,335	$2,500,441	$18,011,548	$128,607,346
$ Difference	**$5,149,529**	**($25,278)**	**($7,423,163)**	**$12,597,970**
% Difference	3.6%	-1.0%	-29.2%	10.9%
TOTAL R3	($17,605,016)	($25,277)	($11,208,331)	($6,371,408)

The Department lowered projected expenditures in FY 2015-16 primarily because FY 2014-15 expenditures were lower than expected. The Department describes this as a bucketing issue where the Department overestimated CHP+ caseload and underestimated the Medicaid SB 11-008 children with family income from 107 percent to 147 percent of the FPL.

The FY 2016-17 shift in financing from cash funds to federal funds is due to the annualization of an increase in the FMAP rate. In October of 2015 the federal match rate for CHP+ increased 23 percentage points pursuant to provisions of the Affordable Care Act.

CHP+ Enhanced Federal Medical Assistance Percentage (eFMAP)					
State	Ave.	eFMAP by Quarter (of state fiscal year)			
Fiscal Year	eFMAP	Q1-July	Q2-October	Q3-January	Q4-April
FY 12-13	65.00	65.00	65.00	65.00	65.00
FY 13-14	65.00	65.00	65.00	65.00	65.00
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	*88.29*	88.50	*88.22*	*88.22*	*88.22*
FY 17-18	*88.17*	*88.22*	*88.15*	*88.15*	*88.15*

Italicized figures are projections.

At the federal level CHP+ is authorized through October 1, 2019. Provisions of the Affordable Care Act prohibit states from reducing eligibility for children for both Medicaid and CHP+ until the same date. The maintenance of effort requirement does not apply to pregnant adults on CHP+. Beyond October 2019 the future of CHP+ is uncertain. Some federal policy makers take the position that people eligible for CHP+ should be able to obtain health insurance through the exchanges and therefore the need for CHP+ is waning.

Projected revenues for the CHP+ Trust exceed projected expenditures for the time period the program is authorized at the federal level. Considering that budget constraints lead the Governor to propose provider rate reductions and a restriction on revenues from the Hospital Provider Fee, it is interesting that the Governor did not propose measures to reduce the projected fund balance of the CHP+ Trust in order to provide General Fund relief. The Department could not speak to the Governor's rationale, but did offer some potential arguments for being cautious about taking money from the CHP+ Trust. First, the money in the CHP+ Trust is liquid and potentially available immediately for General Fund relief, whereas solutions like a provider rate reduction or a restriction on Hospital Provider Fee revenues take time to implement. This could be an argument for keeping the CHP+ Trust available for shortfalls in the current year budget, rather than planning a future year budget based on the CHP+ balance. Second, CHP+ enrollment and expenditures are historically highly volatile and don't always move in concert with changes in the economy, because CHP+ has both an upper and lower income limit on eligibility. The recent dramatic increase in the federal match rate for the program has reduced the CHP+ Trust's exposure to enrollment volatility, but there is still an element of uncertainty in the forecast. Third, while federal authority for the program extends to October of 2019, the federal funding to date has been provided only to October 2017. Maintaining a balance in the CHP+ Trust could help the state adapt if there are changes in the federal funding.

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

There are two standard ways the JBC could use the CHP+ Trust to provide General Fund relief. Both would require a bill. One way would be to make a transfer or transfers from the CHP+ Trust to the General Fund. Another way would be to change the statutory allocations from Tobacco Settlement moneys to divert some of the funds currently going to CHP+ to the General Fund or to a purpose that offsets the need for General Fund (such as to pay Medical Services Premiums). Department staff suggest it might be possible without a change in statute to use the

CHP+ Trust in lieu of General Fund to pay expenses in the Medical Services Premiums line item for certain populations. The JBC staff is researching whether this would be consistent with the CHP+ Trust statutes.

Medicare Modernization Act State Contribution Payment forecast

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

R4 Medicare Modernization Act	General Fund
FY 15-16	
FY 15-16 Approp	116,816,749
FY 15-16 Forecast	115,497,948
$ Difference	(1,318,801)
% Difference	-1.1%
FY 16-17	
FY 15-16 Forecast	115,497,948
FY 16-17 Forecast	133,682,247
$ Difference	18,184,298
% Difference	15.7%
TOTAL R4	16,865,498

Expenditures in this line are driven by the pharmacy utilization of people eligible for both Medicaid and Medicare and the federal formula that determines the state's share of costs.

Issue: Hospital Provider Fee ($100 million from HPF)

This issue brief discusses how the Hospital Provider Fee works, the Governor's request to reduce revenue from the fee by $100 million, and the effect if the fee were designated as a TABOR enterprise.

SUMMARY:

- Through the Hospital Provider Fee the state collects money from hospitals, matches the money with federal funds, and then pays the Hospital Provider Fee plus the matching federal funds back to the hospitals, providing a net increase in reimbursements to hospitals. A portion of the Hospital Provider is also used to pay for Medicaid eligibility expansions.
- The Hospital Provider Fee is the second largest source of non-General Fund revenue subject to TABOR and revenues from the Hospital Provider Fee have increased significantly in recent years.
- The Governor proposes reducing revenue from the Hospital Provider Fee by $100 million in order to reduce the projected General Fund obligation for a TABOR refund.
- When a TABOR refund is due, the Hospital Provider Fee is an inefficient way to reimburse hospitals compared to using General Fund for a rate increase.
- Designating the Hospital Provider Fee as an enterprise under Tabor would save $189.1 million General Fund compared to the Governor's request, but if it is found unconstitutional the state would need to refund illegally retained revenues.

DISCUSSION:

The Governor's budget request includes a proposal to reduce revenue from the Hospital Provider Fee in FY 2016-17 by $100 million in order to reduce the projected General Fund obligation for the TABOR[5] refund by $100 million. This frees up $100 million General Fund for other budget priorities.

This issue brief examines the Governor's request as well as some potential variations and alternatives. It begins with a background section that is intended to establish a common baseline level of knowledge about the Hospital Provider Fee.

Background

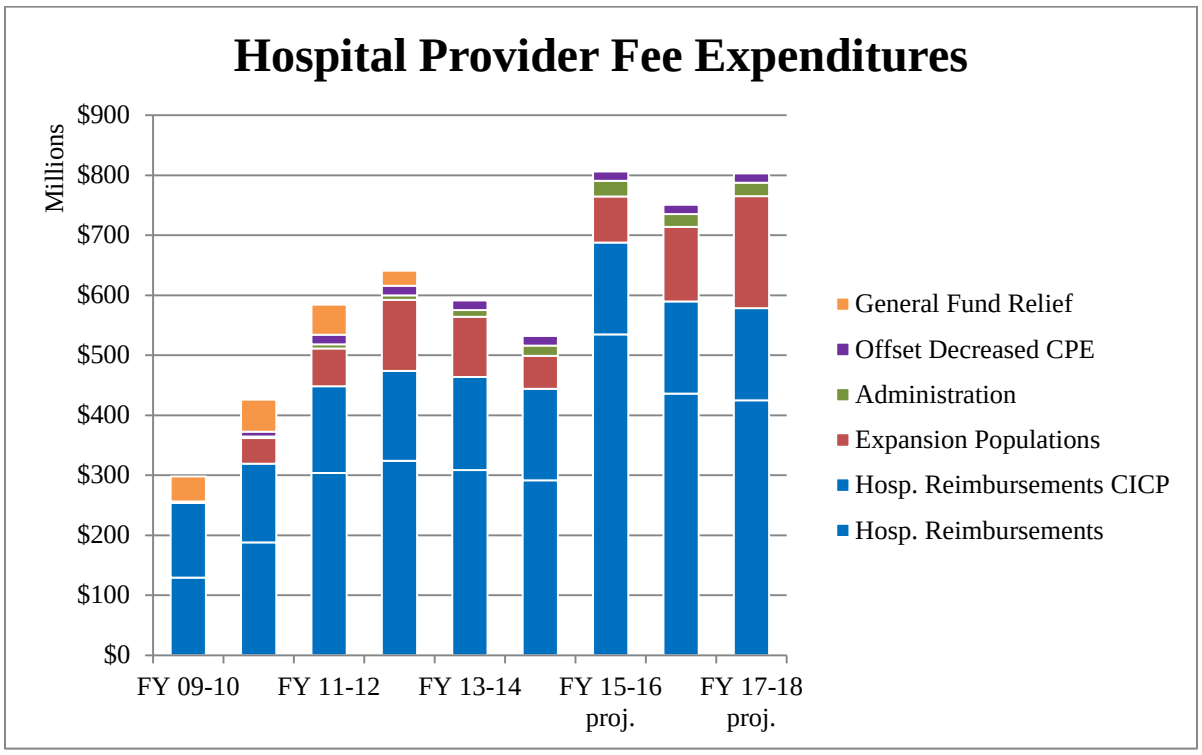
What is the Hospital Provider Fee?

The Hospital Provider Fee is an assessment on hospitals that includes one component based on beds filled per day and another component based on a percentage of outpatient charges. High volume Medicaid and Colorado Indigent Care Program providers and essential access providers pay discounted rates. Certain hospitals are exempted from the fee, including psychiatric hospitals, Medicare certified long-term care hospitals, and Medicare certified rehabilitation hospitals.

[5] Taxpayer's Bill of Rights (TABOR), or Article X, Section 20 of the Colorado Constitution.

How is the Hospital Provider Fee used?
The revenue from the Hospital Provider Fee is matched with federal funds and then used to increase reimbursements to hospitals, to pay for specific Medicaid eligibility expansions, to cover associated administrative costs, and in certain limited circumstances to offset the need for General Fund.

The table below summarizes actual and projected expenditures over time. These are just the expenditures from the Hospital Provider Fee and do not include the matching federal funds. The projections for FY 2016-17 and FY 2017-18 are before any potential adjustment for the Governor's proposed reduction in Hospital Provider Fee revenues.



In the graph the Hosp. Reimbursements and Hosp. Reimbursements CICP are both types of increased reimbursements to hospitals, but they are kept separate in the graph because they are appropriated in different line items. The Hosp. Reimbursements include payments to maximize inpatient and outpatient hospital reimbursements to up to the upper payment limits and quality incentive payments, pursuant to Sections 25.5-4-402.3 (4) (b) (I) and (III), C.R.S., that are appropriated in the Medical Services Premiums line item. The Hosp. Reimbursements CICP includes payments under the Colorado Indigent Care Program, pursuant to Section 25.5-4-402.3 (4) (b) (II), C.R.S., that are appropriated in the Indigent Care division in the Safety Net Provider Payments line item.

The General Fund relief was authorized by S.B. 10-169 and S.B. 11-242 and was essentially in place of provider rate decreases for hospitals in those years. The first bill, S.B. 10-169, allowed

the difference between the Hospital Provider Fee required for a fifty percent federal match and the Hospital Provider Fee required with the enhanced federal match provided by the American Recovery and Reinvestment Act (ARRA) to be applied to offset the need for General Fund. The second bill, S.B. 11-242, allowed for specific dollar amounts of $50 million in FY 2011-12 and $25 million in FY 2012-13 to be used to offset the need for General Fund.

The Offset Decreased CPE in the table could also be viewed as General Fund relief, although it is not described that way in statute. Prior to the adoption of the Hospital Provider Fee the General Assembly documented expenditures by local governments to support public hospitals and used these as certified public expenditures (CPE) to match federal funds for Medicaid reimbursement in lieu of using the General Fund. Implementation of the Hospital Provider Fee reduced the claimable CPE under federal rules[6] and so the Hospital Provider Fee took over the cost off offsetting the General Fund pursuant to Section 25.5-4-402.3 (4) (b) (VII), C.R.S., and continues to pay it at the historic level of $15.7 million per year.

How does the Hospital Provider Fee benefit hospitals?
The Hospital Provider Fee is primarily used to increase reimbursements to hospitals. Depending on the year, somewhere between 75 percent and 85 percent of the Hospital Provider Fee expenditures are on increasing hospital reimbursements. For each dollar collected for this purpose, hospitals receive in aggregate approximately two dollars in return. The formulas used to distribute the money result in some hospitals receiving a larger net benefit and some actually losing money on the exchange, but in aggregate hospitals come out significantly ahead financially by paying the Hospital Provider Fee. The financial incentive for hospitals is to maximize this portion of the Hospital Provider Fee. Even better than paying $1 and getting $2 in return is paying $2 and getting $4 in return.

In addition to increasing hospital reimbursement, the Hospital Provider Fee finances Medicaid and CHP+ eligibility expansions. The financial benefit to hospitals from subsidizing the expansion populations is a mixed bag. The eligibility expansions reduce uncompensated care for hospitals, potentially bring in new business for hospitals, and the federal match rates under the ACA are very favorable. However, some of the money from the Hospital Provider Fee that is used for expansion populations goes to providers other than hospitals. Also, expanding Medicaid and CHP+ eligibility may increase utilization of hospital services and to the extent that Medicaid and CHP+ reimburse below costs this could have a negative effect on hospital budgets compared to if the population did not utilize the services due to a lack of insurance. To varying degrees, depending on the institution, an increased utilization of hospital services may offset more or less of the value to hospitals of reducing uncompensated care. Trying to quantify the net benefit to hospitals from the portion of the Hospital Provider Fee devoted to financing expansion populations is a complicated and controversial analysis.

Where do hospitals get the money to pay for the Hospital Provider Fee? Do they increase charges to patients?

[6] The Hospital Provider Fee increased hospital reimbursements to the upper payment limit (UPL) allowed by the federal government, so certified public expenditures could not be used to claim additional federal reimbursement.

Hospitals get the money for the Hospital Provider Fee from cash on hand to pay future obligations, such as payroll or leased space. The Hospital Provider Fee is collected monthly and the payments are disbursed almost as quickly as the money is collected, typically in a matter of minutes or hours rather than days.[7] The Hospital Provider Fee transaction is complete before hospitals need the money for the other obligations. There is no need for hospitals to increase charges on patients to pay the Hospital Provider Fee and hospitals are explicitly prohibited from putting a line item on patient bills for the Hospital Provider Fee.[8]

Who determines the Hospital Provider Fee rates?
The Hospital Provider Fee rates are set annually by the Medical Services Board based on recommendations from the Hospital Provider Fee Oversight and Advisory Board. The rates must be set within federal limits. The federal Centers for Medicare and Medicaid Services (CMS) must approve both the rates and the plan for distributing the revenues.

Who is the Hospital Provider Fee Oversight and Advisory Board?
The Hospital Provider Fee Oversight and Advisory Board consists of 13 members appointed by the governor, with at least six from the hospital industry.

What are the federal limits on the Hospital Provider Fee?
Federal policies limit the Hospital Provider Fee to the lesser of the Upper Payment Limit or six percent of net patient revenues. Total Medicaid reimbursements to hospitals from all sources, including the Hospital Provider Fee, may not exceed the federal Upper Payment Limit (UPL). There are nuances to the calculation of the UPL, but it can be thought of as the amount Medicare would have paid for the same services. There are separate UPLs for different categories of service, so the UPL for hospitals is not the same as the UPL for nursing homes. At the same time total reimbursements to hospitals may not exceed the UPL, the Hospital Provider Fee may not exceed six percent of hospital net patient revenues. Net patient revenues are the actual payments received from patients (as opposed to the charges to patients) after factoring out discounts to insurers and uncompensated care. The net patient revenue limit is on aggregate revenues, rather than per hospital.

In addition to limiting total collections and expenditures, federal policies require that the Hospital Provider Fee be redistributive. In other words, hospitals may not receive exactly what they paid, as if the money never left their possession. Some hospitals must receive more than what they paid and some hospitals must receive less than what they paid in order to comply with the federal redistributive principal.

What are the Hospital Provider Fee revenue trends?
The recent expansion of Medicaid eligibility caused a level shift increase in revenues from the Hospital Provider Fee. Prior to the expansion, the most restrictive federal limit on Hospital Provider Fee revenues was the UPL. With the expansion there are more instances of an incremental difference between the Medicaid and Medicare reimbursement, so the dollar room

[7] Reimbursements to hospitals must occur as near to simultaneous with the collection of the fee as feasible, and no later than two days after the collection of the fee, pursuant to Section 25.5-4-402.3 (3) (e), C.R.S.
[8] Section 25.5-4-402.3 (3) (f), C.R.S.

under the UPL has increased significantly. The most restrictive federal limit is now six percent of net patient revenues.

While the level shift increase can be seen in the projections for the Hospital Provider Fee, there are variations in expenditures and revenues by state fiscal year that don't follow an overall upward pattern. This is mostly due to a delay in federal approval of the model year 2014-15 plan that caused revenues to move between fiscal years, but there are other factors contributing to the peripatetic revenue pattern. In 2012-13 the Department over-collected revenues due to a forecast error. Rather than refunding the money to the hospitals, the Oversight and Advisory Board recommended, and the Medical Services Board approved, carrying a balance to the next year and reducing the fee in model year 2013-14 accordingly. The model year 2013-14 revenue collections were also low due to conservative forecasting after some federal disallowances in prior years and due to uncertainty about Medicaid expansion populations. In model year 2014-15 the Department proposed a significant increase in the Hospital Provider Fee to recover from the low rates in model year 2013-14 and to incorporate the expected effect of the Medicaid expansion on the available room under the UPL. Approval from CMS of the large increase was delayed so that the Department had to operate under the model year 2013-14 plan for all of FY 2014-15. When CMS finally granted approval of the increase it was too late to reconcile revenue collections and disbursements in state FY 2014-15. All of the reconciliation occurred at the beginning of FY 2015-16. This explains the spike in revenue in FY 2015-16, but the spike could have been higher. Up until FY 2015-16 the Department had always collected three quarters of the model year's revenues in the first fiscal year and the remaining quarter in the second fiscal year. For model year 2015-16 the Department changed the schedule of collections to allow more time for potential delays in CMS approval. For the first three quarters of model year 2015-16, which are the last three quarters of state FY 2015-16, the Department will collect and disburse revenues at the model year 2014-15 rate and then in the last quarter of model year 2015-16, which is the first quarter of state FY 2016-17, the Department will increase collections and disbursements to account for the differences in the model years.

Hospital Provider Fee (in Millions) by State Fiscal Year and Model Year (without $100 M Reduction)												
Model Year	State Fiscal Year									TOTAL	$ Change	% Change
	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18			
09-10[1]	$302.9	$85.2								$388.1		
10-11		$355.8	$118.6							$474.5	$86.4	22.3%
11-12			$464.0	$154.7						$618.7	$144.3	30.4%
12-13				$496.4	$165.5					$661.8	$43.1	7.0%
13-14					$399.0	$133.0				$532.0	($129.8)	-19.6%
14-15[2]						$399.0	$289.4			$688.4	$156.4	29.4%
15-16[3]							$516.3	$211.0		$727.3	$38.9	5.6%
16-17[3]								$545.3	$222.8	$768.0	$40.7	5.6%
17-18[3,4]									$576.0	NA		
TOTAL	$302.9	$441.1	$582.7	$651.1	$564.5	$532.0	$805.8	$756.3	$798.8			
$ Change		$138.2	$141.6	$68.4	($86.6)	($32.5)	$273.8	($49.5)	$42.5			
% Change		45.6%	32.1%	11.7%	-13.3%	-5.7%	51.5%	-6.1%	5.6%			

[1] *Model Year 09-10 includes 5 quarters - July 2009 through Sept 2010.*

[2] *Model Year 14-15 reconciliation occurred in SFY 15-16.*

[3] *Assumes reconciliation occurs in beginning of next SFY (i.e., Model Year 15-16 reconciled in SFY 16-17).*

[4] *Does not include fees for Model Year 17-18 that will be collected in SFY 18-19.*

Is the Hospital Provider Fee the cause of the projected FY 2016-17 TABOR refund?

The Hospital Provider Fee is only one of many contributing revenue sources and not the cause of the projected FY 2016-17 TABOR refund. Whether a TABOR refund is due is based on total actual TABOR revenues from all sources compared to the limit. The popular notion that the Hospital Provider Fee is to blame for the projected TABOR refund is somewhat incongruous with the expected decrease in Hospital Provider Fee revenues in FY 2016-17 compared to FY 2015-16, with or without the Governor's request to restrict Hospital Provider Fee revenues.

However, there are several characteristics that set the Hospital Provider Fee apart from other revenue sources contributing to the projected TABOR refund. First, while the Hospital Provider Fee contributes to the need for a TABOR refund, the General Fund pays all of the cost for the TABOR refund under current law. This distinguishes the Hospital Provider Fee from the General Fund, but not from other cash funds. Second, the Hospital Provider Fee is relatively large, representing 19.2 percent of non-General Fund sources subject to TABOR in FY 2014-15 and the second largest source of non-General Fund subject to TABOR after the Highway Users Tax Fund. Third, the Hospital Provider Fee came about in FY 2009-10 and did not exist in FY 2007-08 when the Referendum C cap was established. Fourth, last year both Legislative Council Staff and the Office of State Planning and Budgeting made large mid-year adjustments to their revenue forecasts for the Hospital Provider Fee as the economists learned more about the level shift in Hospital Provider Fee revenue associated with the Medicaid expansion and the movement of revenue collections between state fiscal years. Fifth, there have been recent proposals to limit revenue from the Hospital Provider Fee or make the Hospital Provider Fee an enterprise. These characteristics may explain the amount of attention focused on the Hospital Provider Fee's contribution to the TABOR refund versus the contributions from other revenue sources.

Analysis of the Governor's request

The Governor proposes to reduce Hospital Provider Fee revenues by $100 million in FY 2016-17. The executive branch's revenue projections assume this reduction will continue into FY 2017-18. The primary benefit of adopting the Governor's request would be to reduce the General Fund obligation for the TABOR refund by $100 million, allowing the General Fund to be spent on other priorities. The $100 million is not linked to any specific priorities in the Governor's request, but it is necessary for the overall request to balance under the midpoint revenue forecast that the Governor selected.

Changing the revenue and projected TABOR refund by reducing the Hospital Provider Fee could potentially affect scheduled transfers to roads and capital construction pursuant to S.B. 09-228. If the TABOR refund is greater than 1 percent through 3 percent of TABOR revenues, these scheduled transfers are cut in half for that fiscal year. If the TABOR refund is greater than 3 percent of TABOR revenues, then the scheduled transfers are eliminated for that fiscal year. Under both the Governor's midpoint revenue forecast and the Legislative Council Staff's September revenue forecast, a $100 million reduction to the Hospital Provider Fee would not be enough to change the projected FY 2016-17 transfers for roads and capital construction. However, under the Governor's original September revenue forecast, a $100 million change to the Hospital Provider Fee would be enough to increase the projected transfers from $0 to $108.6 million for roads and $27.2 million for capital construction. While the reduction in the Hospital Provider Fee is not specifically to pay for roads and capital construction, the policy could make a difference in whether the scheduled transfers for roads and capital construction occur, depending on what happens with actual revenue.

The Governor proposes that the revenue reduction be accomplished through a statutory change. The JBC has requested a legal opinion regarding whether a statutory change is necessary. The Governor's budget transmittal letter promised statutory options to implement the lower fee collections, which were delivered to the JBC staff. Below are the three options identified by the Governor's office.

- Insert a specific revenue cap in statute for FY 2016-17 and FY 2017-18. This is the Governor's preferred approach and the benefits cited include: eliminating ambiguity about the amount that can be collected; establishing budget expectations for two years for planning purposes; and allowing for a negotiation in FY 2018-19 about the size of the fee.
- Insert language requiring the General Assembly to denote a revenue limit annually through a footnote in the Long Bill. Similar to the first option, this eliminates ambiguity about the amount that can be collected, but it could result in protracted annual negotiations of the revenue restriction that could present budget planning challenges.
- Rely on the existing statutory authority in Section 25.5-4-402.3 (3) (b) (III), C.R.S., that requires the Medical Services Board to set the Hospital Provider Fee so that the amount collected from the fee is "approximately equal to or less than the amount of the appropriation". From the executive branch's perspective, this type of directive regarding the revenue cap is not as explicit as the previous two options and could lead to differences of interpretation between the Hospital Provider Fee Oversight and Advisory Board and the

Medical Services Board. It also presents the same risks as the second option for protracted annual negotiations and budget uncertainty.

None of these options address the priority order for expenditures from the Hospital Provider Fee currently in statute, which is the main legal constraint the JBC staff sees with trying to implement the Governor's proposal. The statutory priority order places the financing of the Medicaid expansion populations last. The Governor is not proposing a reduction in Medicaid eligibility or benefits. One of the statutory priorities before Medicaid eligibility expansion is to "maximize" inpatient and outpatient hospital revenues up to the upper payment limit, which would be in jeopardy if revenues were reduced. If there are insufficient revenues to "fully fund" all of the prioritized uses of the Hospital Provider Fee, the Medical Services Board is required to adopt rules for reducing Medicaid eligibility or benefits. These rules have to be approved by the JBC before they could take effect, but if the JBC doesn't like the rules, then the JBC has to propose rules for limiting eligibility or benefits. Senate Bill 13-200 included provisions protecting the Medicaid expansion populations required to receive the ACA's enhanced federal match from reductions due to insufficient hospital provider fee revenues. Also, the ACA included a maintenance of effort requirement for eligibility for children until October 2019. The remaining eligibility criteria and benefits that are financed from the Hospital Provider Fee that could potentially be reduced are the disabled buy-in program, services for pregnant adults on CHP+, and continuous eligibility for children.[9]

The primary tradeoff if the proposed reduction to the Hospital Provider Fee is adopted is that hospitals would receive less federal funding in aggregate. Based on the expected federal match rates and the timing of the fee collections, $100 million from the Hospital Provider Fee would be projected to generate $102.2 million federal funds in FY 2016-17, and then the Hospital Provider Fee plus the matching federal funds would be paid back to hospitals according to formulas based on uncompensated and undercompensated care. In aggregate the net benefit to the hospitals from paying $100 million through the Hospital Provider Fee would be to gain $102.2 million federal funds, although the effect would vary by hospital. If the $100 million is not collected through the Hospital Provider Fee, the hospitals would lose $102.2 million federal funds, with varying effects by hospital.

When asked to estimate the fiscal impact of the $100 million reduction in the Hospital Provider Fee by hospital, the Department indicated it was not possible, because the annual distribution formula is not complete:

> *The Department cannot estimate the $100 million SFY 2016-17 fee reduction impact on net reimbursement by hospital because the new FFY 2015-16 model is under development. Distribution of net reimbursement (total supplemental payments less total fees) amongst hospitals in the new model will depend on changes in utilization patterns of all patients, Medicaid patients, and uninsured patients for each hospital relative to other hospitals. Because of these multiple variables, the distribution of net reimbursement to individual hospitals in FFY 2015-16 may vary greatly compared to the distribution of net reimbursement in FFY 2014-15.*

[9] The ACA maintenance of effort requirement for children applies to eligibility standards as of the passage of the ACA and so it does not apply to Colorado's continuous eligibility for children, which was implemented after the ACA.

The Department hopes to have a draft distribution formula that would show the effect by hospital prior to the December 15 meeting of the Hospital Provider Fee Oversight and Advisory Board. In the meantime, to provide a sense of the biggest beneficiaries from the Hospital Provider Fee, who would presumably be most affected by a restriction on revenue, the table below shows the net benefit of the increased reimbursements to hospitals in model year 2014-15 by hospital.

Hospital Provider Fee Model for Federal Fiscal Year 2014-15					
Hospital	Fees	Increased Reimbursements*	CICP Prior to HB 09-1293**	Net Gain	% of Total Net Gain
State Hospitals					
Colorado Mental Health Institute-Ft Logan	$0	$0	$0	$0	0.0%
Colorado Mental Health Institute-Pueblo	0	0	0	0	0.0%
University of Colorado Hospital	44,141,000	83,037,000	36,264,000	2,632,000	0.8%
	44,141,000	83,037,000	36,264,000	2,632,000	0.8%
Government Hospitals					
Arkansas Valley Regional Medical Center	2,782,000	7,604,000	1,375,000	3,447,000	1.0%
Aspen Valley Hospital	1,284,000	4,006,000	491,000	2,230,000	0.7%
Delta County Memorial Hospital	3,212,000	4,905,000	913,000	780,000	0.2%
Denver Health Medical Center	24,226,000	133,666,000	64,455,000	44,985,000	13.4%
East Morgan County Hospital	687,000	3,075,000	175,000	2,213,000	0.7%
Estes Park Medical Center	813,000	1,882,000	435,000	634,000	0.2%
Grand River Medical Center	864,000	4,271,000	191,000	3,217,000	1.0%
Gunnison Valley Hospital	577,000	2,629,000	42,000	2,009,000	0.6%
Haxtun Hospital	79,000	1,493,000	0	1,415,000	0.4%
Heart of the Rockies Regional Medical Center	1,245,000	4,320,000	248,000	2,827,000	0.8%
Keefe Memorial Hospital	141,000	1,407,000	0	1,266,000	0.4%
Kit Carson County Memorial Hospital	364,000	2,337,000	0	1,974,000	0.6%
Kremmling Memorial Hospital	363,000	2,346,000	117,000	1,866,000	0.6%
Lincoln Community Hospital and Nursing Home	253,000	1,302,000	0	1,049,000	0.3%
Melissa Memorial Hospital	180,000	1,171,000	40,000	951,000	0.3%
The Memorial Hospital	910,000	4,238,000	168,000	3,160,000	0.9%
Memorial Hospital	36,200,000	61,193,000	16,143,000	8,850,000	2.6%
Montrose Memorial Hospital	4,461,000	8,803,000	1,054,000	3,287,000	1.0%
North Colorado Medical Center	22,379,000	45,235,000	6,183,000	16,673,000	5.0%
Pagosa Mountain Hospital	309,000	1,396,000	0	1,087,000	0.3%
Pioneers Hospital	174,000	1,222,000	0	1,048,000	0.3%
Poudre Valley Hospital	22,569,000	41,024,000	5,935,000	12,520,000	3.7%
Prowers Medical Center	773,000	5,865,000	407,000	4,684,000	1.4%
Rangely District Hospital	96,000	1,469,000	0	1,373,000	0.4%
Sedgwick County Memorial Hospital	188,000	1,242,000	27,000	1,027,000	0.3%
Southeast Colorado Hospital	199,000	1,762,000	34,000	1,528,000	0.5%
Southwest Memorial Hospital	1,374,000	5,863,000	383,000	4,106,000	1.2%
Spanish Peaks Regional Health Center	368,000	2,863,000	136,000	2,359,000	0.7%
St. Vincent General Hospital District	207,000	2,106,000	118,000	1,781,000	0.5%
Weisbrod Memorial County Hospital	54,000	615,000	0	560,000	0.2%
Wray Community District Hospital	348,000	1,976,000	107,000	1,520,000	0.5%
Yuma District Hospital	454,000	2,000,000	98,000	1,448,000	0.4%
	128,133,000	365,286,000	99,275,000	137,874,000	41.2%

Hospital Provider Fee Model for Federal Fiscal Year 2014-15					
Hospital	Fees	Increased Reimbursements*	CICP Prior to HB 09-1293**	Net Gain	% of Total Net Gain
Private Hospitals					
Animas Surgical Hospital	823,000	1,959,000	0	1,136,000	0.3%
Boulder Community Hospital	17,665,000	17,226,000	1,064,000	(1,502,000)	-0.4%
Castle Rock Adventist Hospital	4,334,000	2,167,000	0	(2,167,000)	-0.6%
Cedar Springs Behavior Health System	0	0	0	0	0.0%
Centennial Peaks Hospital	0	0	0	0	0.0%
Centura Health - Avista Adventist Hospital	6,401,000	13,170,000	0	6,770,000	2.0%
Centura Health - Littleton Adventist Hospital	17,655,000	12,161,000	0	(5,495,000)	-1.6%
Centura Health - Parker Adventist Hospital	11,236,000	11,466,000	0	230,000	0.1%
Centura Health - Penrose -St. Francis Health Services	35,732,000	38,389,000	2,196,000	462,000	0.1%
Centura Health - Porter Adventist Hospital	17,359,000	15,311,000	0	(2,048,000)	-0.6%
Centura Health - Saint Anthony Central Hospital	20,813,000	24,179,000	0	3,366,000	1.0%
Centura Health - Saint Anthony North Hospital	10,429,000	19,562,000	0	9,133,000	2.7%
Centura Health - Saint Anthony Summit Hospital	2,050,000	3,359,000	0	1,309,000	0.4%
Centura Health - St. Mary-Corwin Medical Center	14,654,000	31,021,000	2,978,000	13,389,000	4.0%
Centura Health - St. Thomas More Hospital	3,218,000	8,126,000	780,000	4,128,000	1.2%
Centura Health - Ortho Colorado	1,589,000	80,000	0	(1,510,000)	-0.5%
Colorado Acute Long Term Hospital	0	195,000	0	195,000	0.1%
Colorado Plains Medical Center	3,057,000	6,561,000	163,000	3,342,000	1.0%
HealthOne Medical Center of Aurora	29,470,000	32,787,000	0	3,317,000	1.0%
HealthOne North Suburban Medical Center	13,926,000	24,067,000	0	10,141,000	3.0%
HealthOne Presbyterian/St. Luke's Medical Center	25,626,000	41,339,000	0	15,712,000	4.7%
HealthOne Rose Medical Center	21,328,000	24,383,000	0	3,055,000	0.9%
HealthOne Sky Ridge Medical Center	18,616,000	8,763,000	0	(9,853,000)	-2.9%
HealthOne Spalding Rehabilitation Hospital	0	106,000	0	106,000	0.0%
HealthOne Swedish Medical Center	32,425,000	32,312,000	0	(112,000)	0.0%
Community Hospital	3,495,000	5,121,000	171,000	1,456,000	0.4%
Conejos County Hospital	200,000	2,087,000	100,000	1,787,000	0.5%
Eating Recovery Center	0	0	0	0	0.0%
Craig Hospital	0	520,000	0	520,000	0.2%
Exempla Good Samaritan Medical Center	16,109,000	8,910,000	0	(7,199,000)	-2.2%
Exempla Lutheran Medical Center	29,514,000	35,260,000	0	5,746,000	1.7%
Exempla Saint Joseph Hospital	24,059,000	31,806,000	0	7,746,000	2.3%
Family Health West Hospital	475,000	1,604,000	0	1,129,000	0.3%
Haven Behavioral Senior Care at St. Mary-Corwin	0	0	0	0	0.0%
Highlands Behavioral Health System	0	0	0	0	0.0%
HealthSouth Rehabilitation Hospital - Denver	0	114,000	0	114,000	0.0%
HealthSouth Rehabilitation Hospital - COSprings	0	220,000	0	220,000	0.1%
Kindred Hospital	0	15,000	0	15,000	0.0%
Longmont United Hospital	10,277,000	18,654,000	1,634,000	6,743,000	2.0%
McKee Medical Center	7,297,000	11,606,000	2,132,000	2,178,000	0.7%
Medical Center of the Rockies	12,928,000	19,540,000	1,585,000	5,027,000	1.5%
Mercy Medical Center	6,291,000	14,408,000	535,000	7,583,000	2.3%
Mount San Rafael Hospital	978,000	4,855,000	135,000	3,742,000	1.1%
National Jewish Health	2,715,000	11,807,000	1,683,000	7,409,000	2.2%
Haven Behavioral Health at North Denver	0	0	0	0	0.0%
Vibra Long Term Acute Care Hospital	0	31,000	0	31,000	0.0%
Northern Colorado Long Term Acute Care Hospital	0	1,000	0	1,000	0.0%
Northern Colorado Rehabilitation Hospital	0	156,000	0	156,000	0.0%
Parkview Medical Center	27,857,000	47,088,000	3,604,000	15,628,000	4.7%

Hospital Provider Fee Model for Federal Fiscal Year 2014-15					
Hospital	Fees	Increased Reimbursements*	CICP Prior to HB 09-1293**	Net Gain	% of Total Net Gain
Peak View Behavioral Health	0	0	0	0	0.0%
Pikes Peak Regional Hospital	647,000	2,631,000	56,000	1,928,000	0.6%
Platte Valley Medical Center	4,917,000	12,844,000	1,499,000	6,428,000	1.9%
Rio Grande Hospital	407,000	1,955,000	51,000	1,497,000	0.4%
San Luis Valley Regional Medical Center	3,033,000	11,471,000	962,000	7,476,000	2.2%
Select Long Term Care Hospital	0	1,000	0	1,000	0.0%
Select Specialty Hospital - Denver	0	1,000	0	1,000	0.0%
St. Mary's Hospital and Medical Center	21,469,000	32,996,000	1,747,000	9,780,000	2.9%
Sterling Regional MedCenter	1,470,000	5,861,000	795,000	3,596,000	1.1%
Children's Hospital Colorado	21,866,000	58,140,000	2,855,000	33,419,000	10.0%
Kindred Hospital Aurora	0	2,000	0	2,000	0.0%
Vail Valley Medical Center	4,283,000	7,202,000	0	2,919,000	0.9%
Valley View Hospital	5,402,000	17,833,000	445,000	11,987,000	3.6%
Colorado West Psychiatric Hospital Inc	0	0	0	0	0.0%
Yampa Valley Medical Center	2,137,000	4,438,000	169,000	2,132,000	0.6%
	516,232,000	737,867,000	27,339,000	194,302,000	58.0%
TOTAL	$688,506,000	$1,186,190,000	$162,878,000	$334,808,000	100.0%

* These are direct payments only and do not include amounts earned from treating expansion populations.

** Removes from the net gain amounts that would have been paid through the Colorado Indigent Care Program prior to the creation of the Hospital Provider Fee.

Hospitals have benefited significantly from the Hospital Provider Fee. The direct net increase in hospital reimbursements from the Hospital Provider Fee identified in the table above for federal fiscal year 2014-15 is $334.8 million. In addition, hospitals receive indirect benefits to varying degrees from the increase in Medicaid eligibility. In R1 the Department estimates Medicaid eligibility expansions will cost $78.6 million from the Hospital Provider Fee and provide $1,428.9 million in additional federal funds to the state in FY 2016-17.

However, another way to look at the magnitude of the increase in hospital reimbursements attributable to the Hospital Provider Fee would be to view it as indicative of significant underfunding. The Hospital Provider Fee allows hospitals to be reimbursed up to the upper payment limit. The upper payment limit is essentially what Medicare would have paid for a similar service. So, the Hospital Provider Fee is filling a gap between Medicaid rates and Medicare rates. To the extent that Medicare rates are viewed as the appropriate level of reimbursement, the Hospital Provider Fee is helping to solve chronic underfunding by Medicaid. While the Hospital Provider Fee closes a large portion of the gap between Medicaid and Medicare rates, the net benefit to the hospitals is only half of the total closure in the gap, because half the money to close the gap comes from the hospitals themselves. So, while the hospitals are better off with the Hospital Provider Fee, there is a still a significant difference between the net reimbursement under Medicaid with the Hospital Provider Fee and Medicare rates.

Switching Hospital Provider Fee Reimbursements for a Rate Increase

In an environment where a TABOR refund is due, the Hospital Provider Fee is an inefficient way to deliver funding to hospitals. As noted above, the expected net benefit to hospitals of collecting $100 million through the Hospital Provider Fee is $102.2 million. The cost to the General Fund is an increase in the TABOR refund of $100 million. So, indirectly the General Assembly is spending $100 million General Fund to give the hospitals $102.2 million. It is almost the same as a direct General Fund appropriation with no federal match. Compare this to if the General Assembly did away with $100 million in Hospital Provider Fee revenues and instead spent $100 million General Fund on a rate increase for the hospitals. At the projected standard FMAP rate for state FY 2016-17 of 50.42 percent, $100 million General Fund would match $101.7 million federal funds to provide a net benefit to the hospitals of $201.7 million. The hospitals would not have to pay $100 million through the Hospital Provider Fee to get the rate increase. Already, this is a more efficient way to deliver funding to the hospitals with the same amount of General Fund, but in reality the state could get a much higher federal match. Enhanced federal matching funds are available for hospital rates based on the population served and in some cases the services provided. The largest example is hospital rates for services to people newly eligible for Medicaid under the Affordable Care Act, which are eligible for a 100 percent federal match for calendar year 2016 and a 95 percent match for calendar year 2017. Based on the projected caseload and service mix in the Department's request, an increase in hospital rates would be expected to receive an average federal match of 68.42 percent in FY 2016-17. At that average match rate, allocating $100 million General Fund for a provider rate increase would match $216.7 million federal funds to provide a net benefit to hospitals of $316.7 million.

Another way to look at this is the General Fund cost to provide a net benefit to hospitals of $102.2 million. In a TABOR refund environment, the General Assembly would need to spend $100 million General Fund on the TABOR refund to provide that much money to hospitals through the Hospital Provider Fee. The General Assembly could provide the same dollar benefit to hospitals through a rate increase at a cost of only $32.3 million General Fund. If the General Assembly eliminated $100 million from the Hospital Provider Fee to save $100 million from the TABOR refund and then spent $32.3 million General Fund on a rate increase for hospitals, the net benefit to the General Fund would be a savings of $67.7 million. This would be less than the $100 million General Fund the Governor proposed saving, but there would be no loss in aggregate funding for the hospitals. Implementing such a switch would require CMS approval with all the associated risks of delays. It might also result in a redistribution of funding between hospitals compared to current practice. To some extent the redistribution of funding could be mitigated through the formula that is currently under development for distributing the remaining Hospital Provider Fee, but switching the Hospital Provider Fee for a rate increase would not likely be a one for one exchange on an individual hospital basis.

	Scenario 1 Governor's Request	Scenario 2 Switch HPF for a Rate Inc.
Net General Fund benefit from limiting HPF revenue		
TABOR refund	($100,000,000)	($100,000,000)
General Fund for rate increase	$0	$32,281,665
General Fund savings	($100,000,000)	($67,718,335)
Net hospital loss from limiting HPF revenue		
Reduced HPF obligation	$100,000,000	$100,000,000
Reimbursements through HPF	($202,221,864)	($202,221,864)
Rate increase	$0	$102,221,864
TOTAL	($102,221,864)	$0

It would also be possible to design a scenario to get the same net General Fund savings as the Governor proposed while mitigating the negative effects on hospital reimbursements or even holding hospital reimbursements harmless. This would require a larger reduction in Hospital Provider Fee revenues to create more General Fund savings to pay for a rate increase.

Because of the statutory prioritization of funding from the Hospital Provider Fee, the JBC staff believes any reduction in Hospital Provider Fee revenues is best accomplished by a bill. However, potentially an argument could be made that if Hospital Provider Fee funds are replaced with a rate increase the expenditures within the Upper Payment Limit remain maximized.

Hospital Provider Fee as a TABOR Enterprise

Last year the Governor proposed that rather than limiting the Hospital Provider Fee revenue, the General Assembly designate the Hospital Provider Fee as part of an enterprise, which would make the revenue exempt from TABOR. He then went one step further and argued that doing so would not require an adjustment to the TABOR base. House Bill 15-1389 (Hullinghorst & Court / Steadman) was introduced to implement the idea, but it was postponed indefinitely in the Senate's State, Veterans, and Military Affairs Committee. If something similar to H.B. 15-1389 was implemented in FY 2016-17, it would remove approximately $756 million in projected revenue attributable to the Hospital Provider Fee from the calculation of whether a TABOR refund is due. This is more than enough to eliminate the projected General Fund obligation for a TABOR refund in FY 2016-17 in all of the revenue forecast scenarios.

Compared to the Governor's request, there would be two main benefits to making the Hospital Provider Fee an enterprise in a manner similar to what was proposed in H.B. 15-1389:

- The General Fund would not need to pay the $189.1 million TABOR refund projected in the Governor's mid-point forecast.
- There would be no budget balancing reason to implement the proposed $100 million reduction in Hospital Provider Fee revenues.

Pursuant to S.B. 09-228, some of the General Fund savings from eliminating the TABOR refund would be directed to roads and capital construction. Using the Governor's mid-point forecast the projected diversions for roads and capital construction would increase by a total of 134.3 million, including $107.4 million for roads and $26.9 million for capital construction. The diversions for

roads and capital construction are in statute and could potentially be modified, if it was the intent of the General Assembly to use the General Fund savings from designating the Hospital Provider Fee as an enterprise for a different purpose.

There would be some secondary effects from designating the Hospital Provider Fee as an enterprise. First, the conservation easement tax credit would remain non-refundable. Pursuant to Section 39-22-522 (5) (b), C.R.S., a portion of the tax credit becomes refundable if a TABOR surplus is due. Legislative Council Staff estimates that this would increase General Fund revenue projections by approximately $5.2 million in FY 2016-17 and $10.5 million in FY 2017-18. Second, the General Assembly would be allowed to eliminate tax expenditures without prior voter approval in FY 2016-17, if it wanted, which could increase General Fund revenues. The conclusion that limiting tax expenditures without prior voter approval is allowable when it doesn't cause a TABOR refund is based on the Colorado Supreme Court's decision in Mesa County Bd. of County Comm'rs v. State.

The two main downsides to designating the Hospital Provider Fee as an enterprise are that: (1) it may not be constitutional; and (2) it eliminates projected TABOR refunds taxpayers could otherwise expect to receive. There could be legal costs if a designation of the Hospital Provider Fee as an enterprise is challenged. If it is found unconstitutional, the state would owe a refund for money retained illegally through the policy for up to four full fiscal years prior to the date a suit is filed, plus 10 percent annual simple interest.

The dollar risk of designating the Hospital Provider Fee as an enterprise and subsequently receiving a court determination that it is unconstitutional is dependent on when a law suit is filed and resolved and on how much revenue is retained. For illustration purposes, the JBC staff assumed a law suit would be filed and resolved within one year. If the General Assembly didn't reduce Hospital Provider Fee revenues and instead designated the Hospital Provider Fee as an enterprise, and this was found to be illegal, then the Governor's midpoint forecast of the inappropriately retained dollars in FY 2016-17 would be $289.1 million. Add to this 10 percent simple annual interest and the refund due would be $318.0 million. In this scenario, designating the Hospital Provider Fee as an enterprise would provide $189.1 million in General Fund flexibility compared to the Governor's request, but would risk $318.0 million General Fund in increased TABOR refunds, plus legal fees, if it was found unconstitutional.

To be an enterprise under TABOR an entity must:

1. Be a government-owned business
2. Have authority to issue revenue bonds
3. Receive less than 10 percent of annual revenue from state and local governments

The argument for the Hospital Provider Fee being a government-owned business is that the Department employees working on the Hospital Provider Fee are acting as brokers between the hospitals and the federal government. It may or may not be relevant to the strength of this argument that only state governments can perform this particular type of intermediary service in the Medicaid program. House Bill 15-1389 would have granted authority to issue revenue bonds to address the second enterprise criteria. No General Fund is used to support the Hospital

Provider Fee, and so the last of the enterprise criteria is not difficult to satisfy. Whether the Hospital Provider Fee meets the TABOR enterprise most likely hinges on whether it is viewed as a government-owned business.

Meeting the TABOR enterprise criteria doesn't provide a General Fund windfall by itself, because TABOR requires that the base be adjusted when an entity qualifies as an enterprise. Referendum C has a similar requirement. The way this is done administratively is by removing the contribution of the entity qualifying as an enterprise from the prior year base and then applying the adjustments for population and inflation to determine the cap for the year the entity qualifies as an enterprise.

The Office of State Planning and Budgeting argues that the Hospital Provider Fee made no contribution to the prior year base, and so the adjustment to the base would be $0. This argument stems from the way Referendum C changed the allowable revenue under TABOR. Referendum C allowed the state to retain revenue based on the highest revenue from FY 2005-06 through FY 2009-10, adjusted annually for inflation, population, any voter-approved debt service, and the qualification or disqualification of enterprises (see the definition of the Excess State Revenues Cap in Section 24-77-103.6 (6) (b) (I) (B), C.R.S.). There is no ratchet down under Referendum C if actual revenue in a given year is less than the Excess State Revenues Cap (Ref. C Cap), so the Hospital Provider Fee is not propping up the Ref C Cap in low revenue years. The year with the highest state revenue that established the Ref. C Cap was FY 2007-08. The state did not generate revenue from the Hospital Provider Fee until FY 2009-10. Revenue from the Hospital Provider Fee did not contribute to the initial establishment of the Ref. C Cap and the Ref. C Cap adjusts annually for inflation and population growth independent of however much or little revenue is generated from the Hospital Provider Fee. Therefore, the argument goes, if the Ref. C Cap is adjusted for the contribution of the Hospital Provider Fee, then the adjustment is $0.

In addition, last year's bill, H.B. 15-1389, eliminated the existing Hospital Provider Fee and replaced it with a new Hospital Provider Fee, adding another argument for why the Ref. C Cap shouldn't be adjusted. The contribution of a brand new fee to the prior year base is clearly $0. For these reasons, the legislative declaration in H.B. 15-1389 explicitly stated that the bill did not require or authorize an adjustment to the TABOR base or Ref. C cap.

Issue: Federal Approval Process for Changes to Medicaid (R1, R12, $100 million from HPF)

This issue brief describes the federal approval process for changes to Medicaid in order to shed light on recent delays the Department has experienced in implementing new policies of the General Fund. It also provides an update on the implementation status of new policies approved by the General Assembly.

SUMMARY:

- There is wide variation in the amount of time required to receive federal approval for a change to Medicaid with some changes requiring more than a year.
- Changes to rates tend to take less time than changes to rate methods which tend to take less time than changes to eligibility and benefits.
- Changes to implement new or unusual policies that have not been used in other states tend to take more time.
- The areas of concern of the federal Centers for Medicare and Medicaid Services (CMS) change over time and CMS is currently paying particularly close attention to waiver amendments, slowing the approval process for these types of amendments.
- Five of the rate increases approved by the General Assembly last year are still pending approval by CMS with the largest pending item being the increase in personal care and homemaker rates.
- None of the eligibility and benefit changes approved by the General Assembly last year have been approved yet.

DISCUSSION:

Summary

Recently, several policies approved by the General Assembly have experienced delays in implementation due to complications in getting approval from the federal Centers for Medicare and Medicaid Services (CMS). These delays cause problems for clients and providers waiting for the changes. They also present problems for accurately forecasting the costs and or savings associated with the policy changes. This issue brief provides some background on the approval process and an update on the status of changes recently submitted to CMS for approval.

Approval Process

Most of the operations of Colorado's Medicaid, including the eligibility criteria, benefits, and provider reimbursements, are governed by the State Plan that is developed by the Department and approved by the state Medical Services Board and the federal CMS. The state plan covers policies that are within the federal standards for all states, or are specifically federally authorized options for states such as the breast and cervical cancer program. A change to eligibility, benefits, or provider reimbursements covered by the State Plan generally requires a State Plan Amendment (SPA) that must be approved by CMS.

In some cases states apply for a waiver to offer eligibility, benefits, or provider reimbursements that differ from the standard federal Medicaid. Waivers are unique from one state to the next. Most of the approved waivers for Colorado are for home and community based services intended to reduce or delay institutionalization. A change to eligibility, benefits, or provider reimbursements covered by a waiver requires a waiver amendment.

The distinction between amendments to the State Plan versus amendments to waivers can be important because the federal approval procedures are different. One of the key differences is the effective date of changes. State Plan Amendments may be retroactive to the first day of the quarter when the SPA was submitted to CMS. Waiver amendments may not take effect until the amendment is approved.

The bullets below summarize the steps required to get federal approval of a SPA or waiver amendment. Depending on the nature of the SPA or waiver amendment, OSPB and legislative approval may also be required.

- **Department Preparation:** Before submitting a SPA or waiver amendment to CMS, the Department must draft the amendment and receive approval from the Medicaid Director. The Department indicates this commonly takes 2-4 months, but the preparation time can be significantly shorter or longer based on factors such as the complexity of the change, the number of people and procedures affected, and whether the proposal is routine or unusual for CMS. The Department is frequently in informal communication with CMS during this stage and may change an amendment before it is submitted based on the feedback received. Some SPAs and waiver amendments also require a corresponding change to the rules that must be approved by the Medical Services Board.

- **Public Notice:** SPAs and waiver amendments require tribal consultation and public notification. The notification must be in an electronic and print format and at least in the Colorado register, but more complex amendments may also need to be in the newspapers of widest circulation for cities with a population of 50,000 or more. The public notification requirements for SPAs are a little less stringent than for waiver amendments. For a SPA tribal consultation must be issued 30 days prior to submission to CMS and public notification must occur prior to the effective date. For practical and regulatory reasons the public notification for SPAs generally occurs at least a month prior to the effective date. For a waiver amendment tribal consultation must be issued at least 60 days prior to submission. Public notification must be at least 30 days prior to submission to CMS, but also must be sufficient in light of the scope to ensure meaningful opportunities for input as determined by CMS.

- **CMS approval:** CMS has 90 days from when they receive a proposed SPA or waiver amendment to take action or the proposal is deemed adopted. However, this can be deceiving, because one of the actions CMS can take is to send a request for additional information (RAI), and if HCPF submits a response to an RAI a new 90-day clock begins for CMS. The Department can also withdraw and resubmit a SPA or waiver amendment to address CMS concerns, starting a new 90-day clock. As a result, the duration of time from

original submission to CMS approval can be much longer than 90 days. The Department also tracks what it refers to as informal RAIs that do not start a new 90 day clock.

Typical Time Required for Approval

There is wide variation in the amount of time required to get CMS approval. Between January 1, 2014 and September 28, 2015 the Department received approval for 72 SPAs and the number of days from original submission to CMS to final approval ranged from 8 to 503. These statistics are just for CMS approval and do not include the time for the department to prepare the submittal or for public notification.

SPAs from 1/1/14 through 9/28/15					
Status	Number of SPAs	Average Days Elapsed	Median Days Elapsed	Minimum Days Elapsed	Maximum Days Elapsed
Pending – Submitted	5	69	74	3	117
Pending - More Information Requested	4	245	214	157	396
Approved	72	84	55	8	503
Total	81	91	56	3	503

The type of SPA or waiver amendment can provide clues to how much time CMS will take for approval. Changes to rates within the existing rate methodology tend to take the least time. A change to the rate methodology will likely take more time than a change to the rate. Changes to benefits tend to take less time than changes to eligibility.

Approved SPAs by Category from 1/1/14 through 9/28/15					
Category	Number of SPAs	Average Days Elapsed	Median Days Elapsed	Minimum Days Elapsed	Maximum Days Elapsed
Rate Change	45	63	54	8	324
Benefit Policy	9	67	56	21	138
Rate Methodology, Benefit Policy, & Provider Policy	1	72	72	72	72
Provider Policy	3	99	83	75	140
Rate Methodology	3	110	69	64	198
Other	5	130	90	8	297
Eligibility Policy	3	133	84	83	232
Rate Methodology & Benefit Policy	3	290	357	10	503
Total	72	84	55	8	503

Some SPAs and waiver amendments must be approved by the CMS central office rather than the regional office and the Department indicates that approval for these proposals typically takes longer. The Department categorizes SPAs and waiver amendments based on whether they are routine or new and unusual, and therefore likely to require CMS central office approval. New or unusual policies are those that few, if any, states have implemented before. The Department is not always accurate in predicting which proposals will require CMS central office approval. For example, the Department might not be aware of CMS efforts to alter a policy. For SPAs the Department expected to be routine, the median days for CMS approval was 54, but there was a range of 8 days to 324 days for CMS approval. For proposals the Department categorized as

new or unusual the average days for CMS approval was 251, with a range of 72 days to 503 days.

Approved SPAs by New or Unusual Policy Flag from 1/1/14 through 9/28/15					
Is Policy New or Unusual to CMS?	Number of SPAs	Average Days Elapsed	Median Days Elapsed	Minimum Days Elapsed	Maximum Days Elapsed
Yes	7	251	232	72	503
No	65	66	54	8	324
Total	72	84	55	8	503

Over the last several months the Department has experienced unusually long delays in getting CMS approval for waiver amendments for Home and Community Based Services (HCBS). The Department indicates that this sometimes happens when a new rule is released or an area of policy becomes a point of emphasis for CMS. The Department can point to various times in the past when there were similar approval delays for amendments related to managed care, amendments affecting the upper payment limit, and amendments related to information technology. However, the Department believes the current delays for HCBS waiver amendments are long even compared to previous delays for CMS areas of emphasis. The Department attributes the current delays to a new federal rule that was implemented in March 2014 that changed the requirements for services offered.

HCBS Waiver Amendments from 1/1/14 through 9/28/15					
Status	Number	Average Days Elapsed	Median Days Elapsed	Minimum Days Elapsed	Maximum Days Elapsed
Pre Final Rules - Approved	10	103	84	62	279
Post Final Rules – Approved	2	357	357	354	360
Post Final Rules – Disapproved	1	90	90	90	90
Post Final Rules - Pending	12	326	364	53	563
Total	25	230	192	53	563

Status of Policy Changes Approved by the General Assembly

The table below summarizes the federal approval status of policy changes that the General Assembly has approved. Some of these are policy changes authorized in the budget and others were authorized in bills. These are generally discretionary policies that cost money. The Department submits many more SPAs and waiver amendments to CMS than just those for policy changes approved by the General Assembly. For example, the Department might submit a SPA to implement a new federal rule, or an amendment to renew an existing waiver that is scheduled to expire. Some of the status updates the Department has shared with the JBC in the past include these SPAs and waiver amendments that are not the direct result of actions by the General Assembly. This table is limited to just the SPAs and waiver amendments for policy changes approved by the General Assembly. This includes all of the policy changes that required a SPA or waiver amendment that were approved by the General Assembly in FY 2015-16 and a few policy changes from prior years that the JBC staff knows are still pending approval.

Status of Policy Changes Approved by the General Assembly

Policy Change	Approved/Denied Status	Approved/Denied Date	Submitted Date	Days Elapsed[1]	Effective Date	Appropriated Funds Total $s	Appropriated Funds GF	Notes
Rate Increases								
Personal care/homemaker to $17/hr.	Submitted		10/29/15	35	TBD	14,547,292	7,073,723	Had to establish new rate methodology per CMS guidance.
Special Connections per diem rate	RAI		6/3/15	183	7/1/15	227,604	111,683	The Department submitted a State Plan Amendment to implement the rate increases on 6/3/2015. CMS had outstanding questions about the FY 2014-15 clinic upper payment limits and issued a Request for Additional Information (RAI). The Department continues to work with CMS to gain approval of the rate increase.
Special Connections outpatient group	RAI		6/3/15	183	7/1/15	23,835	11,696	CMS had outstanding questions about the FY 2014-15 clinic UPLs, and issued an RAI accordingly. Finance staff are currently awaiting informal feedback from CMS; the Department will submit RAI response following receipt of this feedback.
In-home respite	Submitted		10/29/15	35	TBD	66,320	30,977	Pending CMS approval. Originally intended for submission in summer. Had to establish new rate methodology per CMS guidance.
0.5% across-the-board for MSP 1.7% across-the-board for all other lines	Approved except Clinic Services				7/1/15	22,566,820	8,611,911	Separate SPAs submitted for each service category receiving the ATB rate increase. Thus, the dates on which the rate increases were submitted, approved by CMS, and mass adjusted vary depending on the service category. Awaiting approval for Clinic Services, which include Ambulatory Surgery Centers and Dialysis Centers.
Dental fillings and extractions to 65% of customary	Approved	7/1/15	5/26/15	36	7/1/15	15,058,255	4,094,339	
Anesthesia services	Approved	7/28/15	6/3/15	55	7/1/15	12,862,698	4,300,000	
Private duty nursing to $45 per hour	Approved	6/15/15	6/2/15	13	7/1/15	5,167,006	2,512,143	
Eye materials for children	Approved	6/11/15	6/2/15	9	7/1/15	3,995,056	1,837,053	
Physical and occupational therapy services	Approved	6/30/15	6/3/15	27	7/1/15	3,587,269	1,075,534	
Dental sealants for children	Approved	7/1/15	5/26/15	36	7/1/15	1,484,511	682,625	
Emergency medical transportation	Approved	7/15/15	6/3/15	42	7/1/15	1,109,263	300,000	
Prenatal and postpartum care services	Approved	7/28/15	6/3/15	55	7/1/15	624,511	306,442	
Diabetic self-management education group visits	Approved	7/28/15	6/3/15	55	7/1/15	485,433	162,280	
Vision retinal services	Approved	7/28/15	6/3/15	55	7/1/15	407,583	136,255	
Dental X-rays	Approved	7/1/15	5/26/15	36	7/1/15	365,089	99,278	
Prostate biopsy	Approved	7/28/15	6/3/15	55	7/1/15	5,485	1,206	

Status of Policy Changes Approved by the General Assembly

Policy Change	Approved/Denied Status	Approved/Denied Date	Submitted Date	Days Elapsed[1]	Effective Date	Appropriated Funds Total $s	Appropriated Funds GF	Notes
Eligibility/Benefit Changes								
HB 15-1186 Services for children with autism	**DENIED**	9/1/15	6/16/15	77	N/A	10,616,568	367,564	
HB 15-1318 Consolidate IDD waivers	In progress				TBD	2,176,695	788,347	HB15-1318 requires the Department to submit the waiver by 7/1/16
Consumer direction for supported living services	RAI		8/6/15	119	TBD	1,253,761	592,765	Developing new rate methodology per CMS guidance
Lifetime cap on home modifications to $12,500 (from FY 14-15)	Submitted		9/29/14	430	TBD	1,015,384	500,000	The Department did not receive approval from CMS for the increase to $12,500 before the General Assembly approved another increase to $14,067. The Department submitted new waiver amendments with the $14,067 amount on 10/29/15. That increase is also still pending.
Lifetime cap on home modifications to $14,067	Submitted		10/29/15	35	TBD	711,238	350,000	Had to establish new rate methodology per CMS guidance. Dates reflect amendment to BI waiver. Multiple waiver amendments were submitted for each waiver with a home modfication benefit.
HB 15-1309 Protective restorations by dental hygienists	In progress				TBD	37,606	10,815	Working with CMS to see if a SPA is necessary. The Virtual Dental Home project team at Caring for Colorado has what it needs from the Dept. in terms of billing structure to proceed with building their business & budget model with the selected pilot sites. Expect to discuss iC systems needs in Spring 2016.
SB 15-011 Spinal cord injury alternative medicine pilot program	RAI		3/31/15	247	TBD	362,649	179,347	Pending CMS approval. CMS issued a formal RAI on 6/6/15 and provided an extension letter on 6/18/15 and 9/4/15.
Annualized income for adults	In progress				TBD	0	0	On track for implementation 7/1/2016 when funds will be appropriated. Submission estimated April/May 2016.
Denver Health nursing home services for chronically acute long-stay patients	In progress					2,000,000	1,000,000	Submission estimated 12/31/15

[1] *Days elapsed is from the date of submittal to either approval/denial or to 12/3/15 when this update was prepared.*

The largest rate increase still pending CMS approval is for personal care and homemaker services. The Department reduced the Medical Services Premiums forecast in R1 to reflect a revised assumption that the rate increase will not start until January 1, 2016.

As noted earlier, CMS is currently paying particularly close attention to waiver amendments related to home and community based services. With this amendment there were also some technical errors with the Department's noticing procedures. Another issue is that the CMS-approved methodology for determining the rates for Consumer Directed Attendant Support Services references the personal care and homemaker service rates.

To date none of the eligibility and benefit changes on the list have been approved by CMS. One has been denied and four have not yet been submitted to CMS. One has been pending CMS approval for 430 days and another for 247 days.

Issue: Provider Rate Review (R1, R12, $100 million from HPF)

This issue brief provides a status update on the provider rate review process created by S.B. 15-228 and discusses how that process relates to the Governor's FY 2016-17 request.

SUMMARY:

- The Department has convened the rate review advisory committee, set a five-year schedule for reviewing rates, and begun gathering data for a report on the year 1 rates that is due May 1, 2016. Review and comment on the Department's report will happen over the summer. Incorporation of the analysis into the Governor's request will be completed by November 1, 2016. A report to the JBC is due November 1, 2016.
- The Department submitted a comparison of Medicaid rates to Medicare or usual and customary rates that found transportation, dental, and practitioner rates were more than 70 percent below the benchmark. The report found that rates for home health and private duty nursing were above the benchmark.
- The JBC may want to consider engaging the advisory committee informally to provide feedback on the Governor's proposed rate reductions.

DISCUSSION:

Last year the JBC introduced a bill (S.B. 15-228) establishing an annual process for the Department to review Medicaid rates. In addition, the JBC sent a request for information to the Governor asking for a comparison between Medicaid rates and Medicare rates, or for cases without a comparable Medicare rate the usual and customary rate.

The Governor is not proposing increases in provider rates for FY 2016-17, but the review process created in S.B. 15-228 was designed to gather data and provider feedback that could inform decisions about decreases in provider rates just as much as decisions about increases. There are several items in the Governor's request potentially related to the S.B. 15-228 provider rate review. For example, the Governor proposed an across-the-board decrease of one percent in most discretionary provider rates. Also, the Governor's request does not provide funding to renew a primary care rate bump that is scheduled to expire in FY 2016-17, effectively cutting primary care rates compared to FY 2015-16. Another issue that could potentially be viewed as germane to the provider rate review is the proposed $100 million reduction to Hospital Provider Fee revenues, which the Governor requests come out of hospital booster payments. Booster payments fall in a grey area, because they are not a part of the fee-for-service schedule, but they are a part of total compensation to hospitals. There is no definition of what constitutes a provider rate in S.B. 15-228. The Department did not treat booster payments as provider rates subject to review, because it neither scheduled them for review nor specifically requested they be exempted. It may be useful for the JBC to think about how it wants to engage with the S.B. 15-228 provider rate review process as the Committee works through the Governor's request.

S.B. 15-228 Rate Review Process

Senate Bill 15-228 created an advisory committee to assist the Department of Health Care Policy and Financing with the annual rate review. The advisory committee consists of representatives for Medicaid providers and clients appointed by the legislative leadership. The duties of the advisory committee include helping to set the schedule for rate reviews and determining which rates are subject to review, providing comments and feedback on the Department's reports, assisting in public hearings on rates, and recommending process improvements.

As of the drafting of this issue brief the advisory committee had met twice and elected leadership, adopted operating rules, and approved an initial five-year review schedule. The advisory committee was scheduled to meet again December 4, 2015. Rates subject to review must be reviewed at least once every five years, but rates may be reviewed more frequently, and the advisory committee or the Joint Budget Committee may request a rate be reviewed out of order.

The rates scheduled for review in the first year include:

- Non-emergency Medical Transportation
- Emergency Transportation
- Private Duty Nursing
- Home Health
- Pathology and Laboratory
- Physician Administered Drugs

The rate review includes four phases:

1. An analysis of access, services, quality, and utilization and a comparison of rates to available benchmarks, culminating in a report
2. A review of the findings by the Department and the advisory committee, including receiving public comment, and development of strategies for responding
3. Incorporation of the analysis into the executive branch's process for developing statewide budget priorities
4. A report to the Joint Budget Committee and the advisory committee containing recommendations for addressing provider rates, and the data relied upon to arrive at the recommendations, for consideration in formulating the budget

Based on the statutory rate review schedule, the JBC will not receive formal recommendations out of the rate review process until next year. The Department is currently gathering data about the rates scheduled for review in the first year for the phase 1 report due by May 1, 2016. The phase 2 review and comment will happen over the summer. The phase 3 incorporation of the analysis into the Governor's request will be completed by November 1, 2016. The phase 4 report to the JBC is due November 1, 2016.

However, the JBC could consider engaging the advisory committee informally to provide feedback on the Governor's proposed rate reductions. For example, the JBC could ask the

advisory committee to look at the scheduled decrease in primary care rates and provide feedback on whether it makes sense to allow the reduction to occur. The JBC could ask the advisory committee to look at the Department's report about the effect of the primary care rate bump on access to see if there are potentially alternate conclusions from the data, or if there are parts of the story not included. The JBC could ask the advisory committee whether the effect on primary care providers should be mitigated by making reductions in other rates or spreading reductions across a broader range of providers. On a different topic, the JBC might consider asking the advisory board for feedback on how to interpret the Department's report comparing Medicaid and Medicare rates. As described below, some of the findings are surprising and it is possible that the advisory committee could shed light on what is really happening with the rates. The JBC staff is unsure if this type of informal engagement with the advisory committee would be helpful to the Committee's deliberations. It is being presented here as a possible course of action for consideration, rather than as a recommended approach.

Methods for Assuring Access to Covered Medicaid Services (CMS-2328-F)

The rate review process in S.B. 15-228 was intended to align with a new rule CMS was developing to ensure Medicaid rates provide sufficient access to care. However, November 2, 2015 final rule issued by CMS included some unanticipated elements. Based on the final rule, the Department will need to do a review of a subset of Medicaid rates every three years. The subset of rates includes: primary care services; physician specialist services; behavioral health services (including mental health and substance abuse disorder treatment); pre- and post-natal obstetric services including labor and delivery; home health services; services where either payment rates have been reduced or restructured; and services for which a higher than usual volume of beneficiaries, providers, or stakeholders have raised access to care issues. The new CMS rule may require modifications to the Department's rate review schedule.

In addition, all SPAs reducing rates must be submitted with an analysis of access to care and then reviewed for a minimum period of 3 years. The Department believes the requirement for an analysis of access to care will apply to the Governor's requested one percent across-the-board decrease, the end of the primary care rate bump, and the proposed $100 million reduction in Hospital Provider Fee booster payments. The Department does not anticipate that the time required to perform the analysis of access to care will impede the Department's ability to implement the rate reductions proposed by the Governor. Except for the changes to the Hospital Provider Fee, the Department says that it could, if necessary, implement rate reductions July 1 in anticipation of CMS approval and then make retroactive payments if CMS denies approval. As an aside, it is not possible to implement rate increases in anticipation of CMS approval due to the challenges of recovering overpayments. The Department noted that in the federal register CMS states:

> *Nothing in this rule changes the longstanding policies that permit a state to submit a SPA with an effective date as early as the first day of the quarter in which the plan is submitted (but only after public notice of the new rates have been issued). This policy permits states flexibility to implement approvable rate changes without delay while it undergoes federal review. Thus, states may continue to implement rate reductions retroactively to the first day of the quarter in which an approvable SPA is submitted to CMS.*

The Department does not believe it could make reductions in the Hospital Provider Fee in anticipation of CMS approval, because the Hospital Provider Fee requires an approved model from CMS. However, the Department believes the new schedule for collecting the Hospital Provider Fee provides ample time for CMS approval to make the changes in state FY 2016-17.

Comparing Medicaid Rates to Medicare or Usual and Customary Rates

The JBC submitted a legislative request for information to the Department asking for a comparison between Medicaid rates and Medicare rates. For codes without a comparable Medicare rate, the Department was asked to identify a data source to estimate the usual and customary rates. The JBC also asked for the estimated cost to bring rates to a percentage of the benchmark. Finally, the JBC asked for an estimate of the portion of total expenditures excluded from the analysis because the rates are capitated, cost-based, or based on a methodology defined in statute. The table below summarizes the Department's analysis.

Colorado Medicaid Provider Payment Rate Comparison Report					
	Current %	Cost/(Savings) to move to a percent of Benchmark			
Provider Type	of Benchmark	60.0%	75.0%	90.0%	100.0%
Practitioner	66.3%	($58,763,306)	$81,244,243	$221,251,793	$314,590,160
Durable Medical Equipment/Supplies	81.7%	($18,235,442)	($6,224,298)	$5,786,846	$13,794,275
Transportation	51.8%	$2,388,403	$6,794,459	$11,200,515	$14,137,886
Dental	67.9%	($24,768,088)	$22,154,342	$69,076,772	$100,358,392
EPSDT	87.6%	($1,586,864)	($688,234)	$210,395	$809,481
Independent Laboratory	93.8%	($20,522,916)	($11,898,093)	($3,273,269)	$2,476,614
Home and Community Based Services					
District of Columbia	57.6%				
California	69.1%				
Arizona	94.9%				
Illinois	125.0%				
Ohio	140.6%				
Ave. of Highest & Lowest		($109,557,925)	($42,252,275)	$25,053,376	$69,923,810
Home Health/Private Duty Nursing					
North Carolina	111.7%				
Illinois	112.8%				
Idaho	123.5%				
Ohio	126.9%				
Louisiana	179.3%				
Ave. of Highest & Lowest		($163,066,193)	($131,035,848)	($99,005,504)	($77,651,940)
TOTAL estimated cost/(savings)		($394,112,331)	($81,905,704)	$230,300,924	$438,438,678
General Fund share		($170,543,647)	($58,343,917)	$53,855,811	$128,655,631

Key Findings

Transportation is the lowest compensated service category compared to the benchmark, according to the report. The response the Department submitted to legislative request for information #5 regarding emergency and nonemergency medical transportation suggests there are also issues with the management of the transportation benefit (*see Appendix C for more information*). Transportation rates are scheduled for review in the first year of the S.B. 15-228 rate review process. The report notes that Medicare transportation rates make adjustments not accounted for in Colorado Medicaid rates for mileage and rural versus urban settings, limiting

the comparability of the data. Also, utilization data for the Denver region is missing from the Colorado Medicaid FY 2013-14 data used for the report due to an alternate reimbursement method used for the provider.

The Practitioner service category is the next lowest compensated compared to the benchmark, according to the report. This is the percentage of the benchmark after removal of the primary care rate bump. The subset of practitioner codes that is eligible for the rate bump is estimated to be 69.4 percent of the benchmark after removal of the bump. This suggests that ending the primary care rate bump will reduce reimbursements for eligible codes by 30.6 percent. However, this is based on old utilization data from FY 2012-13 and FY 2013-14, which misses much of the effect of the Medicaid expansion and potential changes in utilization due to the way the state extension expanded the rate bump. There is a more recent estimate that the JBC staff believes better captures the fiscal impact of ending the primary care rate bump that suggests it increased expenditures 23.2 percent. *See the issue brief on Primary Care Rates for greater explanation and analysis.* This analysis did not account for Medicare paying different rates based on the facility and number of procedures.

The Dental service category is the last service category compensated at below 70 percent of the benchmark, according to the report. The benchmark in this case is the highest state Medicaid reimbursement in the country. The report found that Arkansas had the highest Medicaid dental rates for adults at 60.5 percent of the American Dental Association mean reimbursement and Delaware had the highest Medicaid dental rates for children at 81.1 percent of the American Dental Association mean reimbursement. Based on Colorado's utilization, Colorado would need to reimburse at 77.1 of the ADA mean for adults and kids combined to match the highest state Medicaid dental reimbursements in the country. The report does not explain why the highest rate was selected as the benchmark rather than an average rate in the manner used for Home and Community Based Services and for Home Health/Private Duty Nursing. Another item of note is that Colorado's adult dental benefit is currently capped at $1,000 annually, and so an increase in rates without a change in the cap would reduce the services available to clients.

Rates for the Home Health/Private Duty Nursing service category were above all five comparison states. The rates for home health that were used for the comparison do not include the large targeted rate increase the JBC provided last year to $17 per hour that is pending federal approval. The rates for private duty nursing do include the JBC's targeted rate increase to $45 per hour. The Department indicates that Medicare uses a prospective payment model for these services, and so Medicare rates could not be used as a benchmark for Colorado's fee-for-service rates. The report notes that Colorado has an extended rate for visits lasting more than one hour, but four out of the five comparison states do not. Department staff noted that the report does not take into account differences in cost of living. Colorado wages are higher than the benchmark states for this measure. Also, Department staff indicated that the comparison of rates does not identify differences in policy, provider qualifications and requirements, and service definitions to interpret a higher rate as overfunding. In light of the recent large increase in provider rates approved by the JBC for this service category, the JBC may want to ask the Department to discuss this finding of the report further at the hearing.

Methodology

The following is a high-level summary of the key elements of the methodology necessary to understand in order to interpret the report. For more detailed information about the methodology used see the report.

The Current % of Benchmark is a weighted average of the Medicaid rates versus a weighted average of the benchmarks rates. The weighting is based on Colorado Medicaid utilization for FY 2012-13 and FY 2013-14. Medicaid and benchmark rates without a direct comparable were taken out of the analysis. The Department provided the following table to illustrate the method.

Table 5.1

Procedure Code	CO Medicaid Utilization	CO Medicaid 1/1/15 Fee	Comparable Fee
99201	100	$120.00	
99202	100		$170.00
99203	100	$105.00	$125.00
99204	100	$110.00	$127.00
Weighted Average fee using all utilization		$83.75	$105.50
Weighted Average fee using utilization in situations only where both Colorado and the comparable fee have rates		$107.50	$126.00

To estimate the cost or savings to move to different percentages of the benchmark, the report used the difference between the target and the weighted average Colorado Medicaid rate and then multiplied this difference by total utilization for the service category, rather than inflating each rate individually and then aggregating the dollars. Dollars for each service category are total funds. The state share varies by service category and was only reported in aggregate.

The report tried to use Medicare rates as the benchmark where possible. When required to identify a "usual and customary" alternative benchmark, the Department used the All Payer Claims Database, other states' Medicaid fee schedules, or the American Dental Association survey. Both the All Payer Claims Database and the American Dental Association survey report claims rather than reimbursements after insurance discounts.

For Home and Community Based Services and for Home Health/Private Duty Nursing the report showed Colorado Medicaid rates as a percentage of Medicaid rates in five different states. The report indicates these services are not typically covered by Medicare or private insurance. The report selected states for comparison based on the availability of public data, whether payment methodologies were comparable (fee-for-service rather than managed care), and the similarity of services. To estimate the cost or savings the report compared Colorado Medicaid's weighted average rate to an average of the highest and lowest weighted average rates among the comparison states.

The following table provides a brief description of each of the service categories.

Service Category	Service Description
Practitioner	Services provided by a medical doctor who attests as having a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association. Payment is made based on the fee-schedule with some selected services eligible for increased payment.
HCBS Waiver	Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria. In Colorado, Home and Community Based Services are offered to adults and children. Medicaid HCBS uses four payment methodologies: 1. Bundled Payments, 2. Fee-for-Service, 3. Negotiated Market Price and, 4. Tiered Rates. Each waiver has an enrollment limit.
HH/PDN	Home health includes services provided by a licensed and certified home health agency for clients who need intermittent skilled services at home. Home health services consist of skilled nursing (provided by a Registered Nurse or Licensed Practical Nurse), Certified Nurse Aide (CNA) services, physical therapy (PT), occupational therapy (OT), and speech/language pathology (SLP) services. Home health services are a state plan benefit for Colorado Medicaid clients, including children and adults. The services are billed fee for service using revenue codes.
Dental	Comprehensive dental services are a Colorado Medical Assistance program benefit for Medicaid clients ages 20 and under who are enrolled in state Medicaid services. Enrolled children are entitled to preventive dental services including exams, cleanings, x-rays, sealants, space maintainers and fluoride treatments. Restorative procedures such as amalgam and tooth colored fillings, crowns, root canals, gum and oral surgery procedures are also available. Orthodontic benefits (braces) may be available in the case of a child with a severe handicapping malocclusion (i.e., bite) problem. Dental services for children are billed fee for service using ADA CDT codes.
EPSDT	Physician services for routine medical care including services provided in the office, at a facility, or in the home. Providers include physicians, mid-level practitioners, optometrists, podiatrists, and nurses. The services are a state plan benefit for all enrolled Colorado Medicaid clients, however, specific procedure codes are age limited.
Independent Laboratory	An independent laboratory is a certified laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital. Payment to independent laboratory services are based on procedure codes and it is calculated by Colorado Medicaid at the lower of submitted charges or the laboratory fee schedule determined by the Department.
Transportation	Emergent (EMT) and Non-Emergent (NEMT) Transportation services provide clients access to medical appointments and hospitals when medically necessary. Transportation services are provided by approved Public Utilities Commission (PUC) contract carriers and are administered by a brokerage in the Denver Metro area and by counties outside of the Denver Metro area. Transportation services are a state plan benefit for Colorado Medicaid clients, including children and adults. The services are billed fee for service using HCPCS codes.
DME/Supplies	The Department pays for Supplies and DME by using the fee-schedule, the Manufacturer's Suggested Retail Price (MSRP) or, by invoice. Codes reimbursed according to the fee-schedule are subject to the lower of payment up to the maximum allowable rate. If the code doesn't have a maximum allowable rate, a reduced percentage of the MSRP is paid. Lastly, if the code doesn't have a maximum allowable rate or MSRP, the Department pays at a percentage over the actual acquisition invoice amount.

Exclusions

The report estimates that it excluded 64.5 percent of total payments because they were capitated, cost-based, or defined in statue. Additional removals were made for things like codes with negotiated rates, codes with multiple rates by vendor, codes with large outliers where the comparability of data was suspect (the biggest example being physician-administered drugs), and codes for paying premiums and coinsurance for Medicare or commercial insurance. Due to the exclusions and removals, the report notes that the estimated costs and savings should be interpreted as a minimum fiscal impact.

Issue: Primary Care Rates (R1)

This issue brief discusses the sunset of a policy that increased Medicaid primary care rates to the equivalent Medicare rate beginning in January 1, 2013 that is scheduled to expire at the end of FY 2015-16.

SUMMARY:

- The forecasted expenditures in R1 Medical Services Premiums are lower by $145.1 million total funds and $49.5 million General Fund due to the end of the primary care rate bump.
- The primary care rate bump was time limited because it was financed with short-duration funding from an increase in the federal match rate for Medicaid and due to insufficient evidence about the policy's effect on access to care.
- A contracted study of the primary care rate bump provides a mixed assessment. By some measures it found no evidence that the rate bump changed client outcomes or provider behaviors, but one statistical model suggested it increased the number of bump-eligible services by providers receiving the increase. The report also found that client outcomes and provider behaviors remained stable during a period of dramatic enrollment increases and suggested that the primary care rate bump may have contributed to maintaining access.
- Costs of options for mitigating the effect of the end of the primary care rate bump are estimated.

DISCUSSION:

The Governor's request does not extend an increase in primary care rates that is scheduled to expire at the end of June 2016. The primary care rate bump, as it is called, increased primary care provider rates to equivalent Medicare rate. The expiration of the rate bump would take providers back to the rates in effect as of December 31, 2012. The Governor proposes exempting physician services from the 1.0 percent across-the-board provider rate decrease in R12 because of the effect of the end of the primary care rate bump. Providers would not be penalized for the proposed 1% decrease in FY 16-17, but they would also not get the benefit of across-the-board increases in prior years of 2%, increase in FY 2013-14, 2% in FY 14-15, and 0.5% in FY 15-16.

Background

From January 2013 through the end of calendar year 2014 state Medicaid programs were required to at least match Medicare Part B rates for certain primary care services and immunizations performed by primary care providers. This requirement is often described by reference to Section 1202 of the Affordable Care Act that established the mandate. During this time, federal funds paid for the incremental difference between state rates and the new requirement. The purpose of the minimum rate requirement was to ensure an adequate supply of primary care providers willing to serve Medicaid patients when the Medicaid eligibility expansions authorized by the Affordable Care Act took effect beginning in January 2014.

During the state FY 2014-15 budget cycle, the General Assembly decided to extend the primary care rate bump with some modifications. Colorado was one of 15 states to fully or partially extend the rate bump. The decision to extend the rate bump was made following unexpected news that the federal match rate, called the federal medical assistance percentage (FMAP), was going to increase for Colorado in federal fiscal year 2014-15 from 50.00 percent to 51.01 percent. The Governor submitted a budget amendment connecting the enhanced primary care rates to the General Fund savings from the increase in the FMAP rate. The Governor proposed that the elevated primary care rates continue an additional 18 months from January 2015 through June 2016.

Part of the rationale for a time-limited extension was that the source of funding financing the extension was expected to have a short-duration. The increase in the FMAP was due to Colorado's per capita personal income falling relative to other states during the economic downturn. As the economy improved, the Department anticipated the FMAP would approach the federal minimum of 50% that Colorado had received each year for at least the preceding decade. The FMAP has decreased as predicted. The Department currently forecasts the FMAP for federal fiscal year 2016-17 will be 50.32 percent and that it will continue to fall in future years.

The second reason for the time-limited extension was that the Department had only anecdotal evidence about whether the change in primary care rates was effective in improving client access to services. As part of the extension of the enhanced primary care rates the Department requested and received funding to study the effect of the rates on access. The Department indicated that the extension would allow time to collect data to inform a decision about whether to request continued funding in future years.

The state extension of the rate bump made some modifications intended to improve the effectiveness of the policy as an incentive for access. First, the state extension removed a requirement that providers self-attest that they meet the federal eligibility qualifications or operate under the personal supervision of a provider meeting the eligibility qualifications. Instead, the state extension paid based on the type of service provided. The Department indicated the self-attestation requirement was administratively burdensome for providers, potentially causing them to not claim the enhanced rate. The change also allowed some new providers to benefit from the enhanced rates, such as independent advanced practice nurses, school based health clinics, nephrologists, or HIV doctors, who often act as the medical home for clients. Second, the Department began paying the enhanced rate on a per claim basis, rather than quarterly as a supplemental payment. This made the enhanced rates more transparent to providers and got the money in the hands of the providers more quickly. The changes also made the payments significantly easier for the Department to administer.

Advocates have raised concerns that ending the provider rate bump will result in a decrease in the number of Medicaid clients that providers are willing to see. They suggest that the rates will be a significant consideration for providers deciding whether to reenroll in Medicaid and note that all providers are required to reenroll by March 31, 2016. The Department of Health Care Policy and Financing provided this background:

New federal regulations established by CMS require enhanced screening and re-validation of providers enrolling with Colorado Medicaid. These regulations are designed to reduce the potential for Medicaid fraud, waste, and abuse. Most providers will see very little change in their enrollment process but some may be required to undergo additional screening before they can be enrolled or re-enrolled in Medicaid. Colorado launched the revalidation and new online provider enrollment tool on September 15, 2015. Providers must re-validate by March 31, 2016. The Department does not believe the new enrollment and re-validation requirements will lower provider enrollment. Additional information on this process can be found here: https://www.colorado.gov/hcpf/provider-resources

Fiscal Impact

The table below shows the estimated cost to continue the primary care rate bump in FY 2016-17. A total of 14,987 unique providers benefited from the rate bump for paid claims between 1/1/15 and 10/31/15.

Cost to Continue the Primary Care Rate Bump in FY 16-17				
	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2016-17	$145,075,634	$49,519,402	$1,642,057	$93,914,175

The effect of the rate bump on payments varied widely by code from a 1.1 percent to 69.4 percent increase, so it is hard to say the exact percentage reduction that will be caused by the end of the rate bump. The effect by provider will vary based on the codes most frequently used by the provider. According to HCPF, more than half of the rate increases from the rate bump were between 10% and 30%. Overall expenditures for eligible codes increased 23.2% due to the rate bump.

The fiscal impact described above corrects a technical error in a previous estimate released by the Department that was lower by $14.6 million total funds and $4.9 million General Fund. The previous estimate mistakenly made calculations based on a rate schedule with rates that were inflated above the intended policy.

Evaluation

The Department contracted for a study of the effect of the primary care rate bump on access. As indicators of access the study looked at client outcomes and at provider behavior, using claims data.

If the rate bump increased access, then the report expected client outcomes to improve. The client outcomes measured were:

- The number of emergency department visits for ambulatory care sensitive conditions per 10,000 adult Medicaid clients. Ambulatory care sensitive conditions are those that are potentially preventable with good primary care, such as visits for diabetes, as opposed to visits for accidents such as a broken arm.
- The percentage of adults having at least one primary care visit in the prior 12 months
- The percentage of children having at least one primary care visit in the prior 12 months

- The percentage of bump-eligible visits with usual care providers, which measures continuity of care

If the rate bump increased access, then the report expected the following provider behaviors to increase:

- Number of providers with bump-eligible visits
- Number of bump-eligible visits in a month

The report had three main findings:

- During a period of significant enrollment growth, client-based access to care measures remained stable and the number of providers of primary care services to Medicaid clients increased with enrollment.
- Graphical and time-series regression analysis of the claims data suggest that the rate bump did not significantly alter the time trends of the client outcomes and provider behaviors measured.
- Preliminary statistical modeling suggests providers delivered an additional three bump-eligible visits per month to Medicaid clients after attesting. This is an additional 11,000 to 13,000 bump-eligible visits per month, or a 10 percent increase.

According to the report:

> *Taken together, these results suggest that access to primary care services for the overall Medicaid population was not negatively impacted by the addition of clients under Colorado's Medicaid expansion and that the increased payments for these services under Section 1202 of the ACA contributed to maintaining access to care for the rapidly growing Medicaid population.*

The study did not include surveys of clients or calls to providers that attempt to schedule appointments for new patients. These are sometimes used as measures of access, but they are expensive and logistically challenging to implement. The report references another study of 10 states that used a "simulated patient" approach with trained interviewers calling providers and attempting to make appointments before and after the rate bump. That study found the availability of primary care appointments for Medicaid patients increased from 58.7 percent to 66.4 percent and the states with the largest increases in rates had the largest increases in appointment availability.

The data included in the evaluation was limited to claims from January 2010 through June 2014 and so it does not reflect the state extension that removed the self-attestation requirement and delayed payments. The administrative burden of claiming the rate bump prior to the state extension may have dampened the effectiveness of the rate bump. Another report, targeted for release in March, will add claims from July 2014 through June 2015 to capture a year of experience with the rate bump operating under the policies of the state extension.

The report notes that the rate bump did not apply to services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The report estimates that FQHCs serve 1 in 4 Colorado Medicaid clients and there was a dramatic 75 percent increase in the number of clients seen by FQHCs from 171,778 in October 2010 to 297,426 in 2014. The

increase in FQHC services may have muted the changes in access that the rate bump might otherwise have caused.

According to the Colorado Health Institute's Colorado Health Access Survey the percentage of Medicaid enrollees in 2015 who did not get needed care because the doctor's office wasn't accepting their insurance remained near the same rate as in prior years of roughly 20 percent. It may be telling that this statistic did not deteriorate with the dramatic increase in Medicaid enrollment.

Options

At the request of the JBC staff and some of the JBC's members the Department prepared cost estimates of some intermediate funding levels to mitigate the effect of the end of the primary care rate bump.

Options to Mitigate the Effect of Ending the Primary Care Rate Bump				
%	Total Funds	General Fund	Cash Funds	Federal Funds
Primary care rates to a percent of Medicare				
100.0%	$145,075,634	$49,519,402	$1,642,057	$93,914,175
90.0%	$91,720,823	$31,612,597	$1,018,136	$59,090,090
80.0%	$38,676,309	$13,813,310	$397,245	$24,465,754
70.0%	$5,622,569	$2,361,125	$22,195	$3,239,249
Primary care rate bump with attestation requirement				
	$58,489,192	$22,313,755	$293,968	$35,881,469
Apply historic and proposed across-the-board rate increases				
2% FY 13-14				
2% FY 14-15				
0.5% FY 15-16	$16,667,766	$5,583,591	$195,451	$10,888,724
R12 -1.0%	($4,086,830)	($1,368,296)	($47,942)	($2,670,592)
TOTAL	$12,580,936	$4,215,295	$147,509	$8,218,132

Primary care rates to a percent of Medicare: The analysis assumes that if the Medicaid rate is higher than the target percentage of Medicare then the Medicaid rate would not be decreased.

Primary care rate bump with attestation requirement: To prepare this estimate the Department took expenditures during the period when the attestation requirement applied and trended them forward using the Department's enrollment projections. The Department cautions that there has been a significant increase in potentially bump-eligible providers since then, and so this should be viewed as a minimum cost estimate. While this approach reduces the cost of continuing the primary care rate bump, it reintroduces an administratively burdensome attestation procedure that may prevent many providers of primary care from claiming the higher rate and thereby reduce the effect of the rate increase on access.

Apply historic and proposed across-the-board rate increases: This option shows the estimated cost of giving the primary care providers the across-the-board rate increases that other providers received in prior years, as well as the cost of applying the 1.0 percent across-the-board reduction proposed for FY 2016-17.

Issue: Optional Eligibility and Benefits

This issue brief provides a list of the eligibility criteria and benefits Colorado has implemented that are optional for participation in Medicaid and provides rough cost estimates for each.

SUMMARY:

- Colorado has implemented some eligibility criteria and benefits that are optional for participation in Medicaid that could be reduced or eliminated.
- Eliminating an optional service does not necessarily result in savings.
- Eliminating some optional services would drastically change the quality of care and could result in higher cost services.

DISCUSSION:

Strategies for reducing Medicaid expenditures generally involved one or more of the following:

1. Restricting eligibility
2. Restricting benefits
3. Reducing reimbursement rates
4. Avoiding unnecessary care
5. Using alternate financing to the General Fund

The Governor's request features several measures to reduce reimbursement rates and continues many Department initiatives to avoid unnecessary care, such as the Accountable Care Collaborative. This issue brief discusses focusses for reducing eligibility and benefits. Certain eligibility categories and benefits are mandatory for federal financial participation in the state Medicaid program. The table on the next page summarizes the eligibility categories and benefits that are optional under federal policy.

Eliminating an optional service does not necessarily result in savings. In some cases, the same service could be provided under a mandatory service. For example, eliminating payment to a podiatrist could result in the Medicaid client receiving the same care from the client's family physician or an orthopedic specialist physician (physician services are a mandatory service). Eliminating other optional services, such as prescription drugs or home and community based services, could drastically change the quality of care for the mandatory Medicaid populations and potentially result in higher cost services (such as sooner placement in a nursing facility or longer hospital stays).

In some cases a benefit may be listed as optional when it cannot be eliminated for all populations. For example, pursuant to the mandatory Early and Periodic Screening, Detection, and Treatment (EPSDT) program, many services provided to children are mandatory if they are required to aid the child's development or educational needs. As result, services such as eye-glasses or speech therapy may be optional for an adult, but mandatory for a child under EPSDT requirements. In other situations there may be federal rules or case law that can be interpreted to

in a way that prevents reducing or eliminating an "optional" service. For example, in 2003 the General Assembly attempted to limit the "optional" non-emergency transportation benefit to wheelchair transport only, but the State Plan Amendment to implement the change was denied by the federal Centers for Medicare and Medicaid Services (CMS). Reducing or eliminating an optional eligibility category or benefit generally requires a State Plan Amendment or waiver amendment that must be approved by CMS before it can be implemented.

Category	C.R.S. Cite	FY 2014-15 Cost	General Fund	Comments
Optional Services[1]				
Prescribed Drugs (Including Over the Counter Medication)	25.5-5-202 (1)(a), (a.5)	$347,936,896	$109,099,853	Not a "mandatory" service under federal law, but a core service in modern medicine. Total is net after drug rebates. Includes over the counter medication offered in order to avoid prescription drugs that may be more costly (i.e. Tylenol instead of codeine).
Clinic Services	25.5-5-202 (1)(b)	$19,541,904	$5,999,859	Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients. Without these services, the clients would use inpatient or other physician services. Costs based on place of service; these are direct substitutes for costs at other locations.
Home and Community Based Services	25.5-5-202 (1)(c)	$785,962,069	$385,409,646	Individuals must be at risk of institutional care in order to receive these waiver services. The Department had to prove budget neutrality when the waiver was approved. Eliminating the service would not result in the "full" amount of cost because it is anticipated that there would be greater nursing facility care (if capacity existed) or hospital utilization. However, there could be some savings resulting from family or other care givers providing more services and from premature death.
Optometrist Services	25.5-5-202 (1)(d)	$989,829	$230,202	
Eyeglasses when necessary after surgery	25.5-5-202 (1)(e)	$190,108	$54,440	
Prosthetic Devices	25.5-5-202 (1)(f)	$6,774,568	$1,847,178	
Rehabilitation Services as appropriate to community mental health centers	25.5-5-202 (1)(g)	Included in BHO capitations		Eliminating services could have public safety concerns, added costs to county jails, and inpatient hospitalization.
Intermediate care facilities for the mentally retarded;	25.5-5-202 (1)(h)	$4,277,851	$2,106,414	HCPF costs for Class II Nursing Facilities. DHS has additional costs for these services.
Inpatient psychiatric services for persons under twenty-one years of age; Inpatient psychiatric services for persons over the age of sixty-five	25.5-5-202 (1)(i),(j)	Included in BHO capitations		Eliminating service does not eliminate need. Would lose federal match and probably would cost the state more in General Fund. Would push more individuals into state institutional care. Would also reduce Medicaid funding for the institutes.
Case Management	25.5-5-202 (1)(k)	Included in BHO capitations		Same as above.

Category	C.R.S. Cite	FY 2014-15 Cost	General Fund	Comments
Therapies under home health services, including: Speech and audiology; Physical; Occupational	25.5-5-202 (1) (l) (I), (II), (III)	$59,857,231	$25,377,428	Home health is a mandatory federal requirement. However, therapy services (speech, occupational, physical) are optional if provided by home health agencies (but could be mandatory if provided through outpatient hospital care). Staff would not anticipate a lot of savings from eliminating home health agencies from providing the service (these are services that are usually part of patient's discharge plan -- i.e. a stroke victim is discharged and receives care at home health with physical, speech and occupational therapies). Only savings that would result would be if reimbursement is different between home health agencies and outpatient.
Services of a licensed psychologist;	25.5-5-202 (1)(m)	$7,452,387	$3,068,943	No real savings anticipated. Service could be provided by family physician or psychiatrist (mandatory) This is a partial accounting of cost, contained primarily in the Mental Health Fee for Service line item; however, the majority of expenditure for this is included in the BHO capitation payments
Private duty nursing services;	25.5-5-202 (1)(n)	$61,567,281	$30,295,346	Eliminating service could result in longer hospitalization or premature death.
Podiatry services;	25.5-5-202 (1)(o)	$5,722,970	$1,544,437	No real savings anticipated. Services could be provided by family physician or orthopedic physician. Physician services are mandatory.
Hospice care;	25.5-5-202 (1)(p)	$47,620,463	$21,887,167	Could result in longer hospital stays or nursing facility stays (both mandatory services).
The program of all-inclusive care for the elderly;	25.5-5-202 (1)(q)	$132,904,764	$65,442,306	This is a managed care long-term care service. Eliminating the provider group doesn't change the need for services -- it would just revert to the fee-for-service nursing facility and HCBS waivers (if waiver services are eliminated then this service category would need to be adjusted also).
Outpatient substance abuse treatment.	25.5-5-202 (1)(s)	$383,871	$131,169	If provided inpatient -- would be mandatory. The majority of these costs are included in BHO capitations.
Cervical cancer immunization for all females under twenty years of age;	25.5-5-202 (1)(t)	$407,848	$84,886	Could be eliminated. Future costs from cervical cancer could be anywhere from 2 to 25 years in the future.
Screening, brief intervention, and referral to treatment for individuals at risk of substance abuse, including referral to the appropriate level of intervention and treatment.	25.5-5-202 (1)(u)	$56,325	$21,660	This program provides screening, brief intervention, and referral to treatment for individuals at risk of substance abuse.
Non-emergency transportation	25.5-5-202 (2)			While this is considered an optional service, federal regulations (42 C.F.R. Section 431.53) and case law (several cases) would prevent Colorado from eliminating the service. This was tested in 2003 when the General Assembly attempted to limit the service to only wheel chair transport and CMS rejected the rule change.

Category	C.R.S. Cite	FY 2014-15 Cost	General Fund	Comments
Adult Dental	25.5-5-207	$91,995,335	$0	
TOTAL		$1,573,641,699	$652,600,935	
[1] This list does not include any optional benefits that are administered by other departments, regardless of whether or not they receive any Medicaid funding.				
Optional Eligibility[1,2]				
Expansion Parents/Caretakers to 133% of FPL	25.5-5-201 (1)(m)	$79,726,327	$0	
Expansion Adults without Dependent Children to 133% of FPL	25.5-5-201 (1)(p)	$1,036,956,078	$0	
Elderly and Disabled Individuals Above the Supplemental Security Income Limit to 300% of FPL	25.5-5-201 (1)(g)	$829,389,506	$408,391,393	
Foster Care Children - Do Not Meet the Requirements of Title IV-E of the SSA	25.5-5-201 (1)(l)	$3,825,747	$1,883,798	
Legal Immigrant Prenatal	25.5-201 (4)	$10,775,718	$5,305,964	
Medicaid Pregnant Adults Over 133%	25.5-5-201 (1)(m.5)	$25,425,018	$10,289,028	
Breast and Cervical Cancer Treatment Program	25.5-5-308 (2)	$5,060,123	$0	
Buy-In for Individuals with Disabilities	25.5-5-206	$30,208,244	$0	
CHP+ Prenatal Over 133%	25.5-8-109 (5)	$9,580,452	$0	
TOTAL		$2,030,947,213	$425,870,182	
[1] This is a high level breakdown of the eligibility categories that are optional under federal law. It does not capture costs for every optional eligibility criteria, as it would require more robust data analysis to identify each of the impacted clients within the broader eligibility groupings.				
[2] The FY 2014-15 costs shown for the optional eligibility groups is not mutually exclusive from the costs shown for the optional covered services shown above.				

Appendix A: Number Pages

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(1) EXECUTIVE DIRECTOR'S OFFICE					
Primary functions: Provides all of the administrative, audit and oversight functions for the Department.					
(A) General Administration					
Personal Services	25,782,006	28,066,886	28,299,126	28,894,861	
FTE	363.7	360.4	388.0	391.0	
General Fund	8,477,796	8,982,621	9,898,385	10,049,433	
Cash Funds	2,564,595	2,676,189	2,860,502	2,936,203	
Reappropriated Funds	1,613,082	1,524,777	1,501,543	1,564,801	
Federal Funds	13,126,533	14,883,299	14,038,696	14,344,424	
Health, Life, and Dental	2,322,449	2,476,612	3,139,489	3,434,070	
General Fund	748,152	928,931	1,137,726	1,230,952	
Cash Funds	227,867	166,066	277,707	337,577	
Reappropriated Funds	72,376	64,887	88,133	104,755	
Federal Funds	1,274,054	1,316,728	1,635,923	1,760,786	
Short-term Disability	42,151	64,185	61,246	55,072	
General Fund	13,671	21,358	22,736	20,569	
Cash Funds	3,764	4,955	4,746	4,588	
Reappropriated Funds	802	1,363	1,457	1,393	
Federal Funds	23,914	36,509	32,307	28,522	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	850,598	1,235,106	1,314,119	1,434,489	
General Fund	273,870	409,819	488,354	535,695	
Cash Funds	76,148	96,428	101,814	119,586	
Reappropriated Funds	16,232	27,452	30,035	36,269	
Federal Funds	484,348	701,407	693,916	742,939	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	767,027	1,157,972	1,269,320	1,419,546	
General Fund	246,370	384,601	472,426	530,115	
Cash Funds	68,744	90,431	98,344	118,340	
Reappropriated Funds	14,654	24,943	27,570	35,891	
Federal Funds	437,259	657,997	670,980	735,200	
Salary Survey	669,740	831,265	321,383	56,903	
General Fund	199,437	283,209	121,695	19,245	
Cash Funds	53,484	64,811	24,853	6,898	
Reappropriated Funds	10,800	3,127	1,794	898	
Federal Funds	406,019	480,118	173,041	29,862	
Merit Pay	372,361	265,923	317,662	0	
General Fund	119,442	98,565	118,042	0	
Cash Funds	28,027	19,363	26,760	0	
Reappropriated Funds	9,889	1,176	1,975	0	
Federal Funds	215,003	146,819	170,885	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Worker's Compensation	47,286	52,712	43,712	57,595	
General Fund	23,643	26,356	21,856	28,798	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	23,643	26,356	21,856	28,797	
Operating Expenses	2,497,422	2,967,212	2,128,109	2,004,697	
General Fund	1,141,931	1,426,580	965,356	917,251	
Cash Funds	121,029	37,759	78,907	65,869	
Reappropriated Funds	1,382	0	10,449	10,449	
Federal Funds	1,233,080	1,502,873	1,073,397	1,011,128	
Legal and Third Party Recovery Legal Services	979,454	1,151,606	1,368,714	1,368,714	
General Fund	346,973	443,159	442,869	442,869	
Cash Funds	153,671	166,747	241,489	241,489	
Reappropriated Funds	0	0	0	0	
Federal Funds	478,810	541,700	684,356	684,356	
Administrative Law Judge Services	538,016	376,861	568,419	688,283	*
General Fund	219,941	146,434	220,867	267,441	
Cash Funds	49,067	41,996	63,343	76,701	
Reappropriated Funds	0	0	0	0	
Federal Funds	269,008	188,431	284,209	344,141	
CORE Operations	504,637	2,717,568	1,598,167	1,446,417	
General Fund	331,447	1,297,165	544,698	474,501	
Cash Funds	173,190	679,257	285,501	248,708	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	741,146	767,968	723,208	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Payment to Risk Management and Property Funds	131,604	166,890	166,912	189,629	
General Fund	65,802	83,445	83,456	94,815	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	65,802	83,445	83,456	94,814	
Leased Space	747,035	1,480,251	2,203,793	2,514,035	
General Fund	195,437	578,965	885,015	1,009,653	
Cash Funds	138,874	124,924	216,881	247,365	
Reappropriated Funds	0	0	0	0	
Federal Funds	412,724	776,362	1,101,897	1,257,017	
Capitol Complex Leased Space	496,658	386,910	549,237	558,783	
General Fund	248,329	193,455	274,619	279,392	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	248,329	193,455	274,618	279,391	
Payments to OIT	201,448	1,578,757	3,775,292	2,805,606	*
General Fund	100,724	784,642	1,876,284	1,394,361	
Cash Funds	0	4,736	11,360	8,443	
Reappropriated Funds	0	0	0	0	
Federal Funds	100,724	789,379	1,887,648	1,402,802	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Scholarships for research using the All-Payer Claims Database	0	500,000	500,000	500,000	
General Fund	0	500,000	500,000	500,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
General Professional Services and Special Projects	7,145,144	5,584,179	9,351,970	7,965,355	
General Fund	2,048,401	2,037,349	3,117,387	2,431,211	
Cash Funds	442,324	511,089	1,463,609	1,413,609	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,654,419	3,035,741	4,770,974	4,120,535	
Purchase of Services from Computer Center	882,219	0	0	0	
General Fund	436,917	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	4,193	0	0	0	
Federal Funds	441,109	0	0	0	
Multiuse Network Payments	139,002	0	0	0	
General Fund	69,501	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	69,501	0	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Information Technology Security	11,374	0	0	0	
General Fund	5,687	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,687	0	0	0	
Management and Administration of OIT	72,130	0	0	0	
General Fund	36,065	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	36,065	0	0	0	
SUBTOTAL - (A) General Administration	45,199,761	51,060,895	56,976,670	55,394,055	(2.8%)
FTE	363.7	360.4	388.0	391.0	0.8%
General Fund	15,349,536	18,626,654	21,191,771	20,226,301	(4.6%)
Cash Funds	4,100,784	4,684,751	5,755,816	5,825,376	1.2%
Reappropriated Funds	1,743,410	1,647,725	1,662,956	1,754,456	5.5%
Federal Funds	24,006,031	26,101,765	28,366,127	27,587,922	(2.7%)
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,426,141	4,776,959	6,130,010	6,130,010	
General Fund	1,257,350	1,477,142	2,315,772	2,315,772	
Cash Funds	0	110,000	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,168,791	3,189,817	3,814,238	3,814,238	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Nurse Home Visitor Program, Transfer from the Department of Human Services	930,166	1,028,130	3,010,000	3,010,000	*
General Fund	(11,847)	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	465,083	478,806	1,481,221	1,492,358	
Federal Funds	476,930	549,324	1,528,779	1,517,642	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,886	5,888	5,887	5,887	
General Fund	2,943	2,944	2,944	2,944	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,943	2,944	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,041	324,041	324,041	
General Fund	147,369	147,368	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,020	162,021	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	4,160	3,852	10,000	10,000	
General Fund	2,080	1,926	5,000	5,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,080	1,926	5,000	5,000	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Public School Health Services Administration, Transfer to the Department of Education	143,721	160,335	160,335	160,335	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	143,721	160,335	160,335	160,335	
Federal Funds	0	0	0	0	
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	205,146	215,955	215,955	
General Fund	0	102,573	107,977	107,977	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	102,573	107,978	107,978	
SUBTOTAL - (B) Transfers to Other Departments	5,834,115	6,504,351	9,856,228	9,856,228	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,397,895	1,731,953	2,579,062	2,579,062	0.0%
Cash Funds	0	110,000	0	0	0.0%
Reappropriated Funds	623,456	653,793	1,656,208	1,667,345	0.7%
Federal Funds	3,812,764	4,008,605	5,620,958	5,609,821	(0.2%)

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	30,637,273	24,715,778	32,784,833	34,937,013	
General Fund	6,594,356	5,655,519	6,823,649	7,198,178	
Cash Funds	1,181,953	934,073	1,919,380	2,089,729	
Reappropriated Funds	293,350	293,350	293,350	293,350	
Federal Funds	22,567,614	17,832,836	23,748,454	25,355,756	
MMIS Reprocurement Contracts	9,933,790	26,955,910	41,437,857	26,916,597	
General Fund	967,847	2,657,672	4,164,679	2,615,317	
Cash Funds	100,036	539,548	1,177,899	701,879	
Reappropriated Funds	0	23,758,690	0	0	
Federal Funds	8,865,907	0	36,095,279	23,599,401	
MMIS Reprocurement Contracted Staff	920,936	407,681	4,448,524	5,145,018	
General Fund	89,321	4,017	353,814	431,304	
Cash Funds	20,954	64,139	131,360	134,757	
Reappropriated Funds	0	339,525	0	0	
Federal Funds	810,661	0	3,963,350	4,578,957	
Fraud Detection Software Contract	144,565	135,000	250,000	250,000	
General Fund	38,938	34,136	62,500	62,500	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	105,627	100,864	187,500	187,500	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Centralized Eligibility Vendor Contract Project	6,875,044	6,824,419	9,133,612	0	*
General Fund	0	0	0	0	
Cash Funds	2,816,997	2,281,751	3,145,326	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,058,047	4,542,668	5,988,286	0	
Health Information Exchange Maintenance and Projects	0	3,746,881	14,168,746	10,622,455	
General Fund	0	524,667	2,321,875	2,046,246	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	3,222,214	11,846,871	8,576,209	
Colorado Benefits Management Systems, Operating and Contract Expenses	0	0	10,885,261	21,639,228	*
General Fund	0	0	3,770,869	7,157,055	
Cash Funds	0	0	1,675,284	3,191,838	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	5,439,108	11,290,335	
Colorado Benefits Management System Administration	0	0	0	648,441	*
General Fund	0	0	0	232,139	
Cash Funds	0	0	0	92,938	
Federal Funds	0	0	0	323,364	
CBMS Modernization Project	789,500	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	789,500	0	0	0	
Federal Funds	0	0	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL - (C) Information Technology Contracts and Projects	49,301,108	62,785,669	113,108,833	100,158,752	(11.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	7,690,462	8,876,011	17,497,386	19,742,739	12.8%
Cash Funds	4,119,940	3,819,511	8,049,249	6,211,141	(22.8%)
Reappropriated Funds	1,082,850	24,391,565	293,350	293,350	0.0%
Federal Funds	36,407,856	25,698,582	87,268,848	73,911,522	(15.3%)
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	140,257	247,001	278,974	278,974	
General Fund	59,400	63,966	63,966	63,966	
Cash Funds	9,932	58,738	73,928	73,928	
Reappropriated Funds	1,593	1,593	1,593	1,593	
Federal Funds	69,332	122,704	139,487	139,487	
Contracts for Special Eligibility Determinations	6,017,314	6,623,800	11,402,297	11,402,297	
General Fund	945,228	664,131	969,756	969,756	
Cash Funds	1,763,845	2,290,311	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,308,241	3,669,358	6,089,073	6,089,073	
County Administration	34,733,208	36,730,383	39,536,478	45,998,063	*
General Fund	8,558,486	10,572,620	11,114,448	11,114,448	
Cash Funds	4,460,662	0	5,859,623	5,859,623	
Reappropriated Funds	0	0	0	0	
Federal Funds	21,714,060	26,157,763	22,562,407	29,023,992	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Hospital Provider Fee County Administration	4,654,643	10,038,778	11,104,684	15,748,868	*
General Fund	0	0	0	0	
Cash Funds	1,752,329	3,208,371	3,585,446	4,945,446	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,902,314	6,830,407	7,519,238	10,803,422	
Administrative Case Management	1,648,048	1,514,868	869,744	869,744	
General Fund	824,024	757,434	434,872	434,872	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	824,024	757,434	434,872	434,872	
Medical Assistance Sites	0	78,000	1,452,000	1,531,968	*
General Fund	0	0	0	0	
Cash Funds	0	39,000	363,000	402,984	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	39,000	1,089,000	1,128,984	
Customer Outreach	4,943,170	5,079,676	6,194,093	5,871,935	
General Fund	2,384,724	2,203,298	2,686,447	2,599,347	
Cash Funds	86,861	336,621	336,621	336,621	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,471,585	2,539,757	3,171,025	2,935,967	
Centralized Eligibility Vendor Contract Project	0	0	0	5,053,644	*
General Fund	0	0	0	0	
Cash Funds	0	0	0	1,745,342	
Federal Funds	0	0	0	3,308,302	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	862,471	774,366	0	0	
General Fund	268,702	74,945	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	593,769	699,421	0	0	
SUBTOTAL - (D) Eligibility Determinations and Client Services	52,999,111	61,086,872	70,838,270	86,755,493	22.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	13,040,564	14,336,394	15,269,489	15,182,389	(0.6%)
Cash Funds	8,073,629	5,933,041	14,562,086	17,707,412	21.6%
Reappropriated Funds	1,593	1,593	1,593	1,593	0.0%
Federal Funds	31,883,325	40,815,844	41,005,102	53,864,099	31.4%
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	6,121,625	8,825,726	11,881,984	11,679,128	
General Fund	1,784,427	2,514,723	3,183,748	3,145,534	
Cash Funds	93,766	329,807	461,089	461,089	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,243,432	5,981,196	8,237,147	8,072,505	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL - (E) Utilization and Quality Review Contracts	6,121,625	8,825,726	11,881,984	11,679,128	(1.7%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,784,427	2,514,723	3,183,748	3,145,534	(1.2%)
Cash Funds	93,766	329,807	461,089	461,089	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	4,243,432	5,981,196	8,237,147	8,072,505	(2.0%)
(F) Provider Audits and Services					
Professional Audit Contracts	2,382,760	2,108,454	2,813,406	3,401,907	
General Fund	1,066,015	947,607	1,119,283	1,266,408	
Cash Funds	204,210	106,620	312,420	415,408	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,112,535	1,054,227	1,381,703	1,720,091	
SUBTOTAL - (F) Provider Audits and Services	2,382,760	2,108,454	2,813,406	3,401,907	20.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,066,015	947,607	1,119,283	1,266,408	13.1%
Cash Funds	204,210	106,620	312,420	415,408	33.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,112,535	1,054,227	1,381,703	1,720,091	24.5%
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	564,482	844,170	700,000	700,000	
General Fund	0	0	0	0	
Cash Funds	282,241	422,085	350,000	350,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	282,241	422,085	350,000	350,000	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL - (G) Recoveries and Recoupment					
Contract Costs	564,482	844,170	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	282,241	422,085	350,000	350,000	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	282,241	422,085	350,000	350,000	0.0%
State of Health Projects					
Pain Management Capacity Program	0	492,000	500,000	0	
General Fund	0	246,000	246,212	1,262	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	246,000	253,788	(1,262)	
Transfer from General Fund to State of Health Cash Fund	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State of Health Projects	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Dental Provider Network Adequacy	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - State of Health Projects	0	492,000	500,000	0	(100.0%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	246,000	246,212	1,262	(99.5%)
Cash Funds	0	0	0	0	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	0	246,000	253,788	(1,262)	(100.5%)
(H) Indirect Cost Assessment					
Indirect Cost Assessment	452,913	245,511	635,877	695,366	
General Fund	0	0	0	0	
Cash Funds	121,193	141,654	178,540	224,727	
Reappropriated Funds	0	2,766	4,720	5,941	
Federal Funds	331,720	101,091	452,617	464,698	
SUBTOTAL - (H) Indirect Cost Assessment	452,913	245,511	635,877	695,366	9.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	121,193	141,654	178,540	224,727	25.9%
Reappropriated Funds	0	2,766	4,720	5,941	25.9%
Federal Funds	331,720	101,091	452,617	464,698	2.7%

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
TOTAL - (1) Executive Director's Office	162,855,875	193,953,648	267,311,268	268,640,929	0.5%
FTE	363.7	360.4	388.0	391.0	0.8%
General Fund	40,328,899	47,279,342	61,086,951	62,143,695	1.7%
Cash Funds	16,995,763	15,547,469	29,669,200	31,195,153	5.1%
Reappropriated Funds	3,451,309	26,697,442	3,618,827	3,722,685	2.9%
Federal Funds	102,079,904	104,429,395	172,936,290	171,579,396	(0.8%)

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	4,618,770,195	5,728,093,904	6,594,830,484	6,573,588,004 *	
General Fund	926,160,050	882,751,482	968,235,300	1,081,555,289	
General Fund Exempt	642,235,957	813,135,957	848,124,468	848,124,468	
Cash Funds	567,267,338	549,802,496	703,597,288	668,973,803	
Reappropriated Funds	2,936,892	0	0	0	
Federal Funds	2,480,169,958	3,482,403,969	4,074,873,428	3,974,934,444	
TOTAL - (2) Medical Services Premiums	4,618,770,195	5,728,093,904	6,594,830,484	6,573,588,004	(0.3%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	926,160,050	882,751,482	968,235,300	1,081,555,289	11.7%
General Fund Exempt	642,235,957	813,135,957	848,124,468	848,124,468	0.0%
Cash Funds	567,267,338	549,802,496	703,597,288	668,973,803	(4.9%)
Reappropriated Funds	2,936,892	0	0	0	0.0%
Federal Funds	2,480,169,958	3,482,403,969	4,074,873,428	3,974,934,444	(2.5%)

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	309,976,756	309,470,584	311,296,186	311,296,186	
General Fund	0	0	0	0	
Cash Funds	154,988,378	152,391,319	153,201,150	153,236,591	
Reappropriated Funds	0	0	0	0	
Federal Funds	154,988,378	157,079,265	158,095,036	158,059,595	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	*
General Fund	3,059,880	3,013,523	3,011,534	3,034,177	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,059,880	3,106,237	3,108,226	3,085,583	
Pediatric Specialty Hospital	11,799,938	13,455,012	13,455,012	13,455,012	*
General Fund	5,899,969	6,625,584	6,621,212	6,670,995	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,899,969	6,829,428	6,833,800	6,784,017	
Appropriation from Tobacco Tax Fund to the General Fund	421,610	423,600	427,593	427,593	
General Fund	0	0	0	0	
Cash Funds	421,610	423,600	427,593	427,593	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Primary Care Fund	26,679,334	26,828,000	26,778,000	26,778,000	
General Fund	0	0	0	0	
Cash Funds	26,679,334	26,828,000	26,778,000	26,778,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Administration	4,013,739	3,653,692	5,033,274	5,033,274	
General Fund	0	0	0	0	
Cash Funds	1,502,836	1,214,777	2,363,824	2,363,824	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,510,903	2,438,915	2,669,450	2,669,450	
Children's Basic Health Plan Medical and Dental Costs	182,753,054	130,538,362	166,723,024	149,119,335	*
General Fund	12,114,378	6,003,180	2,098,125	2,072,848	
General Fund Exempt	438,300	0	427,593	427,593	
Cash Funds	72,640,720	48,154,315	29,111,476	18,011,548	
Reappropriated Funds	0	0	0	0	
Federal Funds	97,559,656	76,380,867	135,085,830	128,607,346	
Hospice Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
TOTAL - (4) Indigent Care Program	541,764,191	490,489,010	529,832,849	512,229,160	(3.3%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	21,074,227	15,642,287	11,730,871	11,778,020	0.4%
General Fund Exempt	438,300	0	427,593	427,593	0.0%
Cash Funds	256,232,878	229,012,011	211,882,043	200,817,556	(5.2%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	264,018,786	245,834,712	305,792,342	299,205,991	(2.2%)

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Primary functions: This division provides funding for the Old Age Pension Medical Program and the Medicare Modernization Act State Contribution Payment. This division also contains funding for programs that eligible for Medicaid funding but are not part of the other divisions.					
Old Age Pension State Medical	6,581,973	431,000	7,574,103	3,634,878	*
General Fund	0	0	2,962,510	2,962,510	
Cash Funds	6,581,973	431,000	4,611,593	672,368	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	3,371,077	5,401,843	8,145,188	8,145,188	*
General Fund	1,685,538	2,652,350	4,013,374	4,038,384	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,685,539	2,749,493	4,131,814	4,106,804	
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	2,804,714	2,804,714	2,804,714	*
General Fund	915,857	1,381,111	1,380,200	1,390,577	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	915,857	1,423,603	1,424,514	1,414,137	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	633,314	633,314	*
General Fund	316,657	311,860	311,654	313,997	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	316,657	321,454	321,660	319,317	
Medicare Modernization Act State Contribution Payment	106,376,992	107,776,447	116,816,749	133,682,247	*
General Fund	68,306,130	107,360,512	116,816,749	133,682,247	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	38,070,862	415,935	0	0	
Public School Health Services Contract Administration	812,550	854,207	2,491,722	2,491,722	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	812,550	854,207	2,491,722	2,491,722	
Federal Funds	0	0	0	0	
Public School Health Services	43,494,624	62,716,218	72,202,649	76,169,434	
General Fund	0	0	0	0	
Cash Funds	21,747,312	31,449,659	35,640,520	37,653,359	
Reappropriated Funds	0	0	0	0	
Federal Funds	21,747,312	31,266,559	36,562,129	38,516,075	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	0	0	0	500,000	
General Fund	0	0	0	500,000	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
TOTAL - (5) Other Medical Services	163,102,244	180,617,743	210,668,439	228,061,497	8.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	71,224,182	111,705,833	125,484,487	142,887,715	13.9%
Cash Funds	28,329,285	31,880,659	40,252,113	38,325,727	(4.8%)
Reappropriated Funds	812,550	854,207	2,491,722	2,491,722	0.0%
Federal Funds	62,736,227	36,177,044	42,440,117	44,356,333	4.5%
TOTAL - Department of Health Care Policy and Financing	5,486,492,505	6,593,154,305	7,602,643,040	7,582,519,590	(0.3%)
FTE	363.7	360.4	388.0	391.0	0.8%
General Fund	1,058,787,358	1,057,378,944	1,166,537,609	1,298,364,719	11.3%
General Fund Exempt	642,674,257	813,135,957	848,552,061	848,552,061	0.0%
Cash Funds	868,825,264	826,242,635	985,400,644	939,312,239	(4.7%)
Reappropriated Funds	7,200,751	27,551,649	6,110,549	6,214,407	1.7%
Federal Funds	2,909,004,875	3,868,845,120	4,596,042,177	4,490,076,164	(2.3%)

Appendix B: Recent Legislation Affecting Department Budget

2014 Session Bills

S.B. 14-012 (Aid to the Needy Disabled): Requires the Department of Human Services to increase the monthly benefit amount for the Aid to the Needy and Disabled program by 8.0 percent in FY 2014-15. From FY 2015-16 to FY 2018-19, subject to available appropriations, the Department is encouraged to increase the monthly award until it is equal to the award level in FY 2006-07, and then to increase the award to account for cost of living in future years. Appropriates $4,697 total funds, including $2,301 General Fund, to the Department of Health Care Policy and Financing for FY 2014-15, and reappropriates these moneys to the Department of Human Services to contract with the Governor's Office of Information Technology to make changes to the Colorado Benefits Management System (CBMS). For more information on S.B. 14-012, please see the "Recent Legislation" section in the Department of Human Services section of this document.

S.B. 14-014 (Heat Fuel Grants): Makes changes to the Property Tax, Rent, and Heat Rebate Program to increase the maximum property tax and rent rebate for income-eligible claimants, establish a flat rate rebate for both the property tax and rent rebate and the heat rebate in an expanded range of income eligibility, and implements various recommendations of the August 2013 legislative audit of the program. Appropriates $1,397 total funds, including $684 General Fund, to the Department of Health Care Policy and Financing for FY 2014-15, and reappropriates these moneys to the Department of Human Services to contract with the Governor's Office of Information Technology to make changes to the Colorado Benefits Management System (CBMS). For more information on S.B. 14-014, please see the "Recent Legislation" section in the Department of Revenue section of this document.

S.B. 14-130 (Nursing Personal Care Allowance): Increases from $50 to $75 per month the personal needs allowance for Medicaid recipients in nursing facilities and inflates this amount by the increase in nursing facility rates in future years. Makes the appropriations contained in the table below to implement the act and, in addition, reduces General Fund appropriations to the Controlled Maintenance Trust Fund by $532,412.

Cost of Implementing S.B. 14-130					
Line Item	**TOTAL**	**GF**	**CF**	**RF**	**FF**
Health Care Policy and Financing					
Medical Service Premiums					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	$1,057,300	$517,971	$0	$0	$539,329
Department of Human Services Medicaid-funded programs					
Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	2,289	1,138	9	0	1,142

Cost of Implementing S.B. 14-130					
Line Item	**TOTAL**	**GF**	**CF**	**RF**	**FF**
Services for People with Disabilities					
Regional Centers	22,345	10,947	0	0	11,398
Human Services					
Office of Information Technology Services					
Colorado Benefits Management System					
Colorado Benefits Management System, Operating Expenses	6,203	2,356	215	2,289	1,343
Services for People with Disabilities -- Medicaid Funding					
Regional Centers for People with Developmental Disabilities					
Wheat Ridge Regional Center Personal Services	0	0	(9,216)	9,216	0
Grand Junction Regional Center Personal Services	0	0	(7,111)	7,111	0
Pueblo Regional Center Personal Services	0	0	(6,018)	6,018	0
Governor - Lieutenant Governor - State Planning and Budgeting					
Office of Information Technology					
Applications					
Colorado Benefits Management System	6,203	0	0	6,203	0
TOTAL	**$1,094,340**	**$532,412**	**($22,121)**	**$30,837**	**$553,212**

S.B. 14-144 (Family Medicine Residency Training in Rural Areas): Expands the responsibilities of the Commission on Family Medicine regarding family medicine residency training programs in rural and underserved areas and appropriates a net $75,000 federal funds to the Commission for this purpose in FY 2014-15.

S.B. 14-151 (Nursing Home Innovations): Modifies the Nursing Home Innovation Grant Program, including establishing minimum annual grants based on the balance in the Nursing Home Penalty Cash Fund, and appropriates $165,000 from the Nursing Home Penalty Cash Fund to the Department of Health Care Policy and Financing for FY 2014-15 for an increase in grant awards.

S.B. 14-159 (Medical Clean Claims): Modifies procedures and deadlines for the Medical Clean Claims Task Force responsible for developing standardized payment rules and edits for payers and providers for undisputed claims, and appropriates $128,688 General Fund to the Department of Health Care Policy and Financing in FY 2014-15 for the Task Force's new duties.

S.B. 14-180 (Transfer Senior Dental Program to HCPF): Transfers the Dental Assistance Program for Seniors, also known as the Old Age Pension (OAP) Dental Program, from the Department of Public Health and Environment (DPHE) to the Department of Health Care Policy and Financing (HCPF) as of July 1, 2015. Renames the Program the Colorado Dental Health Care Program for Low-Income Seniors and modifies the eligibility criteria to align with other

dental benefits for seniors and to target services to economically disadvantaged seniors as defined in rule. Provides funds to qualified grantees, including Area Agencies on Aging, community organizations, Local Public Health Agencies, federally qualified health centers, and private dental practices. Requires HCPF to award grants to qualified grantees on or after July 1, 2015, and to establish rates for dental services under the program. Grantees are required to provide outreach, identify eligible seniors and dental care providers, and pay claims for services. Creates the Senior Dental Advisory Committee. Reduces the appropriation in the DPHE by $55,000 General Fund and increases the appropriation in HCPF by $55,000 General Fund and 0.8 FTE for FY 2014-15.

S.B. 14-215 (Disposition of Legal Marijuana Related Revenue): Creates the Marijuana Tax Cash Fund (MTCF) and directs that all sales tax moneys collected by the state starting in FY 2014-15 from retail and medical marijuana be deposited in the MTCF instead of the Marijuana Cash Fund. Specifies permissible uses of moneys in the MTCF, including increasing the availability of school-based prevention, early intervention, and health care services and programs to reduce the risk of marijuana and other substance use and abuse by school-aged children. Creates the School-based Substance Abuse Prevention and Intervention grant program in the Department of Health Care Policy and Financing (HCPF) to award competitive grants to entities to provide school-based prevention and intervention programs for youth, primarily focused on reducing marijuana use, but including strategies and efforts to reduce alcohol use and prescription drug misuse. Appropriates a total of $6,363,807 to HCPF for FY 2014-15, including $2,000,000 General Fund for the newly created grant program, and $4,363,807 (including $2,000,000 General Fund and $2,363,807 federal Medicaid funds) for school-based prevention and intervention substance use disorder services to be provided by behavioral health organizations. Directs the State Treasurer to transfer $4,260,000 from the MTCF to the General Fund to offset the General Fund appropriations to HCPF. For more information see the "Recent Legislation" section at the end of the Department of Revenue section of this report.

H.B. 14-1045 (Breast and Cervical Cancer Prevention): Reauthorizes and modifies the Breast and Cervical Cancer Prevention Program in the Department of Health Care Policy and Financing and for FY 2014-15: (1) decreases appropriations from tobacco tax money in the Prevention, Early Detection, and Treatment Fund to the Department of Public Health and Environment for transfer to the Department of Health Care Policy and Financing for breast and cervical cancer treatment by $936,892 and increases appropriations to the Department of Public Health and Environment by the same amount for breast and cervical cancer screening; and (2) provides a total of $7,006,802 and 1.0 FTE, including $2,424,017 cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and $4,582,785 from federal funds, to the Department of Health Care Policy and Financing for the reauthorized Breast and Cervical Cancer Prevention program.

H.B. 14-1211 (Complex Rehabilitation Technology in Medicaid): Modifies the Medicaid benefit for Complex Rehabilitation Technology designed and configured to meet a client's unique medical, physical, and functional needs, such as manual wheelchair systems, alternate positioning systems, standing frames, and gait trainers. Appropriates $51,133 to the Department of Health Care Policy and Financing in FY 2014-15 for implementation of the benefit

modifications, including $16,533 General Fund and $34,600 federal funds, and reduces appropriations to the Controlled Maintenance Trust Fund by $16,533 General Fund.

H.B. 14-1213 (Pharmacy Benefit Manager): Changes regulations for pharmacy benefit managers and appropriates, in FY 2014-15, $129,831 to the Department of Health Care Policy and Financing, including $44,519 General Fund and $85,312 federal funds, for increased costs of the Children's Basic Health Plan associated with the new regulations. Reduces appropriations to the Controlled Maintenance Trust Fund by $44,519 General Fund.

H.B. 14-1236 (Supplemental Bill): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2012-13 and FY 2013-14.

H.B. 14-1252 (Intellectual and Development Disabilities Services System Capacity): Amends the Intellectual and Developmental Disabilities Cash Fund (fund) to allow moneys in the fund to be used for administrative expenses relating to Medicaid waiver renewal and redesign and for increasing system capacity for home- and community-based services for persons with intellectual and developmental disabilities. Requires the Department, on or before April 1, 2014, to report to the Joint Budget Committee the plan for the distribution of moneys appropriated for increases in system capacity, and requires the Department to distribute the moneys by April 15, 2014 for increases in system capacity. Requires each community-centered board or provider that receives moneys for increases in system capacity shall report to the department on the use of the funds by October 1, 2014. Appropriates the following in FY 2013-14:

- Makes FY 2013-14 supplemental adjustments to the waivers;
- $4,500,000 General Fund to the Fund;
- $13,852 total funds and 0.2 FTE to the Department for administrative expenses for waiver renewal;
- $400,000 total funds, of which $200,000 is cash funds from the Fund and $200,000 is matching federal funds, for waiver renewal and redesign; and
- $4,293,074 cash funds from the Fund for system capacity improvements.

H.B. 14-1317 (Colorado Child Care Assistance Program Changes): Makes changes to the Colorado Child Care Assistance Program in the Department of Human Services. Includes an appropriation of $44,529 total funds, of which $21,813 is General Fund, to the Department for FY 2014-15. See the "Recent Legislation" section for the Department of Human Services for additional information.

H.B. 14-1336 (Long Bill): General appropriations act for FY 2014-15. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2012-13 and FY 2013-14.

H.B. 14-1357 (In-home Support Services in Medicaid): Modifies the Medicaid benefit for in-home support services, such as household and personal care services, for clients who would otherwise require care in a nursing facility, and appropriates $297,985 to the Department of Health Care Policy and Financing in FY 2014-15, including $145,983 General Fund and

$152,002 federal funds, for implementation of the benefit modifications. Also, reduces appropriations to the Controlled Maintenance Trust Fund by $145,983 General Fund.

H.B. 14-1360 (Sunset Review Licensure of Home Care Agencies): Continues the regulation of home care agencies and home care placement agencies until September 1, 2019, and implements the recommendations of the sunset report. Allows HCPF-certified community-centered boards or services agencies (CCBs) that provide in-home personal care services to obtain a home care agency license, prohibits the Department from conducting inspections related to a home care agency license renewal, or from assessing fees for a new or renewal home care agency license, for certified CCBs until July 1, 2016. Until that date, requires the Department and HCPF to establish a work group with CCBs and recipients of Medicaid Home- and Community-Based Services (HCBS) waivers to identify gaps or conflicts between home care agency license requirements and HCBS provider requirements. Requires the work group to submit recommendations for resolving gaps or conflicts to the State Board of Health and the Medical Services Board, and requires the boards to adopt rules regarding the gaps and conflicts by July 1, 2016. Requires the departments to report on the progress of these requirements during the 2014 and 2015 annual SMART Act presentations to the joint committees of reference. Appropriates $110,000 cash funds to the Department which is reappropriated to the Department of Public Health and Environment for FY 2014-15.

H.B. 14-1368 (Transition Youth Developmental Disabilities to Adult Services): Establishes a plan and appropriates funds to transfer youth into adult services for persons with IDD under Medicaid Home- and Community-Based Services (HCBS) in the Department of Health Care Policy and Financing (HCPF). The bill sets forth criteria for transition planning and instructs the State Board of Human Services and the Medical Services Board to promulgate any rules necessary to guide the transition. Creates the Child Welfare Transition Cash Fund (Fund). Appropriates a total of $5,746,227 total funds, including $2,829,586 cash funds and $2,916,641 federal funds to the Department for FY 2014-15.

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S.B. 15-011 (Spinal cord injury alternative medicine pilot program): Continues and changes the Medicaid Spinal Cord Injury Alternative Medicine Pilot Program. Provides $362,649 total funds, including $179,347 General Fund and $183,302 federal funds, and 0.8 FTE to the Department of Health Care Policy and Financing for the program.

S.B. 15-147 (Supplemental Bill): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2014-15.

S.B. 15-167 (Modify FY 2014-15 Appropriations from Marijuana Revenue): Aligns FY 2014-15 appropriations from and transfers related to the Marijuana Tax Cash Fund with actual marijuana tax revenue collected in FY 2013-14. With respect to the Department of Health Care Policy and Financing, the bill reduces the General Fund appropriation for the School-based Substance Abuse Prevention and Intervention Grant Program by $1,081,344 (from $2,000,000 to $918,656). The bill also reduces the associated statutory transfer from the General Fund to the

Marijuana Tax Cash Fund by $1,151,631 (from $4,260,000 to $3,108,369). For additional information, see the "Recent Legislation" section at the end of the Department of Revenue.

S.B. 15-228 (Medicaid Provider Rate Review): Establishes an annual process for the Department of Health Care Policy and Financing to review Medicaid provider rates, creates an advisory committee, and requires reporting to the Joint Budget Committee. Provides $539,823 total funds, including $269,912 General Fund and $269,911 federal funds, and 4.0 FTE to implement the rate review process.

S.B. 15-234 (Long Bill): General appropriations act for FY 2015-16. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2013-14 and FY 2014-15.

H.B. 15-1186 (**Services for Children with Autism**): For the Children with Autism waiver program the bill:

5. Expands eligibility to add children ages 6 to 8
6. Allows children who begin receiving services before age 8 to receive a full three years of services, and no more than three years
7. Allows General Fund support and thereby eliminates the current enrollment cap of 75 children
8. Eliminates the annual statutory $25,000 per child expenditure cap on services and allows the cap to be adjusted through the budget process
9. Provides for an annual evaluation of the effectiveness of services for people with autism
4.
5. To implement these changes, the bill provides $10.6 million, including $367,564 General Fund, to the Department of Health Care Policy and Financing in FY 2015-16. The table below summarizes the projected costs over the next three years. The source of cash funds is tobacco settlement moneys deposited in the Autism Treatment Cash Fund.
6.

Children with Autism Waiver Expansion			
	FY 15-16	FY 16-17	FY 17-18
Total	$10,616,568	$19,042,713	$22,726,738
General Fund	367,564	8,830,589	10,567,929
Cash Funds	4,840,203	508,566	577,333
Federal Funds	5,408,801	9,703,558	11,581,476

H.B. 15-1309 (Protective Restorations by Dental Hygienists): Allows dental hygienists to receive a permit from the Colorado Dental Board to perform interim therapeutic restorations. The Department must establish an advisory committee to develop standards for interim therapeutic restorations. The bill places various restrictions on dental hygienists performing interim therapeutic restorations, including prohibiting the use of local anesthesia and requiring that a dentist first provide the diagnosis, treatment plan, and instruction for the dental hygienist to perform the restoration. Appropriations include $37,940 cash funds from the Division of Professions and Occupations Cash Funds to the Department of Regulatory Affairs for FY 2015-16, including $30,514 for personal services and $7,426 for the purchase of legal services from

the Department of Law. The bill also appropriates $37,606 to the Department of Health Care Policy and Financing for FY 2015-16, including $10,815 General Fund and $833 cash funds from various cash funds. This provision also anticipates that the Department of Health Care Policy and Financing will receive $25,958 federal funds to implement the act.

H.B. 15-1318 (Consolidate Intellectual and Developmental Disability Waivers): Requires the Department of Health Care Policy and Financing (Department) to consolidate the two existing home- and community-based waivers for adults with intellectual and developmental disabilities into a single waiver by July 1, 2016 or as soon as the Department receives approval from the Centers for Medicare and Medicaid. Requires the redesigned waiver to include flexible service definitions, provide access to services and supports when and where they are needed, offer services and supports based on the individual's needs and preferences, and incorporate the following principles (which are drawn from the Community Living Advisory Report):

(a) Freedom of choice over living arrangements and social, community, and recreational opportunities;

(b) Individual authority over supports and services;

(c) Support to organize resources in ways that are meaningful to the individual receiving services;

(d) Health and safety assurances;

(e) Opportunity for community contribution; and

(f) Responsible use of public dollars.

Requires the use of a needs assessment tool that aligns with the Community Living Advisory Group recommendations and one that is fully integrated with the assessment processes for other long-term services. The tool must ensure an individual's voice and needs are accounted for when determining what services the individual needs. The bill requires the payment system for services to be efficient, transparent and equitable and ensure the fair distribution of available resources. Requires the Department to submit to the JBC as part of the FY 2016-17 Governor's budget request a justification for the continued use of the Supports Intensity Scale (SIS) assessment. If the JBC concludes the justification is insufficient, the Department shall present a transition plan to a different assessment tool for the redesigned waiver.

Requires the Department to develop a plan by July 1, 2016 for the delivery of conflict-free case management services that comply with federal requirements related to person-centered planning. The Department is required to report back to the Joint Budget Committee during the FY 2016-17 budget process regarding plan development and any required statutory changes. The Department is required to get input from Community Centered Boards, Single Entry Points and other stakeholders on the development of the plan. Appropriates $2,176,695 total funds, including $788,347 cash funds and 2.7 FTE to the Department for FY 2015-16.

H.B. 15-1368 (Cross-system Response Pilot Intellectual and Developmental Disabilities): Establishes the Cross-system Response for Behavioral Health Crises Pilot Program (Pilot Program) to provide crisis intervention, stabilization, and follow-up services to individuals who:

- Have both an intellectual or developmental disability and a mental health or behavioral disorder;
- Require services not available through an existing Medicaid waiver; and

- Are not covered under the Colorado behavioral health care system.

Requires the Pilot Program to begin on or before March 1, 2016 and consist of multiple sites that represent different geographic areas of the state. The Pilot Program must provide access to intensive coordinated psychiatric, behavioral, and mental health services as an alternative to emergency department care or in-patient hospitalization; offer community-based, mobile supports to individuals with dual diagnoses and their families; offer follow-up supports to individuals with dual diagnoses, their families, and their caregivers to reduce the likelihood of future crises; provide education and training for families and service agencies; provide data about the cost in Colorado of providing such services throughout the state; and provide data to inform changes to existing regulatory or procedural barriers to the authorized use of public funds across systems, including the Medicaid state plan, home- and community-based service Medicaid waivers, and the capitated mental health system.

Requires the Department of Health Care Policy and Financing (Department) to conduct a cost-analysis study related to the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. Also, requires the Department to provide recommendations for eliminating the service gap. Authorizes the Departments of Human Services and Health Care Policy and Financing to examine the feasibility of allowing a Community Centered-Board to use a vacant Regional Center group home for the Pilot Program. Appropriates $1,695,000 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund to the Cross-system Response for Behavioral Health Crises Pilot Program Fund and reappropriates these monies for the pilots in the Department of Health Care Policy and Financing for FY 2015-16.

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

LONG BILL FOOTNOTES

10 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, Scholarships for Research Using the All-Payer Claims Database -- The purpose of this appropriation is to provide scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.

Comment: The Department is using the funding in compliance with the footnote. The Department has awarded $220,000 of the $500,000 for FY 2015-16 to date. Requests for initiatives to improve quality of care and lower costs are prioriatized.

11 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses – It is the General Assembly's intent that necessary changes be made to the Colorado Benefits Management System to allow, beginning in FY 2016-17, the use of annualized income for purposes of determining Medicaid eligibility for adults who present evidence of fluctuating income. Allowing the use of annualized income in FY 2016-17 is projected to effect 20,430 clients who would receive an average of 3.48 months more of Medicaid services in a year at a cost of $12,281,696 total funds, including $1,410,508 General Fund.

Comment: The Department indicates that it is on pace for a July 1 implementation of the change in eligibility determination policy.

12 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $1 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 plans to submit a state plan amendment by December 31, 2015 to implement this program. The Department cannot implement the program until authorized by the Centers for Medicare and Medicaid Services.

13 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $711,238 total funds, including $350,000 General Fund and $361,238 federal funds for the purpose of increasing the current $12,500 lifetime cap on home modifications by an amount projected to be feasible within this level of funding, up to a maximum lifetime cap of $20,000.

Comment: The Department is awaiting approval by the Centers for Medicare and Medicaid Services (CMS) before it can implement the increase. *See the issue brief Federal Approval Process for Changes to Medicaid for more information.*

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

Comment: The Department is complying with this footnote. *See the 12/14/15 briefing on the Office of Community Living for more information.*

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

Comment: The Department is complying with this footnote. *See the 12/14/15 briefing on the Office of Community Living for more information*

16 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 in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

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

17 Department of Health Care Policy and Financing, Department of Human Services Medicaid-funded Programs, Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program -- This appropriation is intended to include sufficient funding for the Department of Health Care Policy and Financing to implement the following provider rate increases for this program: (a) a $13.98 (91.3 percent) increase in the outpatient group rate; (b) a $31.26 (20.0 percent) increase in the per diem rate; plus (c) an overall rate increase of 1.7 percent.

Comment: The Department submitted a state plan amendment to implement the rate increase 6/3/15. The Centers for Medicare and Medicaid Services (CMS) has outstanding questions about the FY 2014-15 clinic upper payment limits and issued a Request for Additional Information. The Department is working on a response. *See the 12/9/15 briefing on Behavioral Health for more information.*

REQUESTS FOR INFORMATION

Requests Affecting Multiple Departments

3. Department of **Health Care Policy and Financing**, Behavioral Health Community Programs; and Department of **Human Services**, Behavioral Health Services -- The Department of Human Services is requested to work with the Department of Health Care Policy and Financing and any other relevant state agencies to provide a report to the Joint Budget Committee by November 1, 2015, concerning substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women. The report is requested to include the following information: (a) a brief description of each state program that provides SUD prevention or treatment services for adolescents or pregnant women; (b) actual expenditures for SUD prevention or treatment services for adolescents and pregnant women in FY 2014-15, by program and fund source; and (c) information indicating whether there is a need for additional state funding to meet the SUD prevention and treatment needs of adolescents or pregnant women.

Comment: The Department submitted a report as requested. *For analysis of the report see the* 12/9/15 *briefing on Behavioral Health.*

4. Department of **Education**, Assistance to Public Schools, Grant Programs, Distributions, and Other Assistance, Reading and Literacy, Early Literacy Competitive Grant Program; Department of **Health Care Policy and Financing**, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of **Higher Education**, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of **Human Services**, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Behavioral Health Services, Mental Health Community Programs, Mental Health Services for Juvenile and Adult Offenders, and Mental Health Treatment Services for Youth (H.B. 99-1116); and Substance Use Treatment and Prevention, Other Programs, Community Prevention and Treatment; Department of **Military and Veterans Affairs**, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of **Personnel**, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of **Public Health and Environment**, Administration and Support, Local Public Health Planning and Support; Disease Control and Environmental Epidemiology Division, Administration, General

Disease Control, and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by November 1, 2015, for each program funded with Tobacco Master Settlement moneys: the name of the program; the amount of Tobacco Settlement moneys received for the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals; and a recommendation regarding the amount of Tobacco Master Settlement funds the program requires for FY 2016-17 and why.

Comment: The Department submitted a report as requested. *For analysis of the report see the* 11/19/15 *briefing on Tobacco Master Settlement moneys.*

6. **All Departments** -- All Departments that own or have administrative custody of or administrative responsibility for State-owned buildings or structures are requested to provide by October 1, 2015, to the Joint Budget Committee an inventory list of all such department buildings or other department structures that are 50 years or older; each building's or structure's general condition and use status; and the estimated cost to address controlled maintenance needs or to provide for demolition.

   Comment: The executive branch submitted a report as requested. *For analysis of the report see the* 11/12/15 *briefing on Capital Construction.*

Department of Health Care Policy and Financing

1. Department of Health Care Policy and Financing, Executive Director's Office – The Department of Health Care Policy and Financing is requested to submit a report to the Joint Budget Committee, by November 1, 2015, comparing Medicaid reimbursement rates for services to Medicare. For codes without a comparable Medicare rate, the Department shall find and identify a data source that will estimate the usual and customary rate paid in a commercial health plan. The Department shall include the reasoning behind the selection of data sources used to estimate the usual and customary rate. The report shall be submitted in a format that provides the ability to estimate the cost of bringing Medicaid rates to a variable percentage of the applicable Medicare rate or usual and customary rate. For codes unique to the Medicaid program, the Department is requested to collect comparable data from other states' Medicaid programs when and if available. For any codes for which the Department cannot find a comparison rate, the Department shall list the codes, the current Medicaid rate, and the reason the Department was unable to find a comparison. Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report, except that the Department will estimate the portion of total expenditures paid through each of these methods.

Comment: The Department submitted the report as requested. For a summary of the report, see the Provider Rate Review issue brief.

2. Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report by November 1 each year estimating the total savings, total cost, and net cost effectiveness of fraud detection efforts.

   Comment: The Department submitted the report as requested. This footnote was added in conjunction with the JBC's approval of a new FTE for the Department to assist with implementing a prepayment fraud detection model. Software would identify potentially fraudulent claims and deny them before payment, pending additional information, similar to the way anti-theft software might deny a non-standard credit card charge. The Department reports it hired the new FTE on September 21, 2015 and it is in the process of designing the technology strategy. The Department indicates that future versions of the report will analyze the cost, savings, and effectiveness of the new prepayment review model. If the JBC's goal was to also receive information about the cost, savings, and effectiveness of current post-payment fraud detection efforts, then the Department's report did not provide this information.

3. Department of Health Care Policy and Financing, Office of Community Living -- The Department is requested to provide by November 1, 2015, a written report detailing how the Department will implement the recommendations made by the Community Living Advisory Group, Colorado's Community Living Plan developed to comply with the United States Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 14 581 (1999), and the final federal rule setting forth requirements for home- and community-based services, 79 FR 2947. The report shall include: a detailed project plan which includes the timeline for implementing the recommendations and requirements, an explanation of any recommendations or requirements not included in the plan, and an explanation of how outcome measures will be tracked in the future to better understand how changes impact clients. The Department is also requested to provide a financial analysis of the costs of implementing recommendations for FY 2016-17 and FY 2017-18. Additionally the report shall include a description of any FY 2016-17 budget requests that align with the plan.

   Comment: The Department submitted the report as requested. For information about this report, please see the *12/14/15* briefing on the Office of Community Living.

4. Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report to the Joint Budget Committee by June 30, 2015, on how the Department plans to improve the allocation of administrative expenses by cash fund, either using the Public Assistance Cost Allocation Plan (PACAP) technology, or some other method, for the FY 2016-17 budget cycle.

   Comment: The Department submitted the report as requested. The Department indicated it does not have plans to incorporate state funding sources in the PACAP. The PACAP describes a federally mandated annual allocation process to ensure that overhead expenditures receive the correct level of federal financial participation based on the programs

and services they support. The issue the JBC staff raised is that the Department has no similar annual process to ensure that overhead expenses receive the correct level of cash fund participation based on the programs and services they support. In the report the Department indicates that developing an initial plan would require additional resources and implementing the plan would require internal staff time that may not be able to be absorbed within existing FTE. However, the JBC staff notes that this is a relatively standard process performed by other state departments. The JBC staff doubts that an annual allocation process would result in significant increases or decreases in cash fund expenditures compared to the scale of the Department's total funding, but with the increasing complexity of cash fund financing for the Department's activities, the development of an annual allocation process seems warranted to the JBC staff to ensure that cash funds are not paying too little or too much for overhead expenses. The JBC staff will continue to work with the Department to try to resolve this issue.

5. Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report to the Joint Budget Committee by November 1, 2015, on performance and policy issues associated with emergency and non-emergency transportation services. Regarding non-emergency transportation, the report should include, but not be limited to, the time to complete a request for transportation, the wait time for a same-day request for transportation (e.g. for a hospital discharge), and a discussion of performance variations by region. Regarding emergency transportation, the report should discuss whether providers are appropriately compensated if they provide services on site and the patient declines transportation. If the information requested is not available, the Department is requested to provide as much relevant information as possible.

   Comment: The Department submitted the report as requested. Based on the Department's response, continued legislative investigation of this service benefit appears warranted.

Non-emergency Transportation Services (NEMT)

NEMT is categorized as an "optional" service, but based on case law and prior decisions of the Centers for Medicare and Medicaid Services (CMS), the Department believes it is a required benefit. Colorado's policy provides coverage for clients who have "no other means of transportation." Clients are asked to self-verify whether they have a privately owned vehicle or other means to facilitate transportation. Public transportation is not considered an "other means of transportation" that would disqualify the benefit. Mileage reimbursement is available for transportation provided by a member's friend, family, or support system. NEMT is treated as an administrative expense and as such receives a 50 percent federal match rate, regardless of who accesses the service. NEMT is administered through three structures:

- A state-managed contract with Total Transit to provide services in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, and Weld counties.
- Three multi-county collaboratives that have each hired a regional provider. These multi-county collaboratives involve 19 counties.
- County-operated programs in all other counties.

Colorado spent $13.3 million on NEMT in FY 2014-15. The report contained an error that reported the FY 2014-15 expenditures as $8.8 million.

Time to Complete a Request for Transportation
There are no statewide performance targets or indicators for NEMT and so transportation request and response time data is not available for a majority of counties. The Department has some performance data available from Total Transit, which serves nine counties, and the Department conducted a survey of the three multi-county collaboratives that serve 19 counties. The Department reports that these counties have time-based performance standards for processing and completing a request for transportation, but the standards range from 24 hours to 72 hours. The Department did not report the performance data.

The Department reported that total transit had 222,893 calls in the 11 months it held the provider contract prior to the report and had an average call resolution rate of 94.1 percent. The Department did not explain what call resolution means, but it does not sound like a measure of time to completion. The Department also reported that Total Transit made 332,375 trips and was "on time" for 240,589 of those trips, or 72.4 percent. The Department did not define what qualifies as an "on time" trip.

Wait Time for Same-day Requests for Transportation
There are no statewide performance targets or indicators for NEMT. The Department reports that the three multi-county collaboratives surveyed indicated that same-day requests for transportation are "challenging." Total Transit has access to more transportation services and reports that hospital discharges are "always accommodated" and urgent trips with verification can be handled with three hours prior notice. Total Transit made 44,337 urgent trips and was on-time for 29,355, or 66.2 percent, of those trips. This is a measure of trips and not requests. Again, the Department did not define what qualifies as an on time trip.

Performance Variations by Region
There are no statewide performance targets or indicators for NEMT. The Department reports that only eight of the 55 counties not served by Total Transit have policies, procedures, or performance standards related to NEMT.

The Department reported that survey data suggests county administrative activities related to transportation vary considerably:

- 64% verify Medicaid eligibility
- 61% process mileage reimbursement
- 59% bill Medicaid
- 57% verify medical appointments
- 56% verify whether a client has access to other means of transportation
- 40% reported spending 10-20 hours monthly on NEMT; 1 county reported 400 hours
- 14% of counties had only informal procedures for handling NEMT complaints and 9% had no procedures

Emergency Transportation Services

The Department reported that Medicaid reimbursement is not available if services are provided on site and the patient declines transportation. The Department indicated this is a "problem" nationally with both public and private insurance. The Department says it is responding with several initiatives aimed at reducing the overuse of emergency services. As an example, the Department mentioned a partnership between the Regional Care Collaborative Organization in Region 7 and the Colorado Springs Fire Department to respond differently to community members who rely heavily on the emergency response system for potentially preventable or non-emergency needs. The Department also mentioned participation in the Community Paramedicine/Mobile Integrated Healthcare Task Force to explore establishing a Community Paramedicine Services in Colorado. The Department did not mention changing reimbursement to pay for services provided on site when the patient declines transportation or provide any cost estimates with that approach.

Conclusions and Recommendations

The Department ended the report with 14 bullet points, spanning 3 pages, worth of strategies for improving NEMT services. It is also worth noting that the Department's schedule for reviewing provider rates puts reimbursement of emergency and non-emergency transportation in the first year of the review process. One of the bullet points was to develop and enforce statewide performance standards to gather better information about NEMT services. Many of the bullets discuss changes that would require significant time to implement and potentially new resources. For example, one of the bullets mentions studying options for revising the County Administration allocation methodology to ensure transportation activities are properly compensated. Another bullet mentions improvements to the way NEMT is tracked in the Medicaid Management Information System. The 14 bullet points read like a long to do list, but it is not clear how the Department prioritizes the solutions. It is also not clear which strategies could be implemented quickly, the Department's time frame for implementation, or which strategies might cost additional resources. The JBC may want to ask the Department to discuss the 14 strategies for improving transportation services at the hearing.

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

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

7. Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by November 1, 2015, to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and performance results with an emphasis on the fiscal impact.

   Comment: The department submitted the report as requested.

Background

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

The PCMPs function as medical homes for clients and also receive a per member per month fee to coordinate care that includes a payment component based on achieving improved health outcomes. Part of the care coordination provided by RCCOs and PCMPs includes looking beyond health needs to connect clients with wraparound services such as housing assistance, long-term services and supports, behavioral health care, child care, transportation, food assistance, and other community services.

To assist with care coordination and the performance funding the Statewide Data Analytics Contractor (SDAC) collects information and disseminates it to ACC providers and the Department. The client level data helps identify high needs clients and potentially effective interventions. At a population level the data helps identify high performing PCMPs and RCCOs and best practices. Access to the information is monitored based on role-based security protocols and protected under federal health privacy laws.

Enrollment

At the end of FY 2014-15 899,596 clients were enrolled in the ACC. This is more than 70 percent of all clients. This is a 48 percent increase from the clients enrolled the previous year. The Department reports that 76 percent of ACC clients were connected to a PCMP.

Administrative fees and costs

The table below summarizes actual administrative costs for the program in FY 2013-14 and FY 2014-15 and projected costs through FY 2016-17. These figures are from the Department's narrative for R1 and include incentive payments paid in one year that were

earned in another year, and so they differ slightly from the costs identified in the report that are based on when the payments are earned.

Accountable Care Collaborative Administrative Expenses				
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Regional Care Collaborative Organizations	$52,945,462	$79,471,841	$106,868,808	$118,744,642
Primary Care Medical Providers	12,674,868	21,419,450	31,516,838	34,197,830
Statewide Data Analytics Contractor	2,950,000	2,508,950	3,000,000	1,000,000
Administration	$68,570,330	$103,400,241	$141,385,646	$153,942,472

The RCCOs and PCMPs earn base per member per month fees with incentives for meeting performance goals for improved health outcomes.

Performance/savings

The Department's financial modeling estimates FY 2014-15 ACC activities avoided medical costs of $12.3 million. Because the budget is based on cash accounting the estimated savings assumed in the budget request are slightly different.

Accountable Care Collaborative Estimated Savings			
	FY 2012-13	FY 2013-14	FY 2014-15
Administration	$36,728,931	$68,570,330	$83,605,253
Estimated Savings	(43,647,968)	(81,781,107)	(121,288,048)
Net Impact	($6,919,037)	($13,210,777)	($37,682,795)

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

   Comment: This report is not due until February 1 and will be discussed during figure setting.

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

   Comment: The Department submitted the report as requested. The program pays for medically necessary services that are part of a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of covered services include direct medical services, rehabilitative therapies, and Early and Periodic Screening, Diagnostic and Treatment Services. Medical necessity is determined through the federally and state regulated IEP or IFSP process. In FY 2014-15 the program served 16,239 children. Due to delays in the way the eligible costs are determined and the funds are distributed the

Department reported FY 2013-14 total federal funds matched with certified public expenditures, rather than FY 2014-15 funds. The total federal funds distributed were $28,029,129 and this amount was distributed to 50 school health services program providers.

10. Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities – The Department is requested to submit a report to the Joint Budget Committee by November 1, 2015 regarding the status of the distribution of the full program equivalents for the developmental disabilities waivers. The report is requested to include any current or possible future issues which would prevent the distribution of the total number of enrollments noted in the FY 2015-16 Long Bill.

    Comment: The Department submitted the report as requested. *See the 12/14/15 briefing for the Office of Community Living for analysis of the Department's response to this Request for Information.*

11. Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities -- The Department is requested to submit the following information to the Joint Budget Committee by November 1, 2015: how moneys appropriated for the community capacity increase have been and will be used by community centered boards and service providers, the feasibility of implementing a tiered incentivized system for the intellectual and developmental disabilities waivers, and the cost of such a system.

    Comment: The Department submitted the report as requested. *See the 12/14/15 briefing for the Office of Community Living for analysis of the Department's response to this Request for Information.*

12. Department of Health Care Policy and Financing, Executive Director's Office – The Department of Health Care Policy and Financing is requested to submit a report to the Joint Budget Committee, by November 1, 2015, on the performance of the Medicare Savings Program. The report should discuss enrollment trends, obstacles to enrollment, previous and current marketing and outreach efforts, and future implementation strategies. The report should also discuss the effect of the program on health outcomes.

    Comment: The Department submitted the report as requested.

Medicare Savings Programs

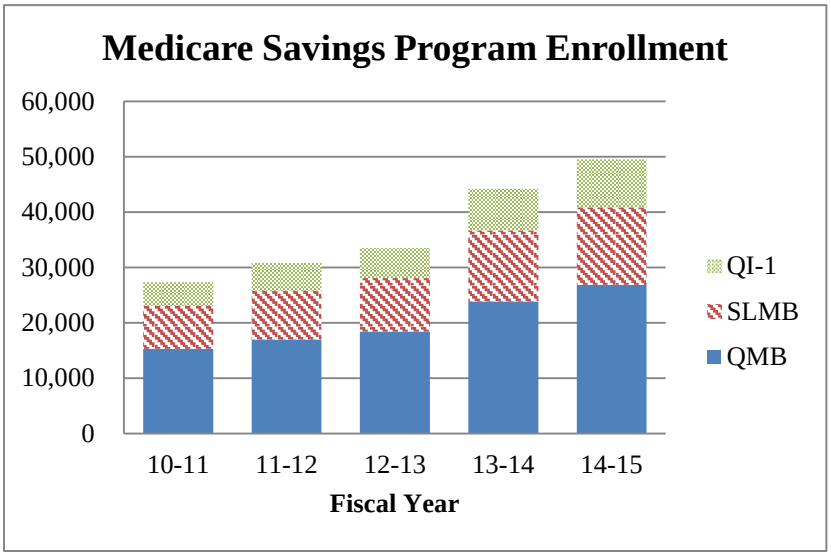
Medicare Savings Programs help people who meet the income qualifications to pay a variable amount, based on income, of Medicare premiums and deductibles. For the lowest income Qualified Medicare Beneficiaries Part A and B premiums are paid as well as coinsurances and deductibles. For slightly higher income Specified Low-income Medicare Beneficiaries (SLMB) and Qualified Individuals-1 (QI-1) only the Medicare Part B premium is paid. For Qualified Disabled Working Individuals (QDWI) the Medicare Part A premium is paid.

Performance

The report argues that access to health care through Medicare may encourage clients to seek medical attention sooner, and this may decrease the number of people who need Medicaid and the duration of people on Medicaid. The report presents no statistics or analysis of the effectiveness of the Medicare Savings Programs.

Enrollment Trends

The Department indicates there has been a steady increase in enrollment in Medicare Savings Programs. Changes in federal policy increased asset limits in 2013, resulting in an uptick in enrollment in FY 2013-14.



Obstacles to Enrollment

Federal policies require the Department to treat the Medicare Savings Program Application Initiation File as an application, but the Department indicates that the data contained in the file cannot be used by the Colorado Benefits Management System to automatically determine eligibility. The Department identified two issues: 1) the file includes all applicants for the Medicare Low-Income Subsidy for Medicare Part D, rather than just those approved; and 2) the file does not break out types of income and assets with enough specificity to determine Medicaid eligibility. Insufficiently specific data entry in CBMS could also affect eligibility determinations for other social services programs that use the same data elements. As a result, a letter is sent to applicants requesting additional information. Applicants who have trouble finding the requested verification documents, for literacy, health, or other reasons, may abandon the application.

Marketing and Outreach

In addition to the letter generated from the Medicare Savings Program Application Initiation File, the Department indicated it develops fact sheets and posts updates on the Department's web site and works closely with eligibility and community partners to conduct outreach. The Department noted that it has had several meetings with the Colorado Gerontological Society

on how to best utilize the Medicare Savings Program Application Initiation File to eliminate barriers to enrollment.

Future Implementation Strategies

The report indicates that the ideas in the bullets below have been suggested for future implementation, but does not describe who suggested the ideas. It does not indicate whether the Department is pursuing any of these strategies.

- Request that the Social Security Administration refine the Medicare Savings Program Application Initiation File to make it useable for automatic eligibility determination.
- Expand Medicaid eligibility to match that of the partial Low-Income Subsidy for Medicare Part D. The Department indicates this could be accomplished through a regulation change, a State Plan Amendment, and funding from the General Assembly, but does not estimate the cost or expected effect on enrollment.
- Expand Medicaid eligibility by eliminating the asset test for Medicare Savings Programs. This would require a statutory change. There are other states that have eliminated the asset test and indicated that the administrative savings help offset the cost of increased enrollment. Again, the Department did not estimate the cost or expected effect on enrollment.

Appendix D: SMART Act Annual Performance Report

Pursuant to Section 2-7-205 (1) (a) (I), C.R.S., the Office of State Planning and Budgeting is required to publish an Annual Performance Report for the Department of Human Services by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2014-15 report dated October 2015 can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbSlI3UkVmQ05VY28/view

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of Human Services is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2015-16 updated plan dated October 28, 2015 can be found at the following link:

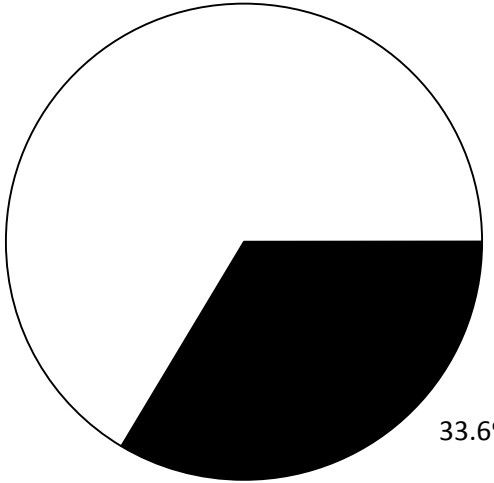
https://drive.google.com/folderview?id=0BzIopKKDzSSTfnRpV1JXYTA1Z051THJWbmhHTkpJLVNvOXJkSm5qbWlJM1ZRSUVyTEhJTmM&usp=drive_web

JBC Staff Briefing
Department of Health Care Policy and Financing

Presented by:

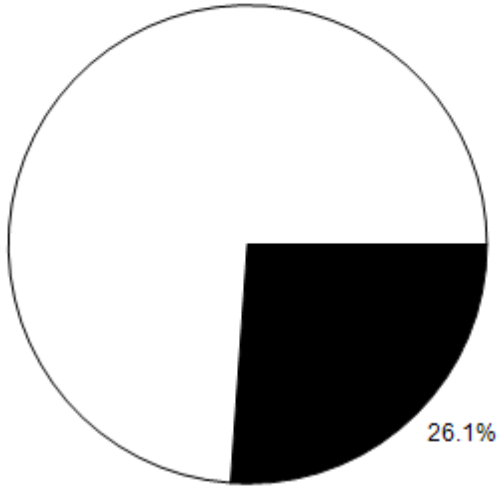
Eric Kurtz, JBC Staff
December 2, 2014

Department's Share of Statewide Total Funds



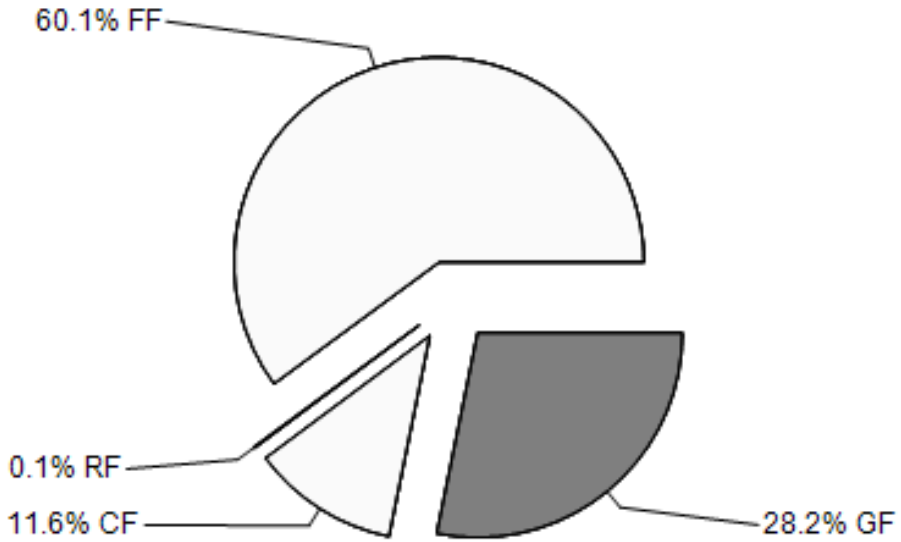
33.6% of Total Funds

Department's Share of Statewide General Fund

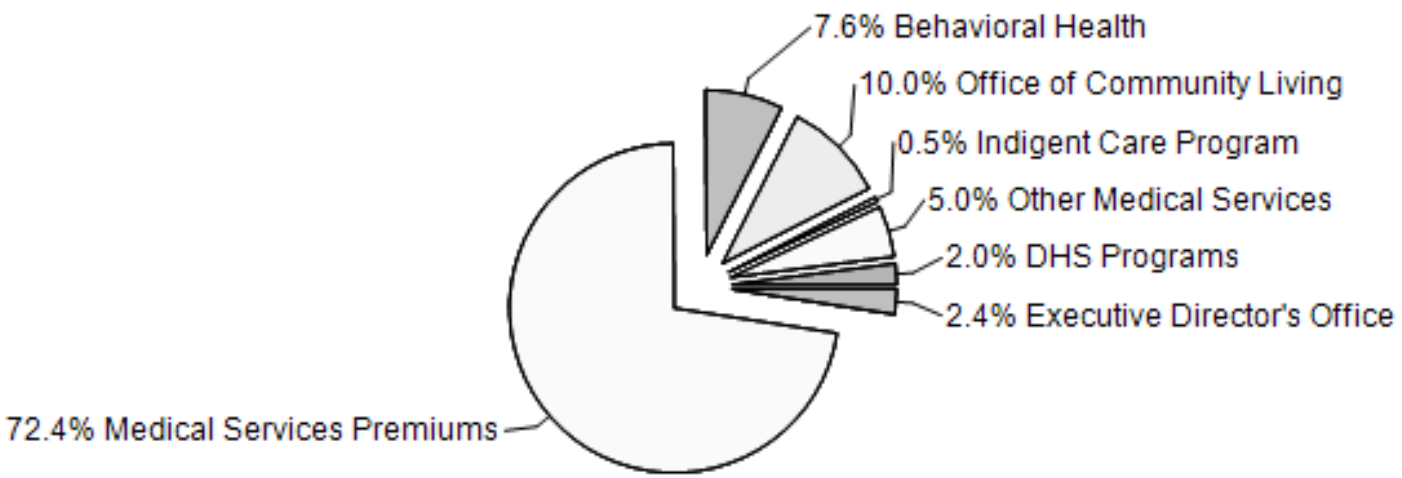


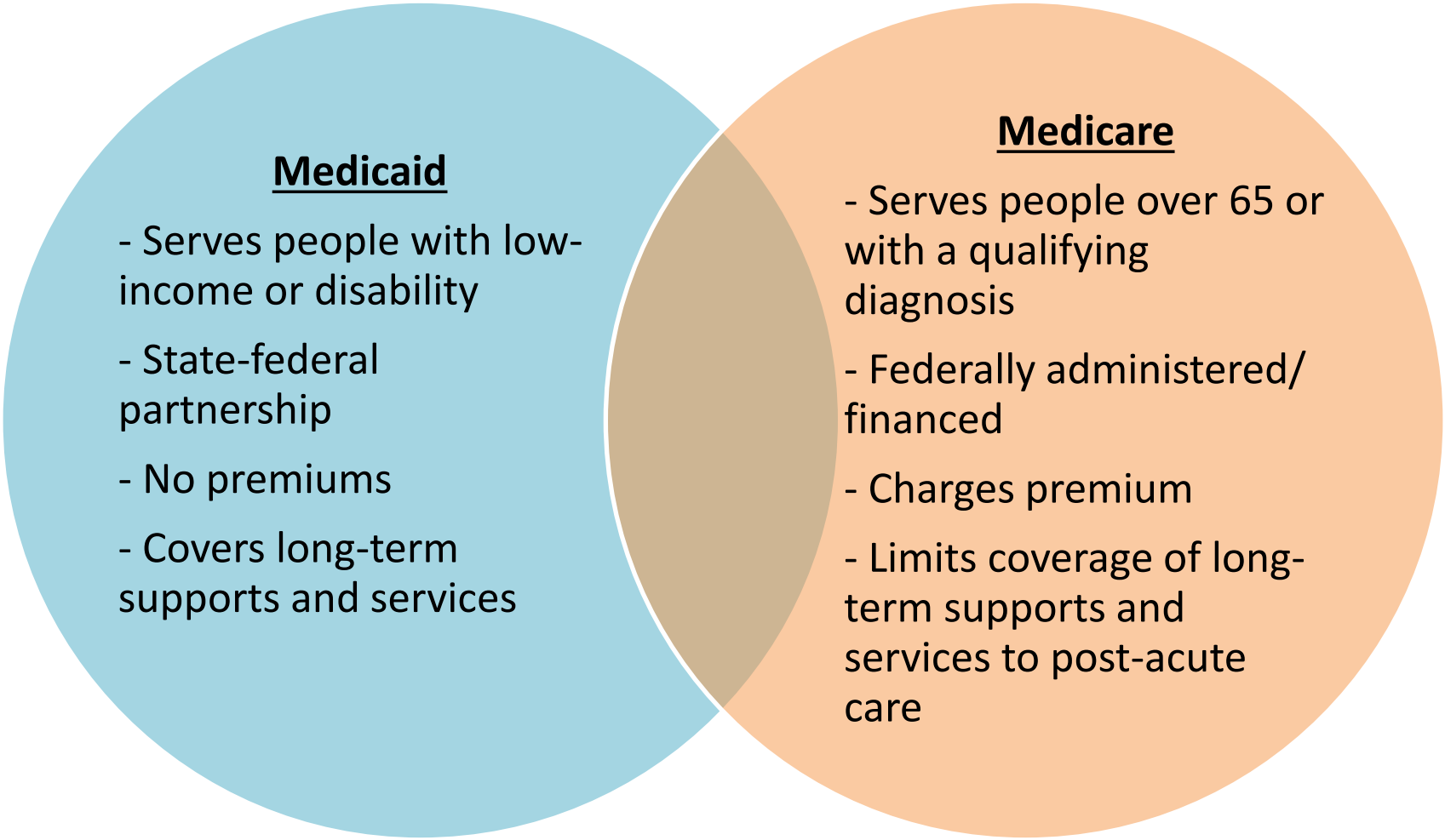
26.1% of GF

Department Funding Sources



Distribution of General Fund by Division



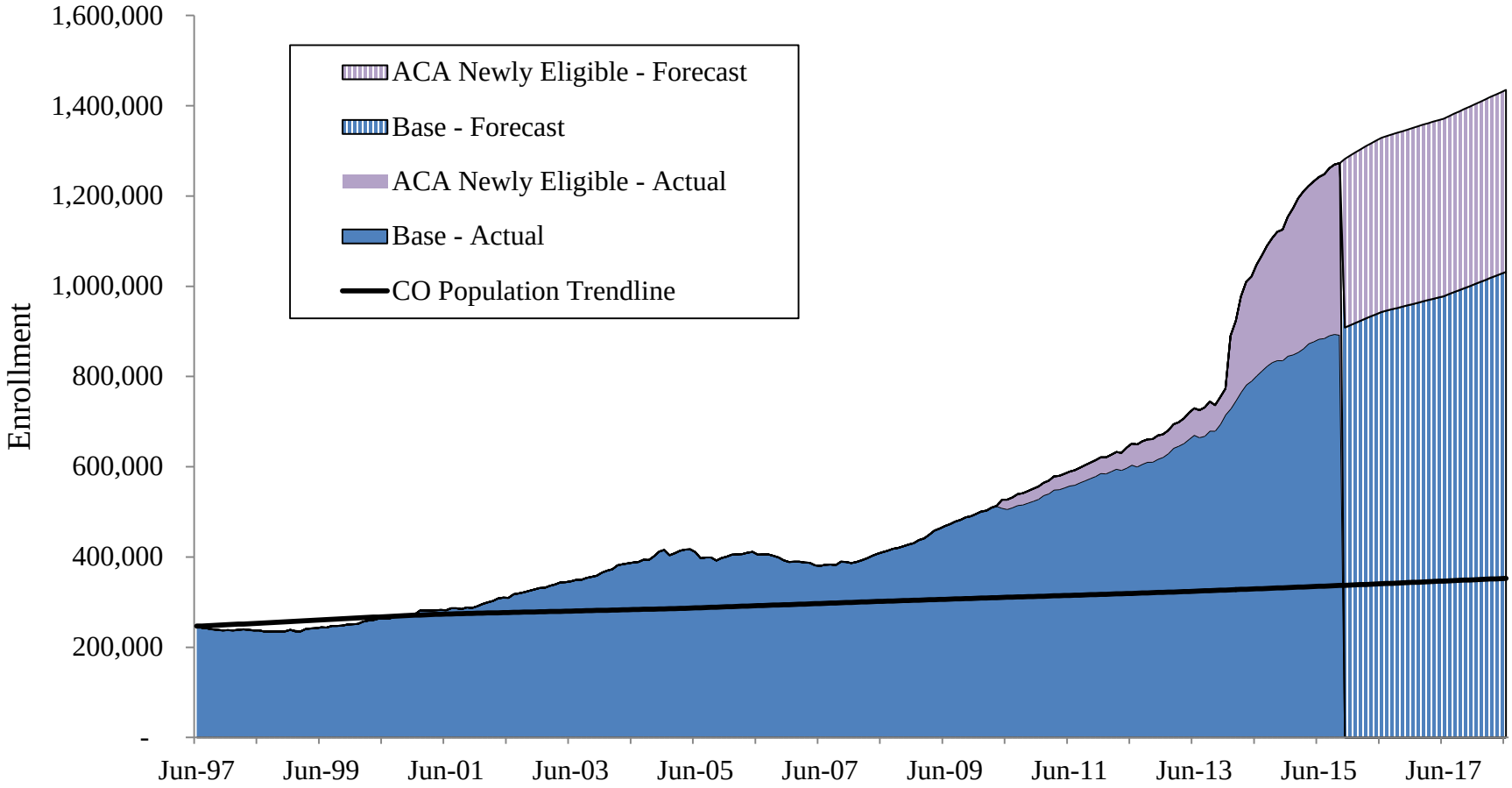

Medicaid
- Serves people with low-income or disability
- State-federal partnership
- No premiums
- Covers long-term supports and services
Medicare
- Serves people over 65 or with a qualifying diagnosis
- Federally administered/ financed
- Charges premium
- Limits coverage of long-term supports and services to post-acute care

Medicaid Federal Medical Assistance Percentage (FMAP)					
State Fiscal Year	Ave. FMAP	FMAP by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 13-14	50.00	50.00	50.00	50.00	50.00
FY 14-15	50.76	50.00	51.01	51.01	51.01
FY 15-16	50.79	51.01	50.72	50.72	50.72
FY 16-17	*50.42*	50.72	*50.32*	*50.32*	*50.32*
FY 17-18	*50.24*	*50.32*	*50.21*	*50.21*	*50.21*

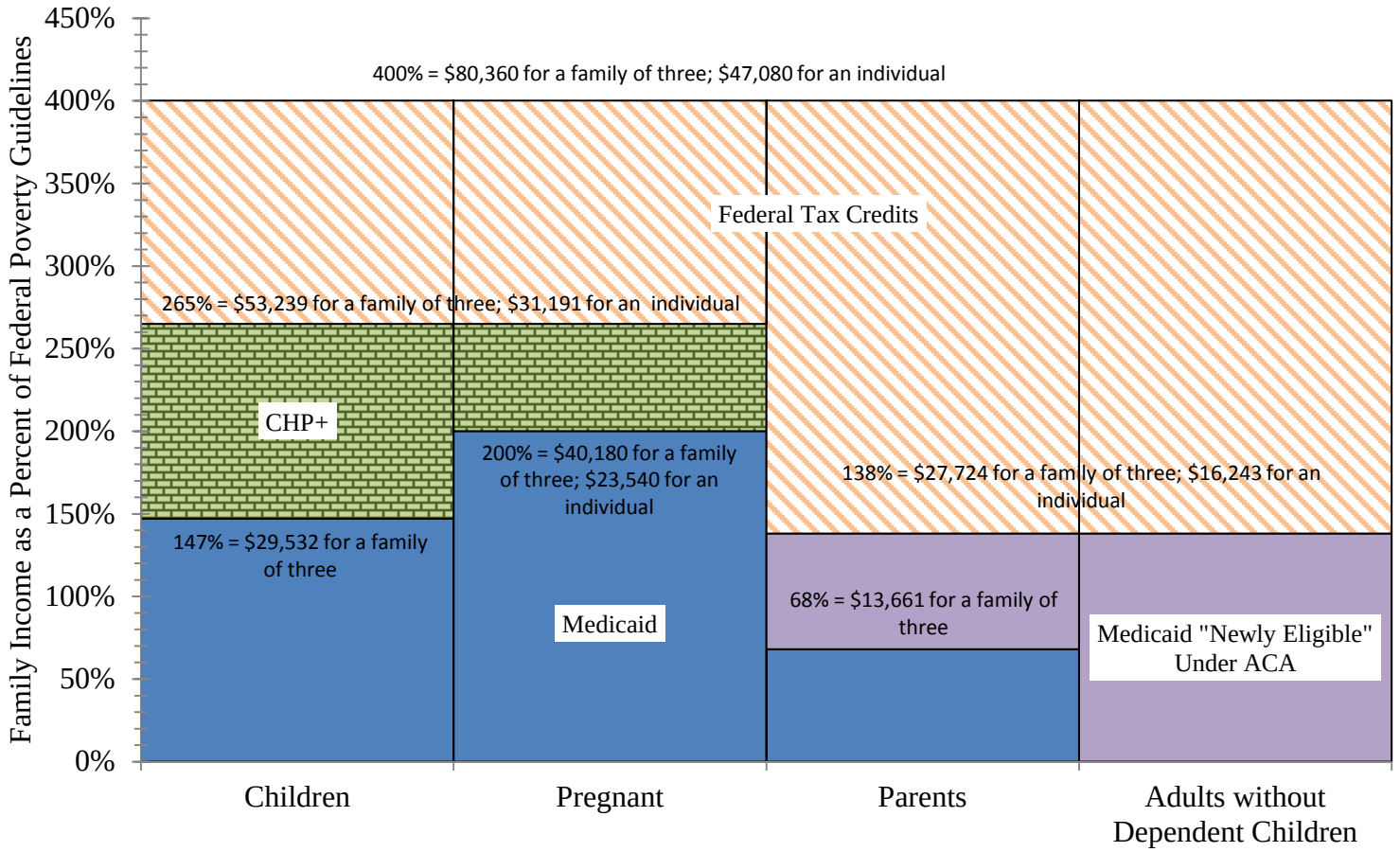
Italicized figures are projections.

"Newly Eligible" Pursuant to the Affordable Care Act					
State Fiscal Year	Ave. FMAP	FMAP by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 13-14	NA	NA	NA	NA	NA
FY 14-15	NA	NA	NA	100.00	100.00
FY 15-16	100.00	100.00	100.00	100.00	100.00
FY 16-17	97.50	100.00	100.00	95.00	95.00
FY 17-18	94.50	95.00	95.00	94.00	94.00
FY 18-19	93.50	94.00	94.00	93.00	93.00
FY 19-20	91.50	93.00	93.00	90.00	90.00
FY 20-21	90.00	90.00	90.00	90.00	90.00

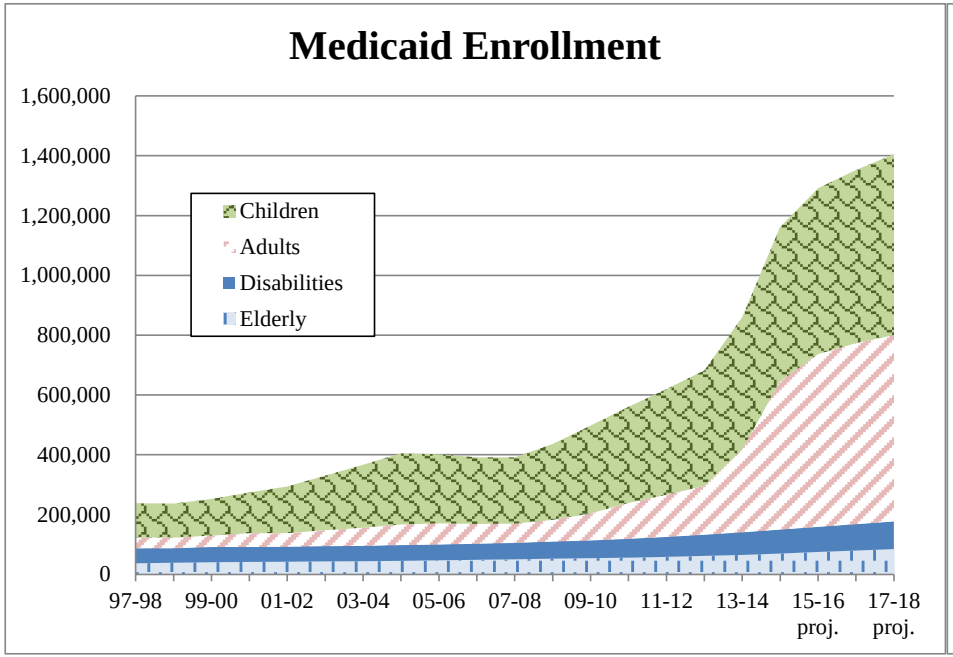
Medicaid Enrollment

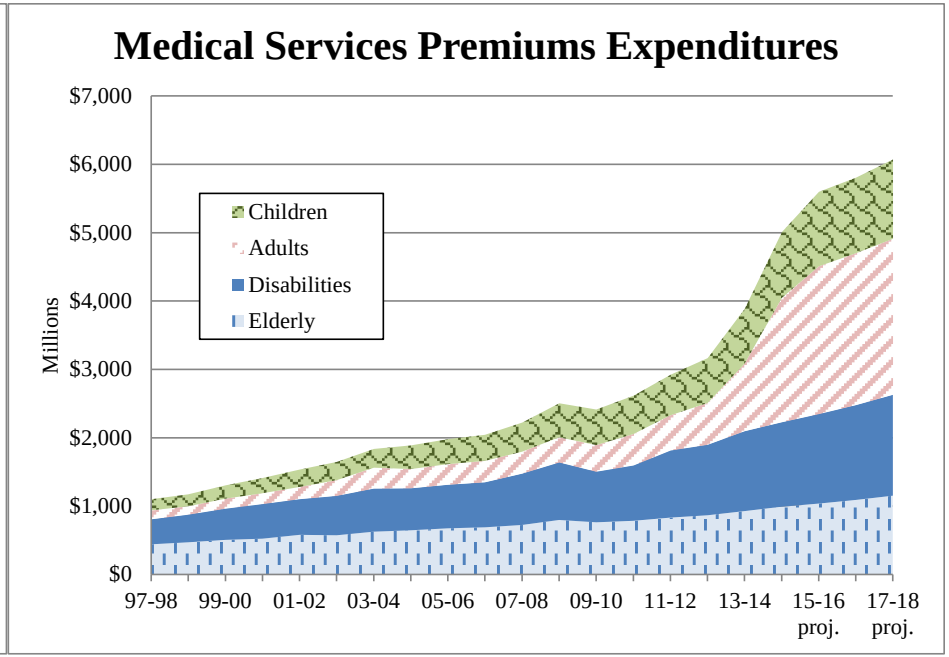


Effective Income Eligibility for Benefit

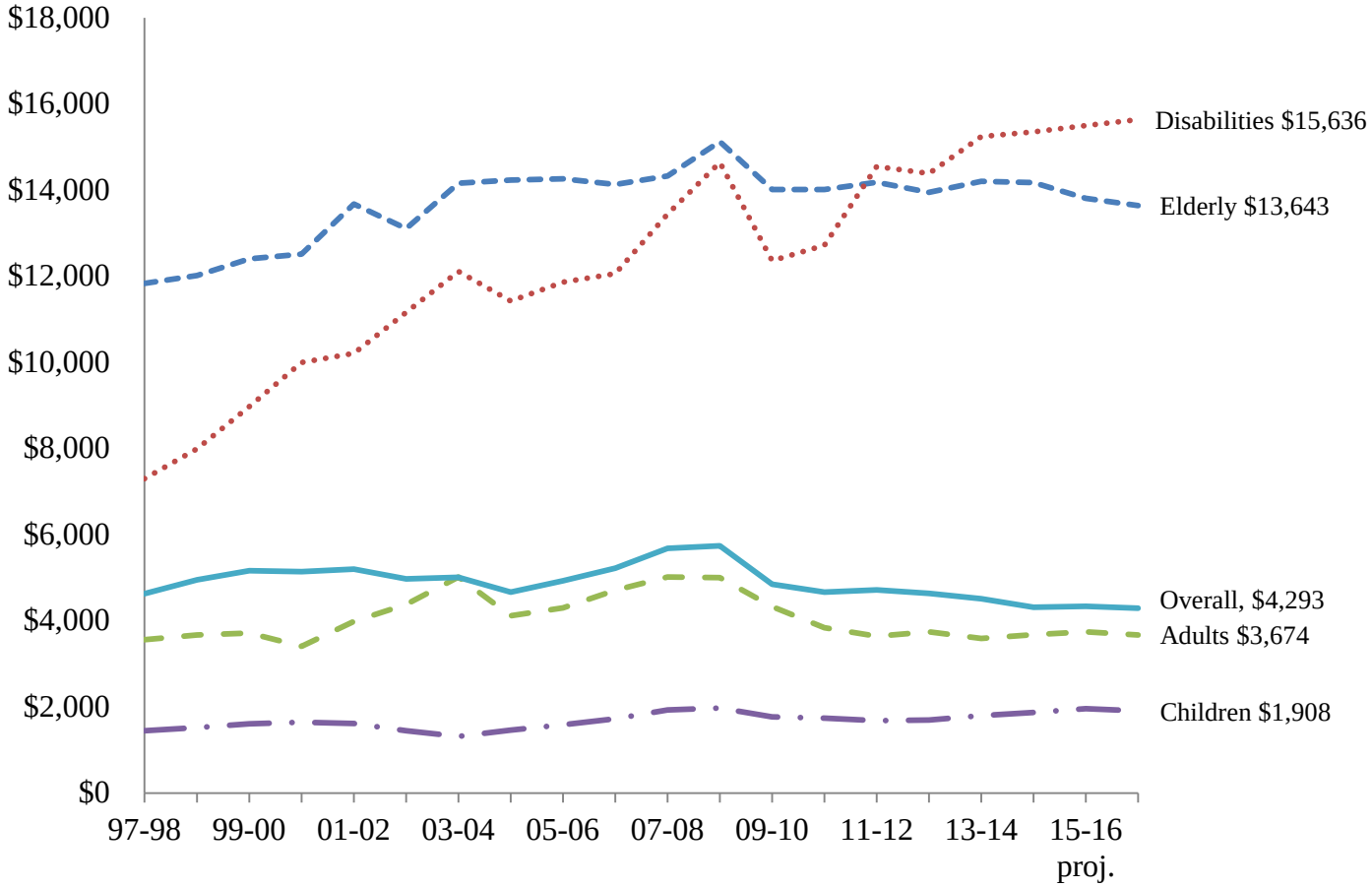


Special Medicaid Eligibility Categories	
Category	**Eligibility Standard**
Elderly 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities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

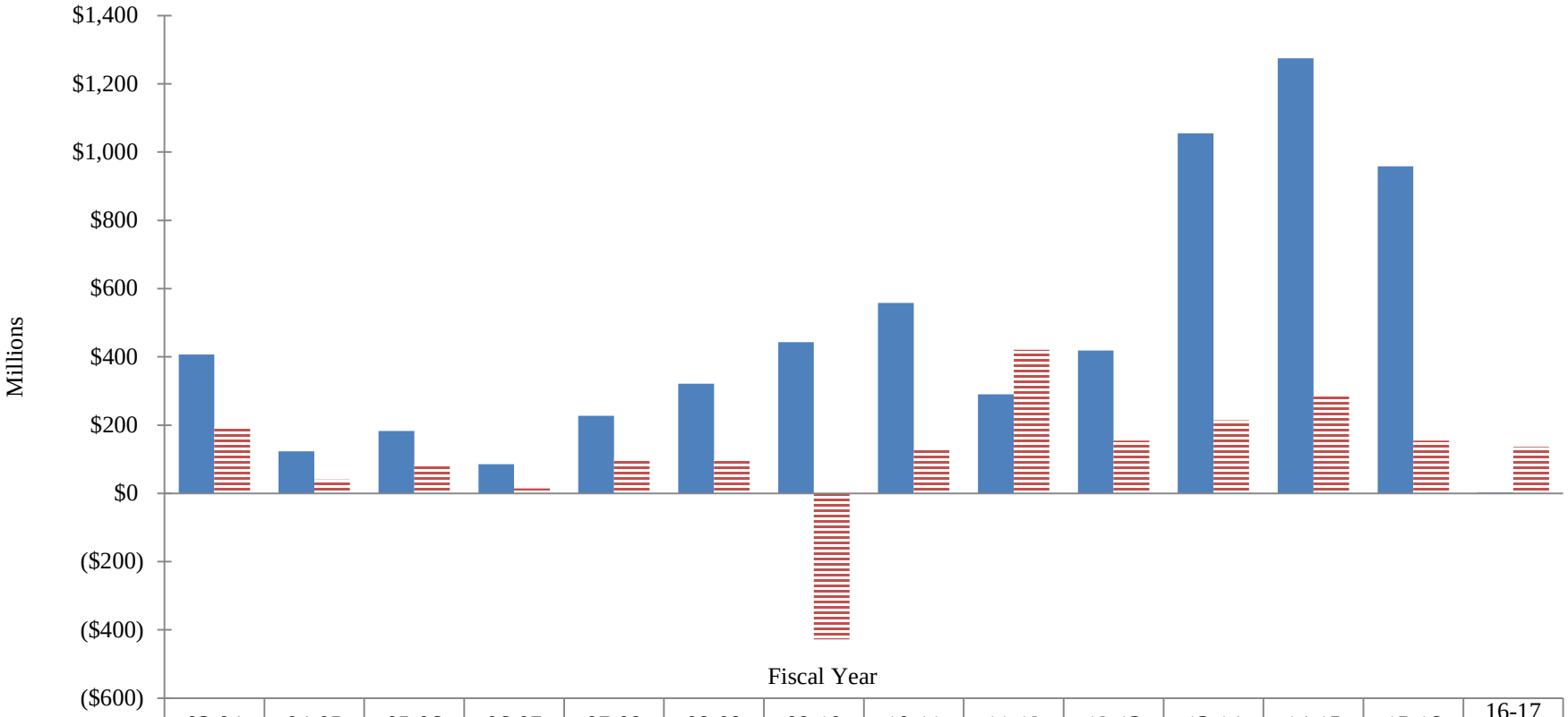

Medicaid Enrollment
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Children
Adults
Disabilities
Elderly
97-98
99-00
01-02
03-04
05-06
07-08
09-10
11-12
13-14
15-16 proj.
17-18 proj.


Medical Services Premiums Expenditures
Millions
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Children
Adults
Disabilities
Elderly
97-98
99-00
01-02
03-04
05-06
07-08
09-10
11-12
13-14
15-16 proj.
17-18 proj.

Per Capita Medicaid Expenditures

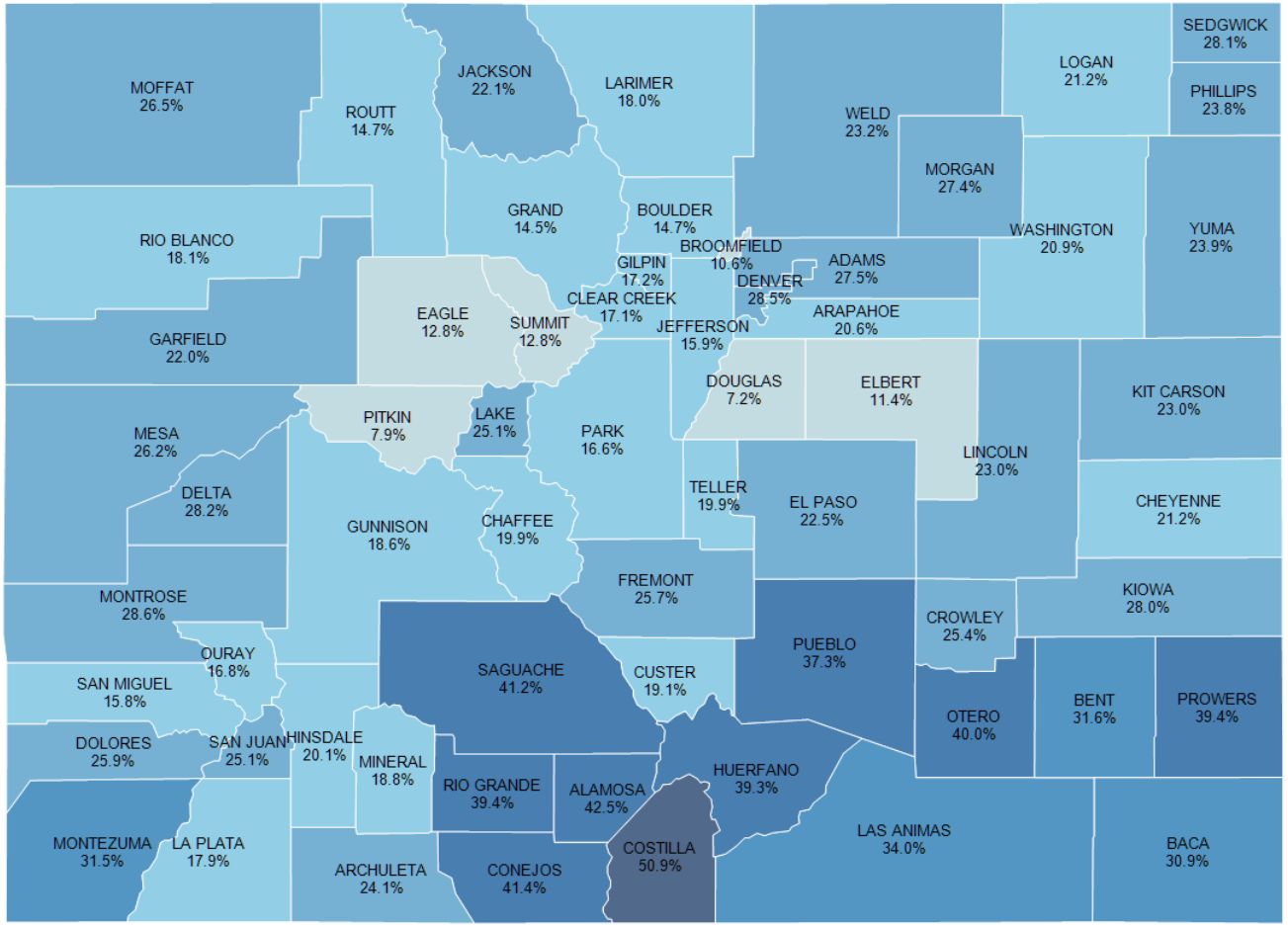


Annual Change in Expenditures



	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17 Req.
TOTAL Funds	$407	$123	$183	$86	$227	$321	$443	$558	$291	$418	$1,055	$1,275	$959	$3
General Fund	$197	$40	$85	$14	$102	$98	($428)	$128	$420	$154	$214	$285	$155	$136

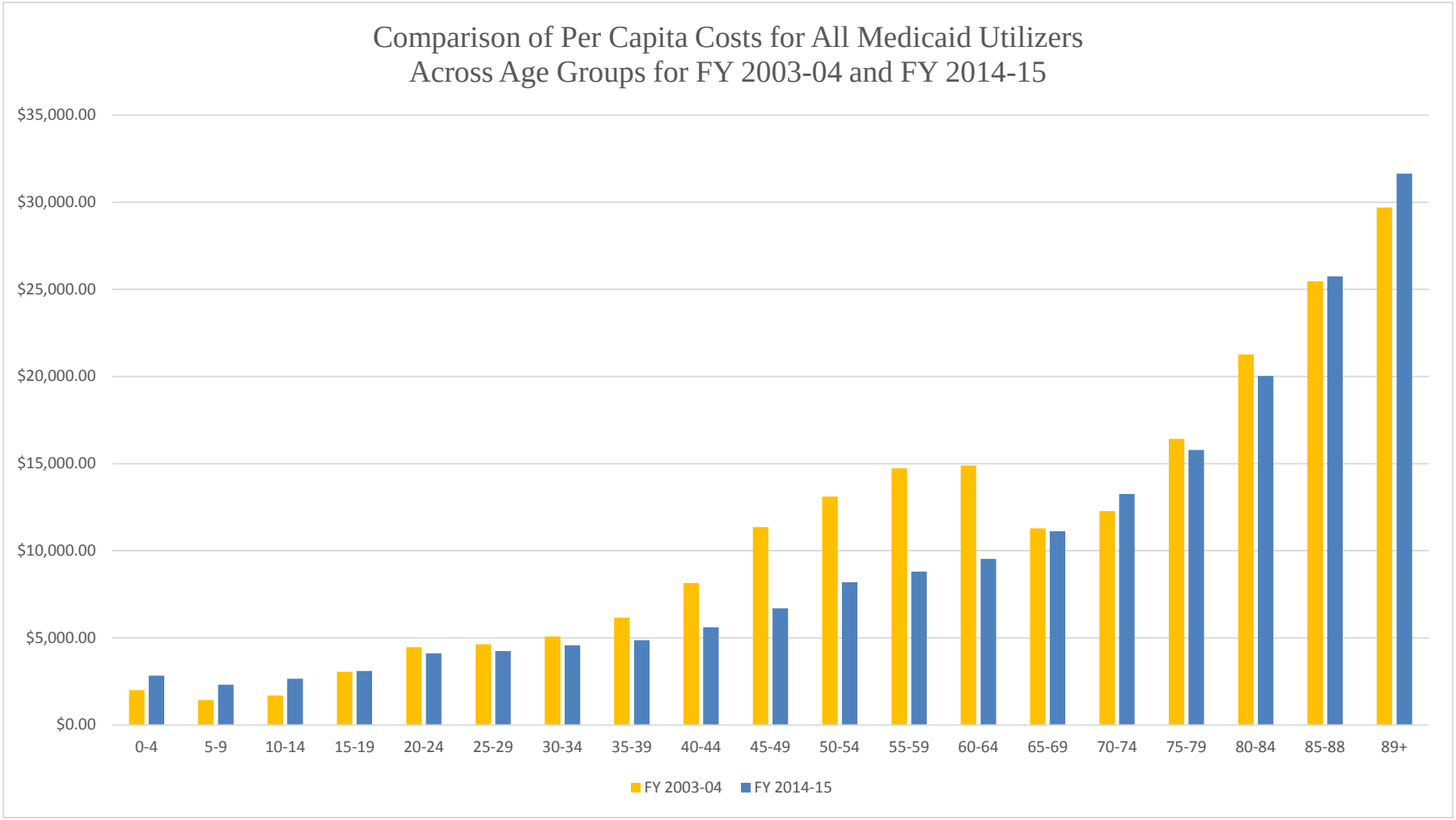
Percentage of Population Enrolled in Medicaid, FY 2014-15



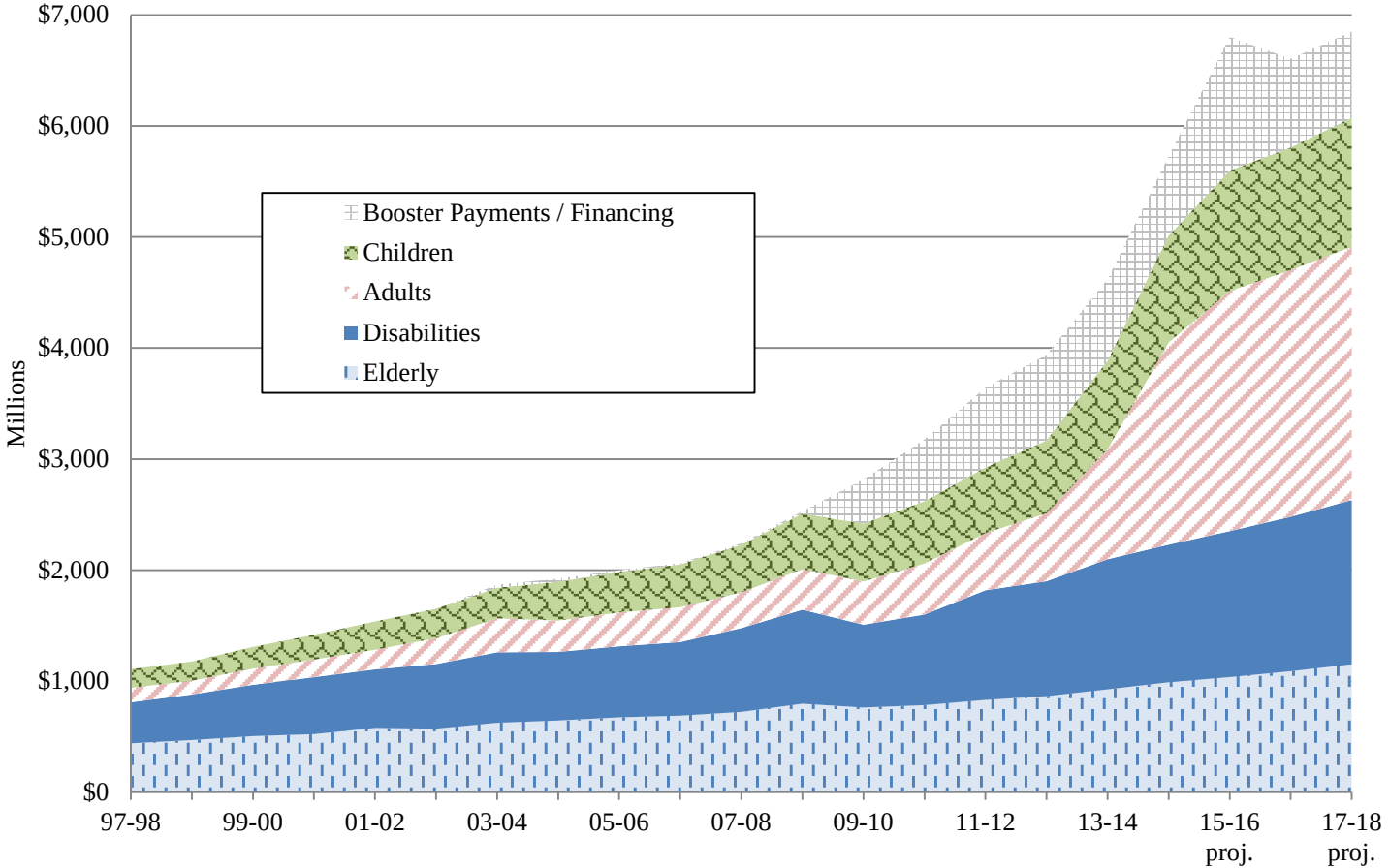
Sources:
Health Care Policy and Financing Medicaid Caseload Report for FY 2014-15
Colorado Population Estimate from State Demographer for CY 2014

Percentage of State Population Enrolled in Medicaid: 21.7%

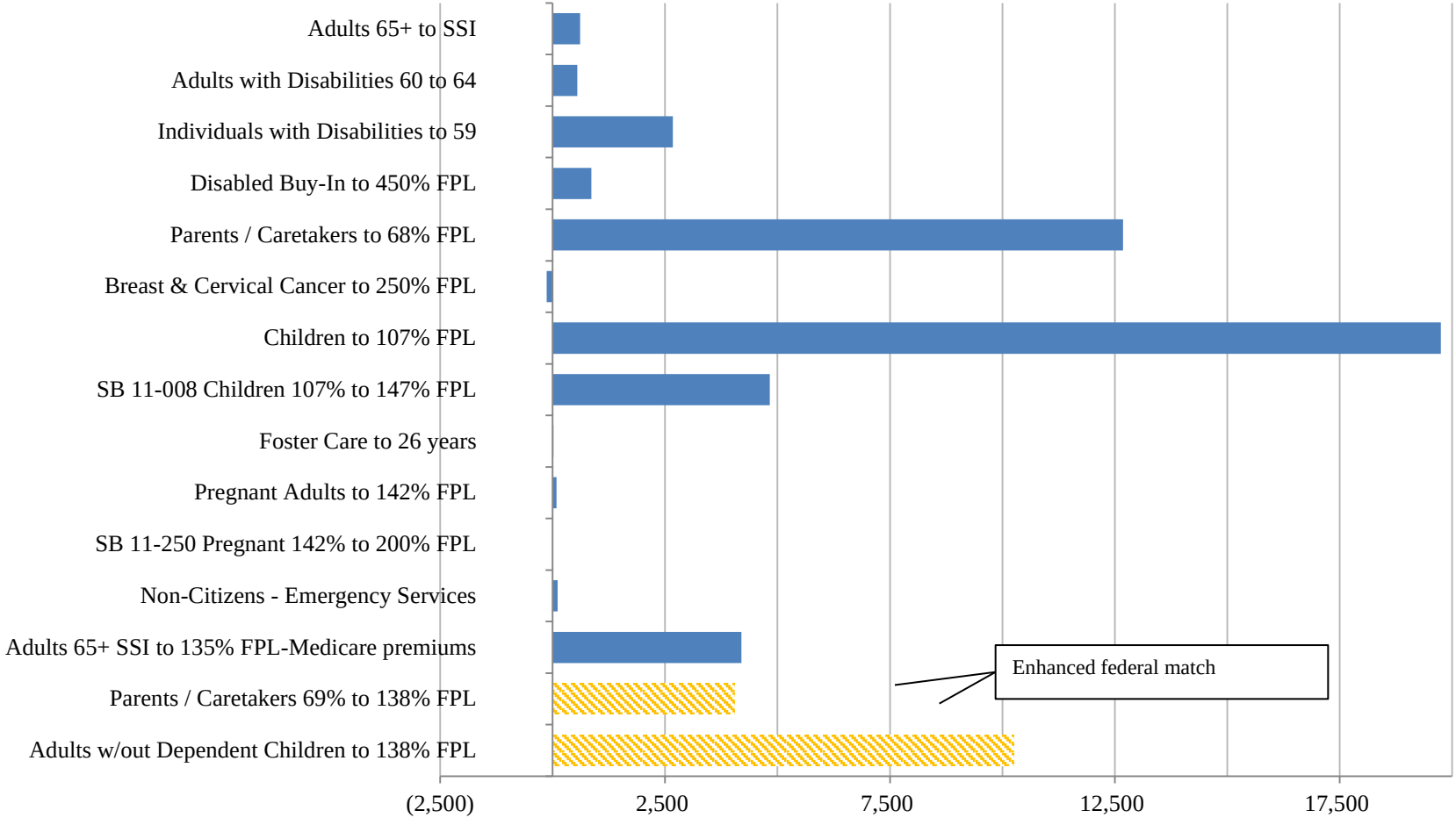
7.2% — 50.9%


Comparison of Per Capita Costs for All Medicaid Utilizers
Across Age Groups for FY 2003-04 and FY 2014-15
$35,000.00
$30,000.00
$25,000.00
$20,000.00
$15,000.00
$10,000.00
$5,000.00
$0.00
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-88
89+
FY 2003-04
FY 2014-15

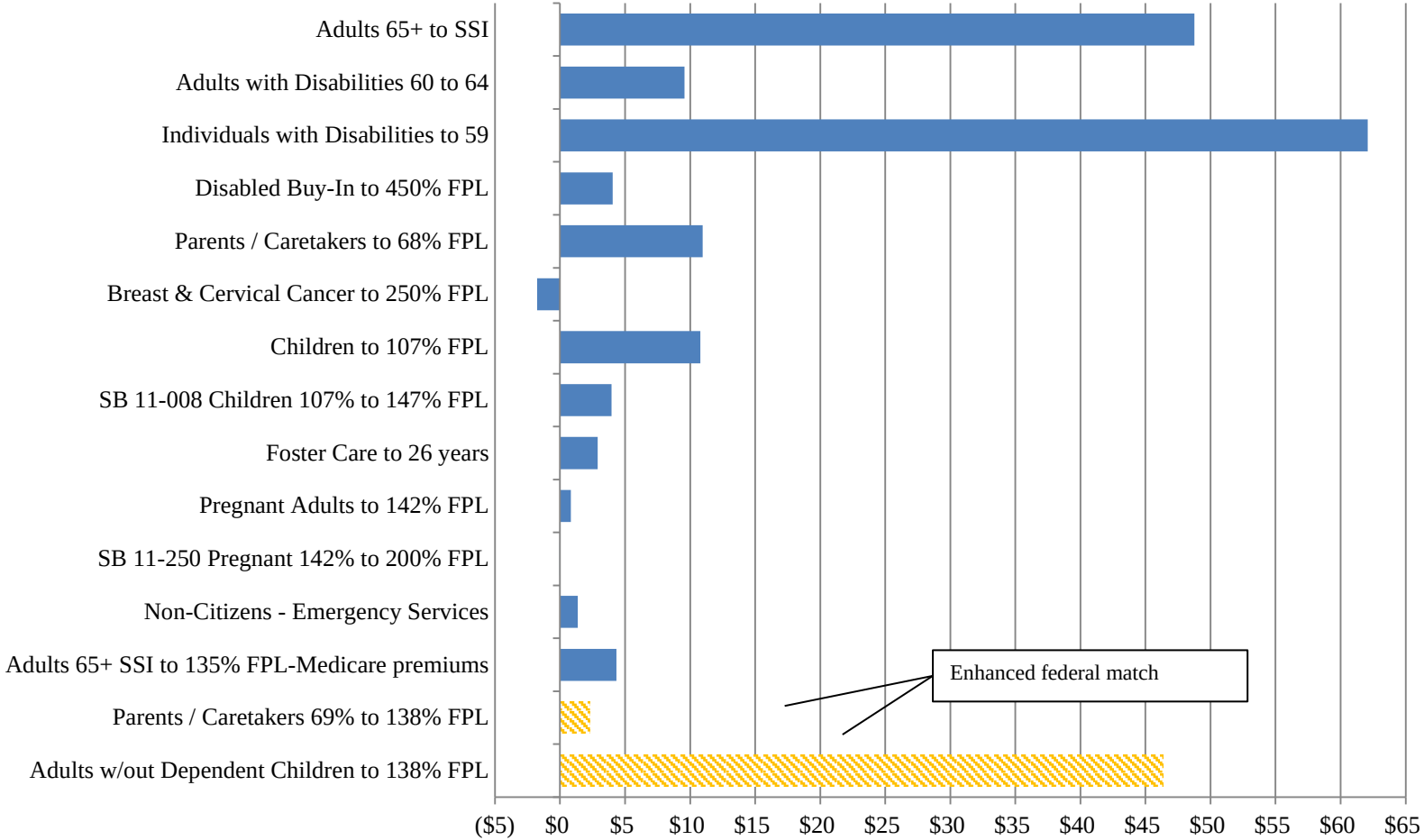
Medical Services Premiums by Population



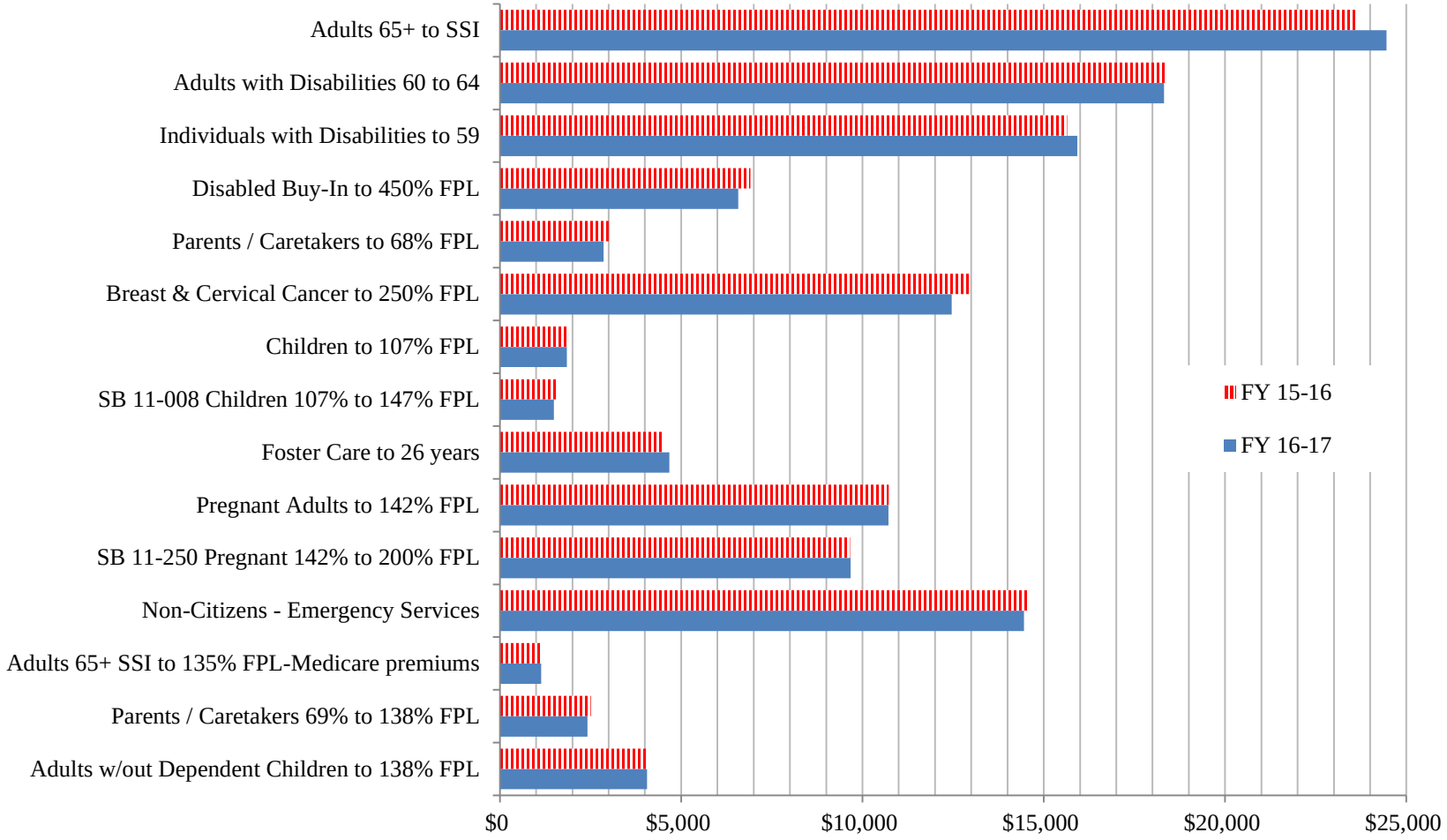
Enrollment Changes FY 15-16 to FY 16-17

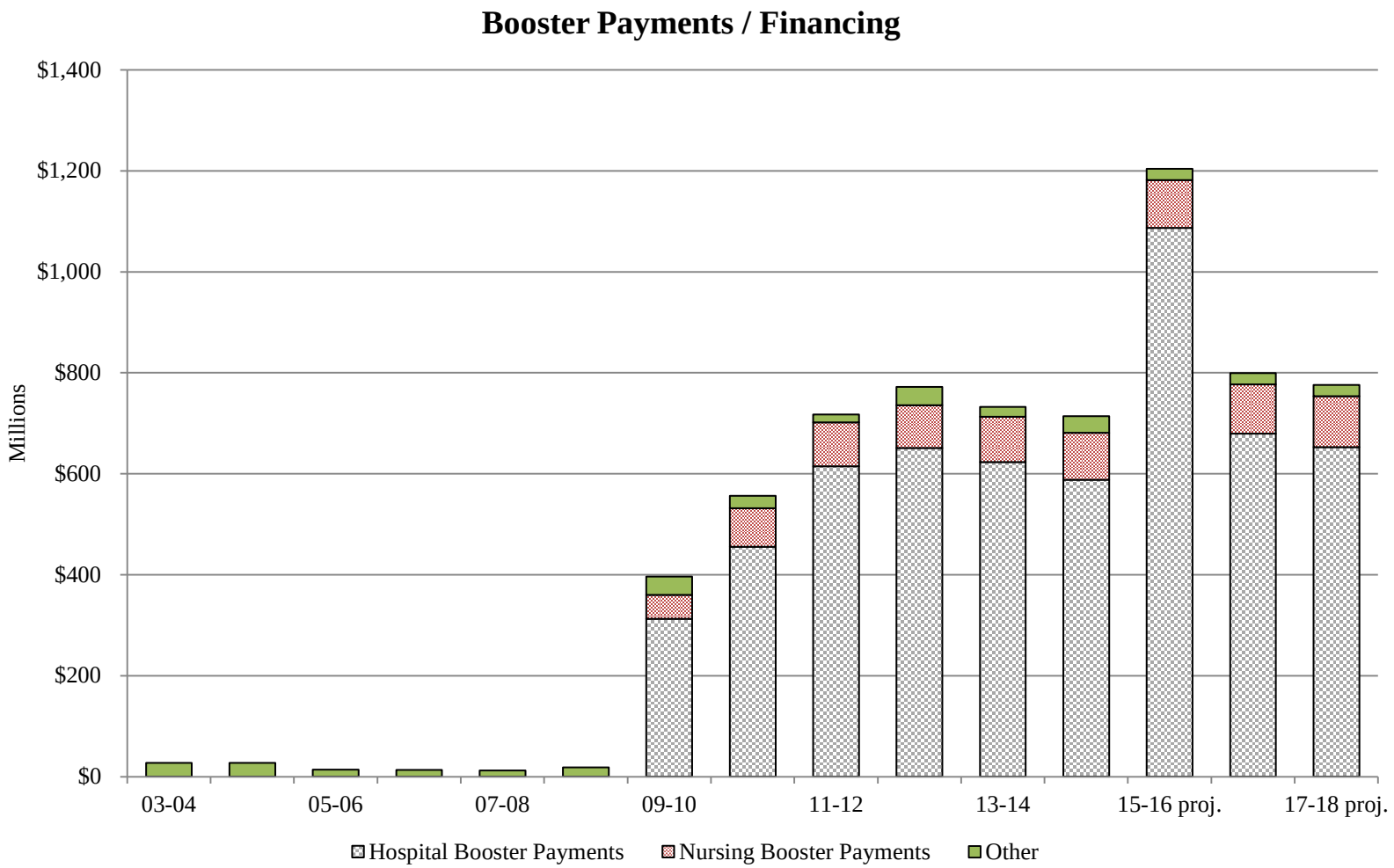


Expenditure Changes FY 15-16 to FY 16-17

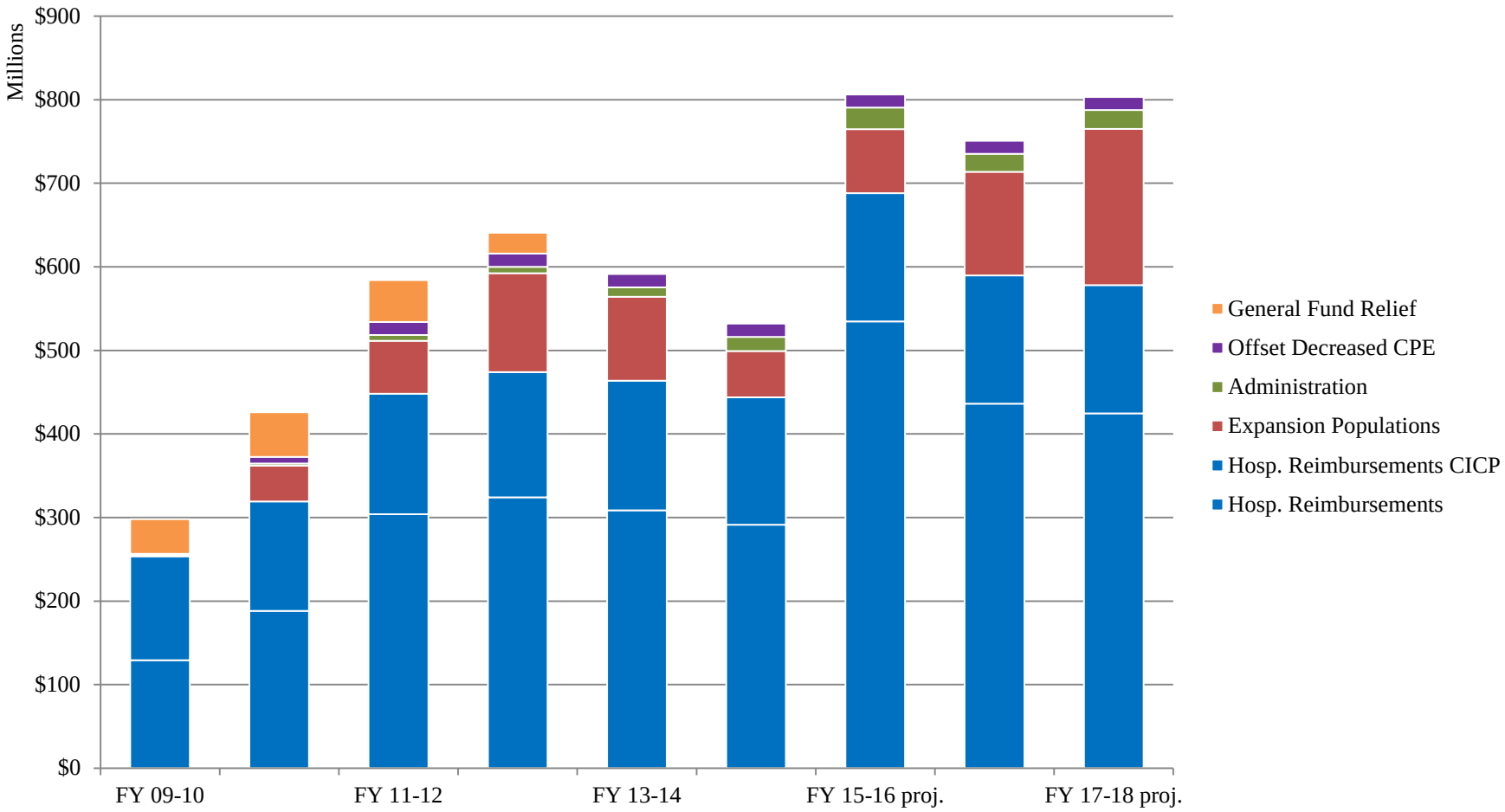


Per Capita Expenditures




Booster Payments / Financing
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
Millions
03-04
05-06
07-08
09-10
11-12
13-14
15-16 proj.
17-18 proj.
Hospital Booster Payments
Nursing Booster Payments
Other

Hospital Provider Fee Expenditures



Hospital Provider Fee (in Millions) by State Fiscal Year and Model Year (without $100 M Reduction)												
Model Year	State Fiscal Year									TOTAL	$ Change	% Change
	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18			
09-10[1]	$302.9	$85.2								$388.1		
10-11		$355.8	$118.6							$474.5	$86.4	22.3%
11-12			$464.0	$154.7						$618.7	$144.3	30.4%
12-13				$496.4	$165.5					$661.8	$43.1	7.0%
13-14					$399.0	$133.0				$532.0	($129.8)	-19.6%
14-15[2]						$399.0	$289.4			$688.4	$156.4	29.4%
15-16[3]							$516.3	$211.0		$727.3	$38.9	5.6%
16-17[3]								$545.3	$222.8	$768.0	$40.7	5.6%
17-18[3,4]									$576.0	NA		
TOTAL	$302.9	$441.1	$582.7	$651.1	$564.5	$532.0	$805.8	$756.3	$798.8			
$ Change		$138.2	$141.6	$68.4	($86.6)	($32.5)	$273.8	($49.5)	$42.5			
% Change		45.6%	32.1%	11.7%	-13.3%	-5.7%	51.5%	-6.1%	5.6%			

[1] *Model Year 09-10 includes 5 quarters - July 2009 through Sept 2010.*

[2] *Model Year 14-15 reconciliation occurred in SFY 15-16.*

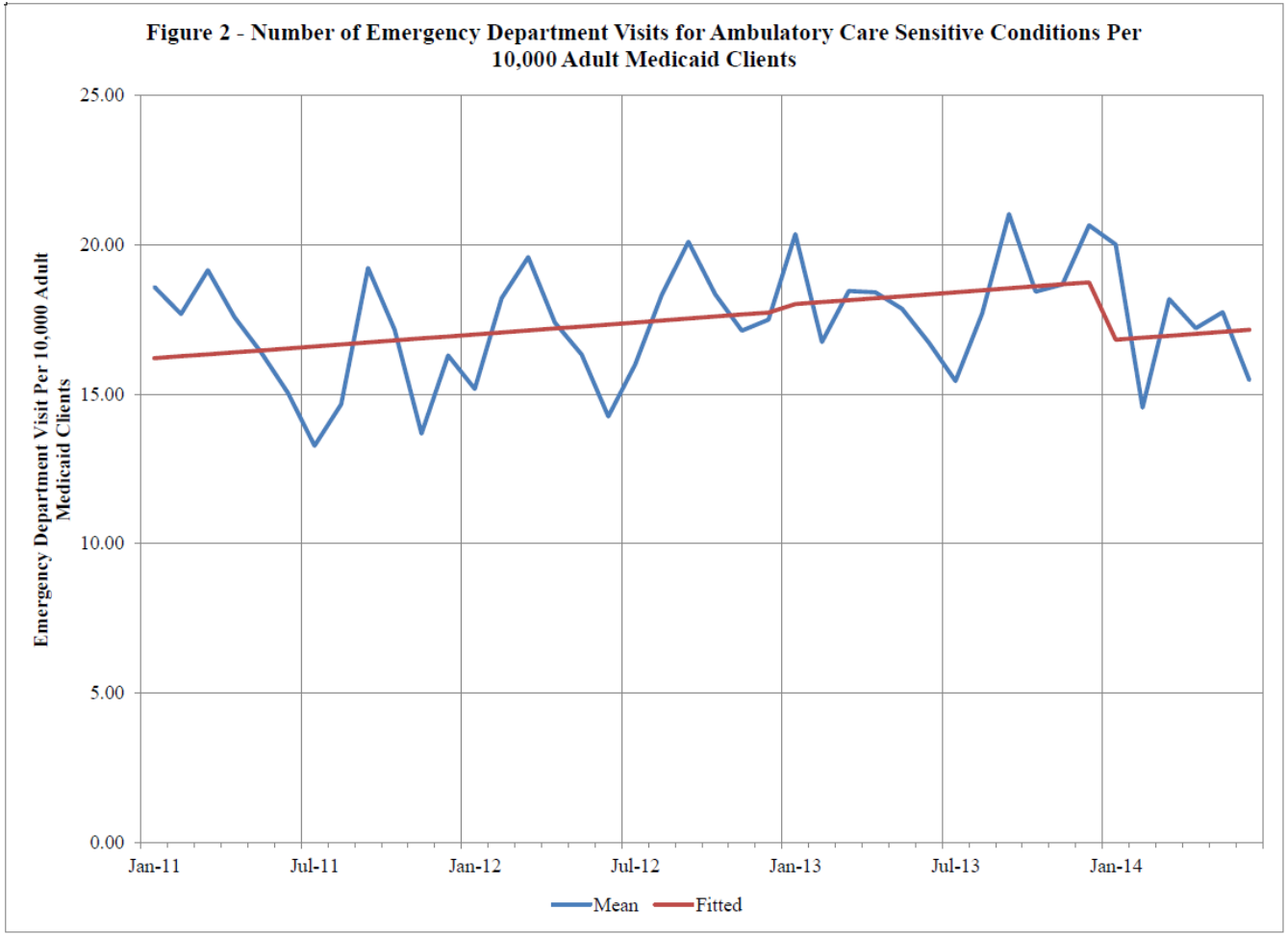
[3] *Assumes reconciliation occurs in beginning of next SFY (i.e., Model Year 15-16 reconciled in SFY 16-17).*

[4] *Does not include fees for Model Year 17-18 that will be collected in SFY 18-19.*

	Scenario 1 Governor's Request	Scenario 2 Switch HPF for a Rate Inc.
Net General Fund benefit from limiting HPF revenue		
TABOR refund	($100,000,000)	($100,000,000)
General Fund for rate increase	$0	$32,281,665
General Fund savings	($100,000,000)	($67,718,335)
Net hospital loss from limiting HPF revenue		
Reduced HPF obligation	$100,000,000	$100,000,000
Reimbursements through HPF	($202,221,864)	($202,221,864)
Rate increase	$0	$102,221,864
TOTAL	($102,221,864)	$0

- Four rate increases still pending CMS approval
  - Personal care/homemaker
  - Special Connections per diem
  - Special Connections outpatient
  - In-home respite
  - Clinic services
- Nine eligibility/benefit changes not yet approved
  - Children with autism DENIED
  - Consolidate IDD waivers
  - Consumer direction for supported living services
  - Lifetime cap on home modifications to $12,500
  - Lifetime cap on home modifications to $14,067
  - Protective restorations by dental hygienists
  - Spinal cord injury alternative medicine pilot program
  - Annualized income for adults
  - Denver Health nursing services for chronically acute long-stay patients

Colorado Medicaid Provider Payment Rate Comparison Report					
	Current %	Cost/(Savings) to move to a percent of Benchmark			
Provider Type	of Benchmark	60.0%	75.0%	90.0%	100.0%
Practitioner	66.3%	($58,763,306)	$81,244,243	$221,251,793	$314,590,160
Durable Medical Equipment/Supplies	81.7%	($18,235,442)	($6,224,298)	$5,786,846	$13,794,275
Transportation	51.8%	$2,388,403	$6,794,459	$11,200,515	$14,137,886
Dental	67.9%	($24,768,088)	$22,154,342	$69,076,772	$100,358,392
EPSDT	87.6%	($1,586,864)	($688,234)	$210,395	$809,481
Independent Laboratory	93.8%	($20,522,916)	($11,898,093)	($3,273,269)	$2,476,614
Home and Community Based Services					
District of Columbia	57.6%				
California	69.1%				
Arizona	94.9%				
Illinois	125.0%				
Ohio	140.6%				
Ave. of Highest & Lowest		($109,557,925)	($42,252,275)	$25,053,376	$69,923,810
Home Health/Private Duty Nursing					
North Carolina	111.7%				
Illinois	112.8%				
Idaho	123.5%				
Ohio	126.9%				
Louisiana	179.3%				
Ave. of Highest & Lowest		($163,066,193)	($131,035,848)	($99,005,504)	($77,651,940)
TOTAL estimated cost/(savings)		($394,112,331)	($81,905,704)	$230,300,924	$438,438,678
General Fund share		($170,543,647)	($58,343,917)	$53,855,811	$128,655,631

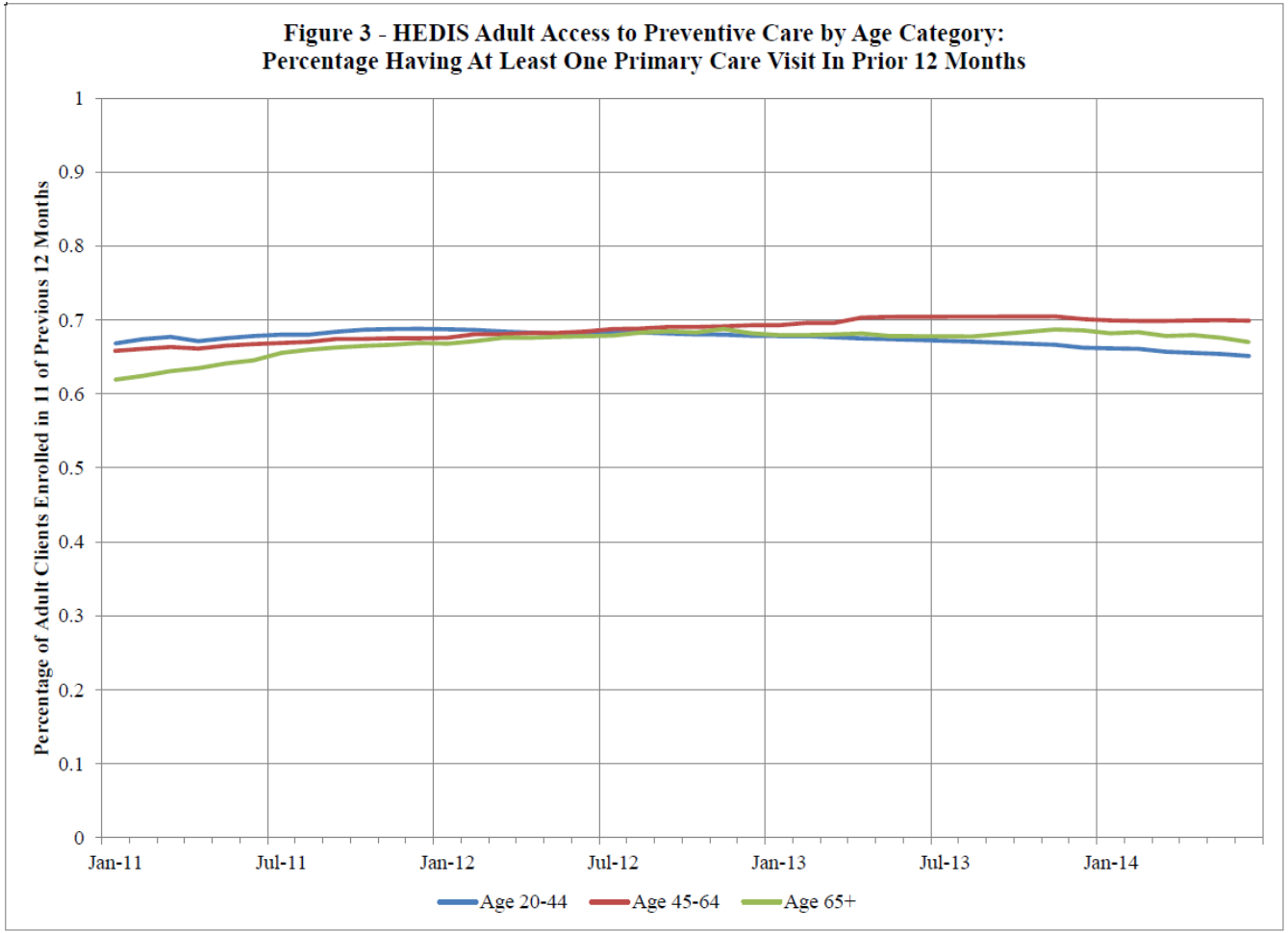


The Impact of Increased Medicaid Payments for Primary Care Services on Access to Care for Medicaid Clients in Colorado

November 30, 2015

University of Colorado
Division of Health Care Policy and Research

Mark Gritz, PhD
Mika Hamer MPH
Carter Sevick MS



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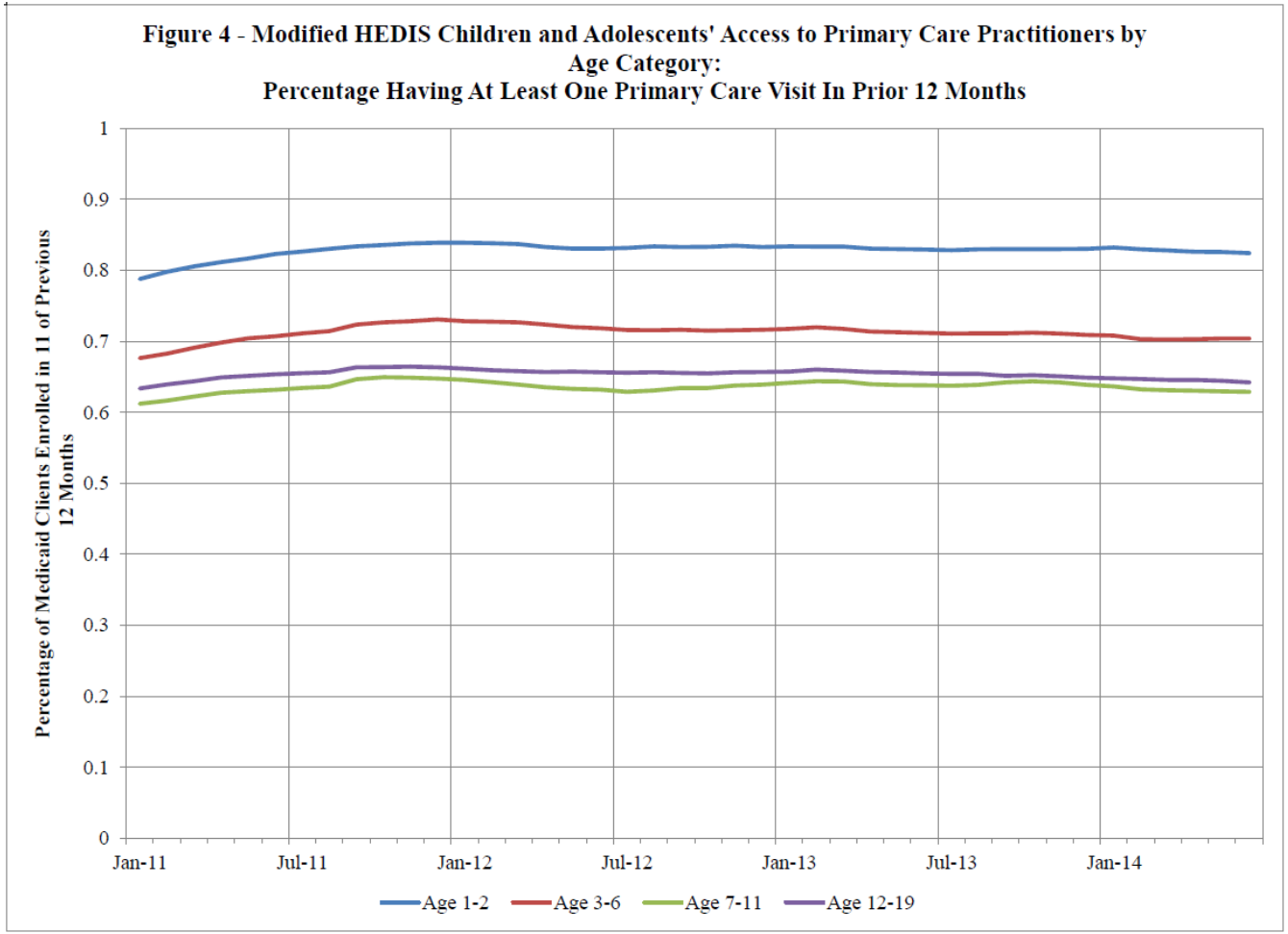

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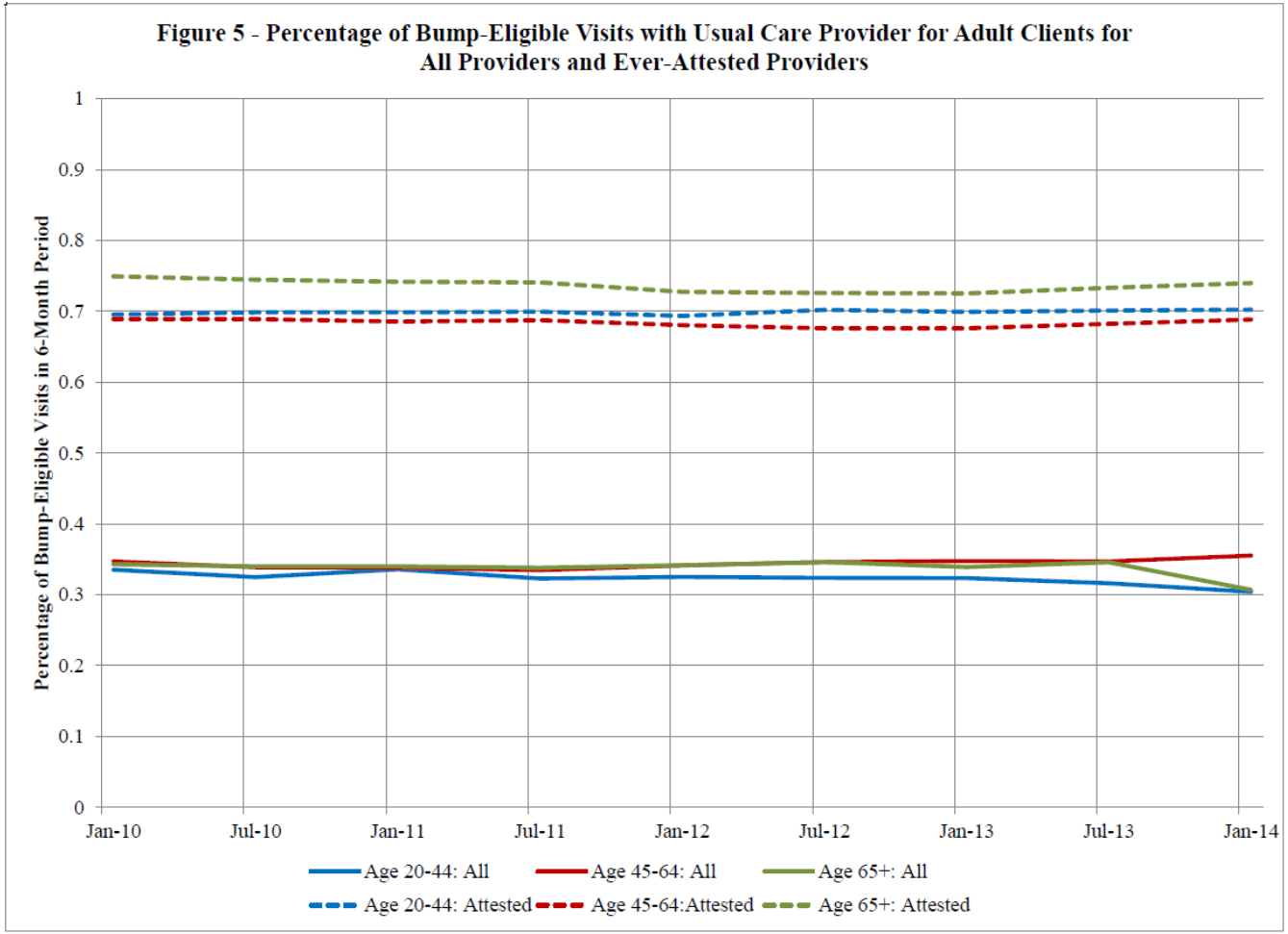

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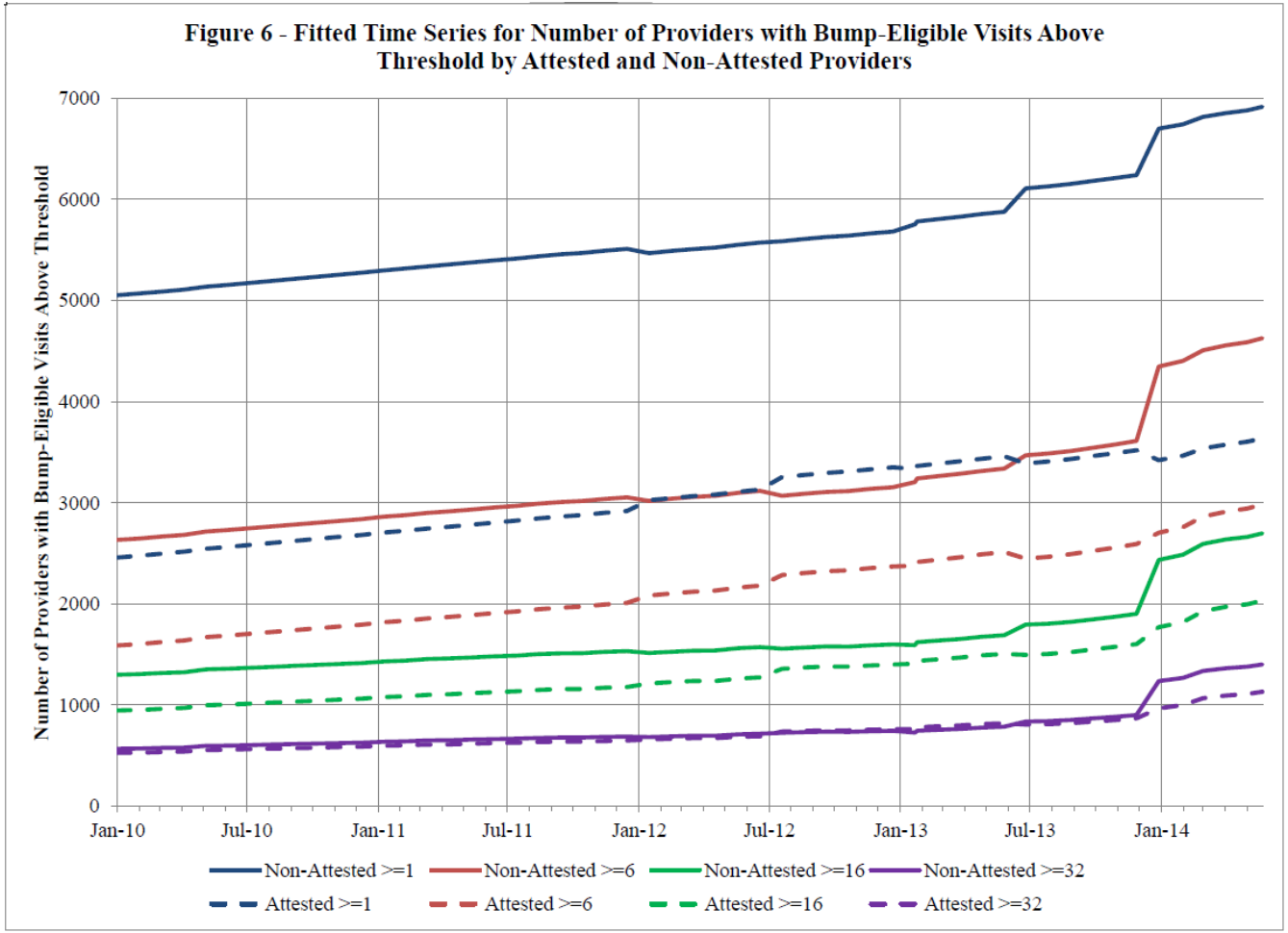

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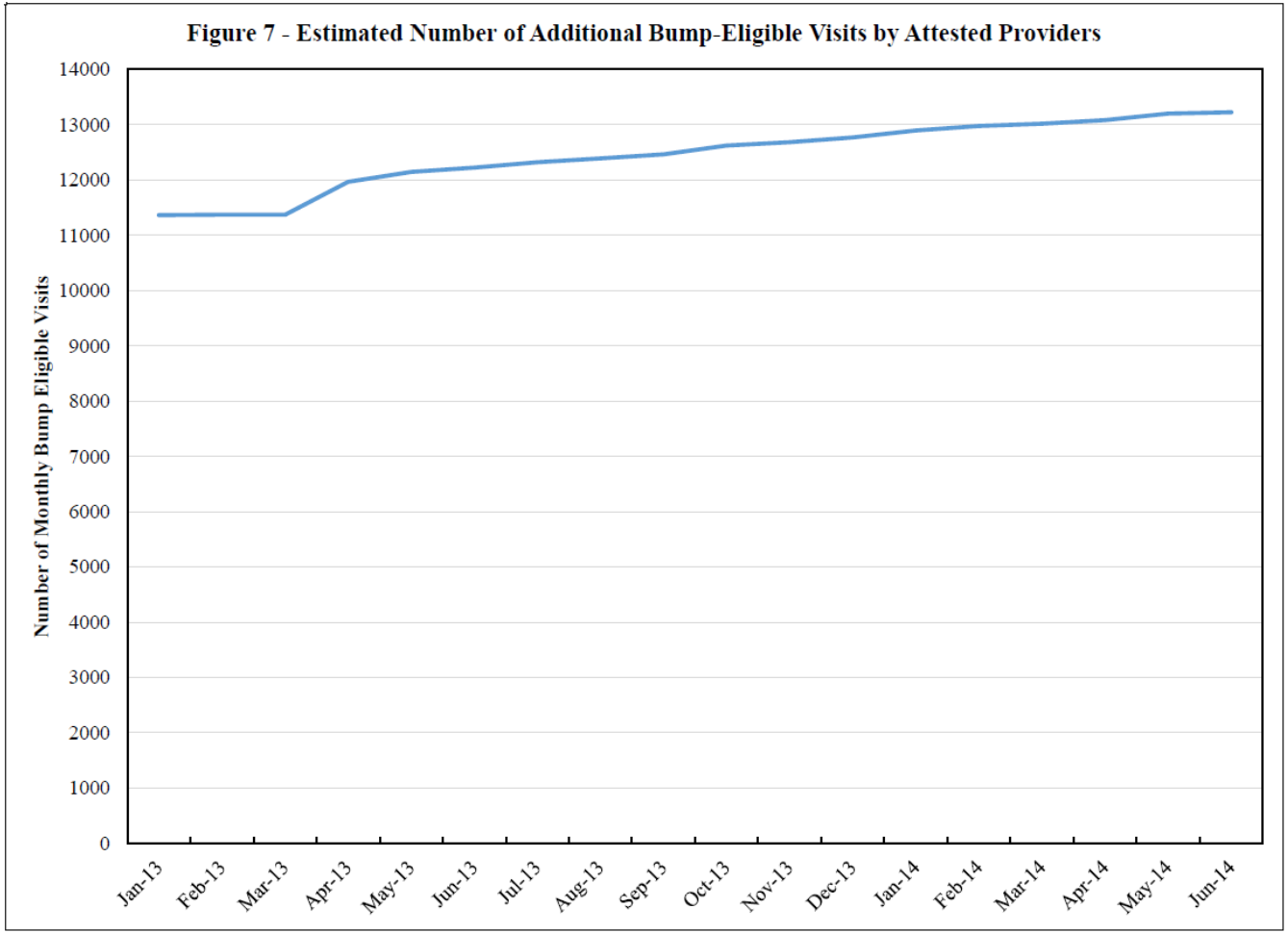

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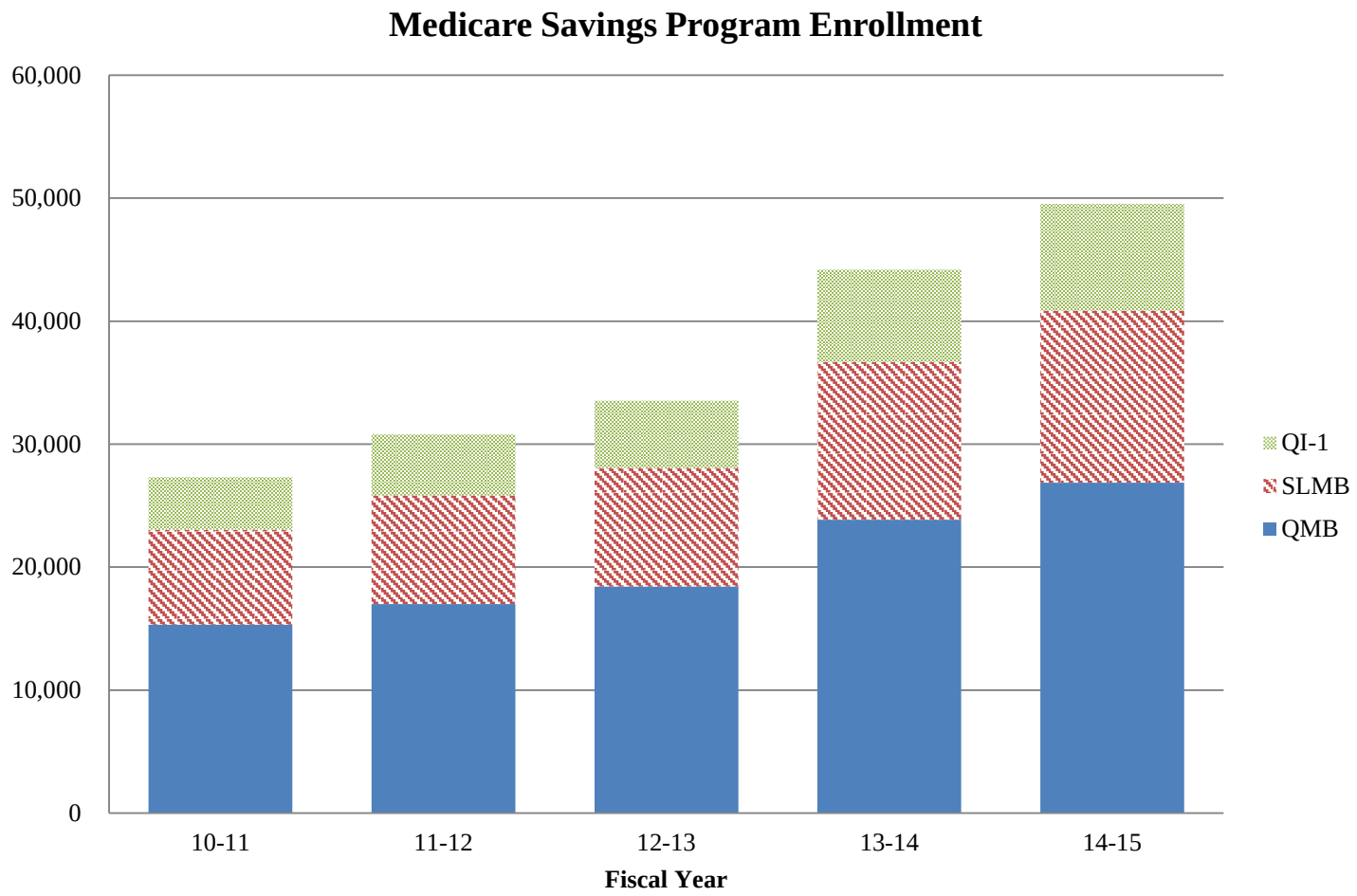
Medicare Savings Program Enrollment
60,000
50,000
40,000
30,000
20,000
10,000
0
10-11
11-12
12-13
13-14
14-15
Fiscal Year
QI-1
SLMB
QMB

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LEGAL MEMORANDUM

TO: The Joint Budget Committee

FROM: Office of Legislative Legal Services

DATE: December 7, 2015

SUBJECT: Reduction in hospital provider fee revenue[1]

Legal Questions and Short Answers

1. Governor Hickenlooper's proposed budget for fiscal year 2016-17 (budget) proposes a $100 million dollar decrease in hospital provider fee (HPF) revenue. Would decreasing HPF revenue by $100 million dollars require additional legislation?

Short Answer: No. Under current law, the Medical Services Board (state board) in the Department of Health Care Policy and Financing (department) is required to set the amount of the HPF approximately equal to the General Assembly's appropriation specified for the fee. If the General Assembly reduces the HPF cash fund appropriation in the annual general appropriation act, the state board should reduce the HPF, thereby reducing HPF revenue to match the appropriation.

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[1] This legal memorandum results from a request made to the Office of Legislative Legal Services (OLLS), a staff agency of the General Assembly. OLLS legal memoranda do not represent an official legal position of the General Assembly or the State of Colorado and do not bind the members of the General Assembly. They are intended for use in the legislative process and as information to assist the members in the performance of their legislative duties.

2. Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million dollars without any reduction in medical benefits or eligibility. Under current law, could HPF revenues be reduced by $100 million dollars without any reduction in medical benefits or eligibility?

> **Short Answer:** No. If HPF revenues and federal matching funds are insufficient to fully fund all of the purposes for the HPF, the HPF statute requires HPF revenue to be used first to fully fund hospital reimbursement and incentive payments and certain administrative expenses relating to the fee, with any remaining HPF revenue used to fund the expansion of medical benefits or eligibility. Without legislation amending the HPF statute, the state board is required to adopt rules, to be approved by the Joint Budget Committee, that reduce medical benefits or eligibility to match available HPF revenue.

3. Any state board rules that reduce medical benefits or eligibility pursuant to the requirement in the HPF statute must comply with the requirement in the "State Administrative Procedure Act"[2] that agency rules not conflict with other provisions of law. Would state board rules adopted pursuant to the HPF statute that reduce medical benefits or eligibility conflict with other provisions of law?

> **Short Answer:** Partly, yes. State and federal law enacted subsequent to the enactment of the HPF statute limits, in part, the state board's authority to reduce medical benefits or eligibility pursuant to the HPF statute.

4. State TABOR[3] revenue for FY 2016-17 is forecast to exceed the state spending limit by over $250 million.[4] Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million, which would reduce the forecasted TABOR refund by $100 million and make $100 million of additional general fund money available for expenditure. By increasing available general fund money, does the proposal convert the HPF from a fee into a tax and trigger TABOR voter approval requirements?

> **Short Answer:** No. Based on relevant Colorado Supreme Court precedents, the HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax. Reducing the amount of HPF revenue collected as

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[2] Section 24-4-101, C.R.S., et seq.

[3] *The Taxpayer's Bill of Rights,* Colo. Const., art X, sec. 20.

[4] Colorado Legislative Council Staff Economics Section, *Focus Colorado: Economic and Revenue Forecast,* September 21, 2015.

proposed does not convert the HPF from a fee to a tax and does not trigger TABOR voter approval requirements.

Discussion

1. The HPF statute requires the state board to establish the HPF approximately equal to the General Assembly's appropriations specified for the fee.

The state board has the authority to establish the amount of the HPF and the rules governing the fee.[5] However, the state board's authority to establish the amount of the HPF is tied to the General Assembly's power to appropriate HPF cash funds. All money in the HPF cash fund is "subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly . . . " for the purposes set forth in the HPF statute.[6] Section 25.5-4-402.3 (3) (b), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (3) (b) The provider fees shall be assessed pursuant to rules adopted by the state board, pursuant to section 24-4-103, C.R.S. **The amount of the fee shall be established by rule of the state board** but shall not exceed the federal limit for such fees. **In establishing the amount of the fee** and in promulgating the rules governing the fee, **the state board shall:**
>
> (III) **Establish the amount of the provider fee** so that the amount collected from the fee is **approximately equal to or less than the amount of the appropriation specified for the fee in the general appropriation act** or any supplemental appropriation act. (**emphasis added**)

Pursuant to section 25.5-4-402.3 (3) (b), C.R.S., if the General Assembly were to reduce its appropriation of HPF cash funds in the annual general appropriations act from the amount appropriated in the previous year, the state board would be required to adopt rules for the assessment of the fee that result in HPF revenue that approximates the General Assembly's reduced appropriation. Therefore, without additional legislation, a $100 million dollar reduction in the General Assembly's appropriation of HPF cash funds should result in a reduction in the HPF and the collection of approximately $100 million dollars less in HPF revenue.

---

[5] Section 25.5-4-402.3 (3) (b), C.R.S.

[6] Section 25.5-4-402.3 (4) (b), C.R.S.

2. The HPF statute contemplates that HPF revenue may be insufficient to fully fund all of the statutory purposes for the HPF.

2.1. The HPF statute prioritizes the use of HPF revenue when revenue is insufficient to fully fund all of the statutory purposes for the HPF.

The statutory purposes for the HPF are set forth in section 25.5-4-402.3 (4) (b), C.R.S. That section reads in part:[7]

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (4) (b) **All moneys in the fund shall be subject to** federal matching as authorized under federal law and subject to **annual appropriation by the general assembly for the following purposes:**
>
> (I) To **maximize** the **inpatient and outpatient hospital reimbursements to up to the upper payment limits** as defined in 42 CFR 447.272 and 42 CFR 447.321;
>
> (II) To **increase hospital reimbursements under the Colorado indigent care program** to up to one hundred percent of the hospital's costs of providing medical care under the program;
>
> (III) To **pay the quality incentive payments** provided in section 25.5-4-402 (3);
>
> (IV) **Subject to available revenue from the provider fee and federal matching funds,** to **expand eligibility for public medical assistance by:**
>
> (A) Increasing the eligibility level for **parents and caretaker relatives** of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1) (m), from sixty-one percent to **one hundred thirty-three percent** of the federal poverty line;
>
> (B) Increasing the eligibility level for **children and pregnant women** under the **children's basic health plan** to up to **two hundred fifty percent** of the federal poverty line;
>
> (C) Providing eligibility under the state medical assistance program for a **childless adult** or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1) (p), who earns up to **one hundred thirty-three percent** of the federal poverty line;
>
> (D) Providing **a buy-in program** in the state medical assistance program for **disabled adults and children** whose families have income of up to **four hundred fifty percent** of the federal poverty line;
>
> (V) To provide **continuous eligibility for twelve months for children** enrolled in the state medical assistance program;

---

[7] Details of the state department's actual administrative costs and repealed provisions have been omitted.

(VI) To pay the **state department's actual administrative costs** of implementing and administering this section, including but not limited to the following costs:

[. . .]

(VII) To offset the loss of any federal matching funds due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008. (**emphasis added**)

While HPF revenue may be used for all of the enumerated purposes, in the event revenue is insufficient to fully fund all of the purposes, the HPF statute prioritizes the use of the existing HPF revenue. Section 25.5-4-402.3 (5) (b), C.R.S., reads in part:

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (5) (b) If the revenue from the provider fee **is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:**

(II) The **hospital provider reimbursement** and **quality incentive payment increases** described in **subparagraphs (I) to (III) of paragraph (b) of subsection (4)** of this section and the **costs** described in **subparagraphs (VI) and (VII) of paragraph (b) of subsection (4)** of this section **shall be fully funded** using revenue from the provider fee and federal matching funds **before any eligibility expansion is funded;** and (**emphasis added**)

Pursuant to section 25.5-4-402.3 (5) (b) (II), C.R.S., in the event there is insufficient revenue to fully fund all of the enumerated purposes, the hospital reimbursements and payments described in subparagraphs (4) (b) (I) to (4) (b) (III) must be "**fully funded using revenue from the provider fee** . . . **before any eligibility expansion is funded**". This includes maximizing the inpatient and outpatient hospital provider reimbursements up to the upper payment limits, increasing hospital reimbursements under the Colorado Indigent Care Program up to one hundred percent, and making quality incentive payments. In addition, fully funding the department's administrative costs and offsetting the loss of federal matching funds in certain circumstances pursuant to subparagraphs (4) (b) (VI) and (4) (b) (VII) take priority over funding any expanded medical benefits or eligibility.

Statutory language further supports the elevation of subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b) (VI), and (4) (b) (VII) over the expansion of medical benefits or eligibility. Subparagraph (4) (b) (IV), which lists expansions in medical benefits and eligibility criteria, begins with the introductory phrase "[s]ubject to available revenue from the provider fee". No such limiting language introduces the other statutory purposes for the HPF enumerated in paragraph (4) (b). Therefore, HPF revenue must first be used to accomplish the goals described in subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b)

(VI), and (4) (b) (VII) before any remaining "available" revenue is used for expanded medical benefits or eligibility pursuant to subparagraph (4) (b) (IV).

Further, while the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) is not defined in statute, the language of section 25.5-4-402.3, C.R.S., taken as a whole, provides some basis for discerning legislative intent. Given the entire statutory scheme creating the HPF and the numerous references to "fully" funding hospital reimbursements before "any" revenue is used to fund the expansion of medical benefits or eligibility, the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) may fairly be interpreted to mean fully funding hospital reimbursements by increasing reimbursements to the highest practicable level allowed by federal guidelines governing the upper payment limit and by the General Assembly's appropriation.

2.2. When revenue is insufficient to fully fund all of the statutory purposes for the HPF, the state board must adopt rules reducing medical benefits or eligibility to the level of available HPF revenue.

The HPF statute specifically contemplates that HPF revenue may be insufficient to fully fund all of the statute's purposes. If medical benefits or eligibility has already been expanded pursuant to subparagraph (4) (b) (IV), in the event HPF revenue is insufficient, the state board, with the approval of the Joint Budget Committee, must reduce medical benefits or eligibility to the level necessary to match available HPF revenue. Section 25.5-4-402.3 (5) (b) (III), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (5) (b) If the revenue from the provider fee is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:
>
> (III) (A) **If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subparagraph (IV) of paragraph (b) of subsection (4)** of this section, and the state department thereafter notifies the advisory board that **the revenue available from the provider fee** and the federal matching funds **will not be sufficient to pay for all or part of the expanded eligibility,** the advisory board **shall recommend** to the state board **reductions in medical benefits or eligibility** so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. **After receiving the recommendations of the advisory board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue shall be sufficient and shall forward any**

adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), C.R.S., following the adoption of rules pursuant to this sub-subparagraph (A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to sub-subparagraph (B) of this subparagraph (III).

(B) **The joint budget committee shall promptly consider any rules adopted by the state board** pursuant to sub-subparagraph (A) of this subparagraph (III). The joint budget committee shall promptly notify the state department, the state board, and the advisory board of any action on such rules. **If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the provider fee and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility.** After approving the rules pursuant to this sub-subparagraph (B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, C.R.S., extend the rules as provided for in section 24-4-103 (8), C.R.S., unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8) (a), C.R.S. (**emphasis added**)

Therefore, in the event that HPF revenue is insufficient to fully fund all of the statute's enumerated purposes, HPF revenue must be used first to fully fund hospital reimbursements and incentive payments and administrative costs and, subject to the limitations discussed in section 3 of this memo, the state board must adopt rules reducing medical benefits or eligibility to match the remaining HPF revenue.

3. Without statutory changes or other state action, the state board's ability to adopt rules reducing medical benefits and eligibility in response to insufficient HPF revenue is limited, in part, by other state and federal law.

Except as provided in section 25.5-4-402.3 (5) (b) (III), C.R.S., relating to delayed filing of the rules, the state board's rules reducing medical benefits or eligibility in response to reduced HPF revenue must comply with the "State Administrative Procedure Act".[8] Section 24-4-103 (4) (b), C.R.S., prohibits the adoption of rules that conflict with other provisions of law.

---

[8] Section 24-4-101, C.R.S., et seq.

Subsequent to the enactment of the HPF statute in 2009, Congress passed the Affordable Care Act[9] (ACA) in 2010. The ACA made numerous changes to the Medicaid program, including increasing income eligibility levels for existing eligibility groups and expanding eligibility to childless adults. Colorado elected to participate in the ACA's expanded Medicaid eligibility for childless adults. In 2013, the General Assembly enacted S.B. 13-200, which amended section 25.5-5-201, C.R.S, relating to optional Medicaid groups. In S.B. 13-200, the General Assembly removed language in section 25.5-5-201 (1) (m) and (1) (p), C.R.S., that specifically permitted the state board to use the mechanism set forth in the HPF statute to reduce income and eligibility levels for parents and caretaker relatives and childless adults in the event HPF revenue is insufficient to fully fund all of the purposes for the HPF. Further, until 2019, the ACA prohibits Colorado from reducing income eligibility for children under the Medicaid program and the Children's Basic Health Plan.[10]

With respect to the expanded medical benefits or eligibility that may be reduced by rule of the state board, state and federal law do not appear to limit the ability of the state board to reduce certain medical benefits or eligibility described in section 25.5-4-402.3 (4) (b) (IV), C.R.S. These medical benefits or eligibility include the Medicaid buy-in program for adults and children with disabilities, continuous eligibility for children enrolled in the Medicaid program, and income eligibility for pregnant women under the Children's Basic Health Plan. However, eliminating these programs may not result in a reduction of $100 million dollars in services.

Therefore, if HPF revenue is reduced by $100 million dollars as proposed in the Governor's budget, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to a reduction in HPF revenue.

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[9] Patient Protection and Affordable Care Act, 42 U.S.C. sec 18001 et seq.

[10] Section 25.5-8-101, C.R.S., et seq.

4. The HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax, and reducing the amount of HPF revenue collected as proposed does not convert it into a fee or require voter approval under TABOR.

4.1. As currently imposed, the HPF is a fee, not a tax, for purposes of TABOR.

Section (4) (a) of TABOR requires "voter approval in advance" for "any new tax, tax rate increase, . . . extension of an expiring tax, or . . . tax policy change directly causing a net tax revenue gain," but does not require such voter approval for increases in other government-imposed charges, such as fees, fines, and penalties, that do not increase tax revenue. TABOR does not define the term "tax", but the Office of Legislative Legal Services has developed a sequential series of tests, based upon Colorado judicial decisions, for the purpose of determining whether a charge is a "tax" for purposes of TABOR. Applying the tests in order, to the extent necessary, to the HPF establishes that the HPF is a fee, not a tax.

The first test is whether the charge being examined is imposed by legislative authority to raise money for a public purpose. If so, it may be a tax. Because the HPF is imposed pursuant to statute and raises money that is used to fund state medical assistance program and Colorado indigent care program services, it satisfies the first test.

The second test requires a determination as to whether the HPF is a type of governmental charge that is not a tax, such as a fee, fine, or penalty. Colorado Supreme Court decisions indicate that while a tax is imposed for the purpose of raising revenue to defray general expenses of government,[11] a fee is a charge that: (1) Is imposed to defray the cost of a particular governmental service; (2) Is imposed in an amount that is reasonably related to the overall cost of the service, even though mathematical exactitude is not required; and (3) At the time it is first imposed, is not made primarily for the purpose of raising revenue for general public purposes.[12]

The General Assembly originally imposed and has continued to impose the HPF not to defray general expenses of government, but instead for the limited purpose of "obtaining federal financial participation under the state medical assistance program . . . and the Colorado indigent care program . . ." so that it can increase reimbursement to

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[11] For example, the vast majority of revenue generated by the state income tax and the state sales and use taxes is credited to the general fund and accounts for over 96% of general fund revenue.

[12] *See Tabor Foundation v. Colorado Bridge Enterprise,* 2014 COA 106, PP 21-44; *Barber v. Ritter,* 196 P.3d 238, 248-49 (Colo. 2008); *Bloom v. City of Fort Collins,* 784 P.2d 304, 308 (Colo. 1989).

hospitals for services provided under the state medical assistance program and the Colorado indigent care program, cover more people with public medical assistance, and defray its own administrative costs of implementing and administering the HPF program.[13] In addition, the requirement that HPF-funded services be limited or prioritized, as detailed in section 2 of this memorandum, when HPF revenue is insufficient to fund hospital reimbursements to the upper payment limit supports the conclusion that the HPF is imposed at a level that is reasonably related to the cost of the HPF program. Because the HPF therefore meets the requirements of a fee, it is not a tax for purposes of TABOR.

4.2. Reducing HPF revenue by $100 million would not convert the HPF from a fee into a tax and would not trigger TABOR voter approval requirements.

HPF revenue is included in state fiscal year spending (TABOR revenue) and counts against the state fiscal year spending limit (limit). For a fiscal year in which TABOR revenue exceeds the limit, reducing HPF revenue reduces TABOR revenue and thereby also reduces the amount of the TABOR refund, which is paid from the general fund, on a dollar for dollar basis until TABOR revenue no longer exceeds the limit. Because such a reduction in the amount that must be refunded from the general fund makes more general fund money available for expenditure, it has been suggested that reducing HPF revenue converts the HPF from a fee into a tax and requires voter approval. But Colorado Supreme Court precedent establishes that such a conversion does not occur.

Between 2001 and 2004, in order to increase the amount of general fund money available to fund various state programs and services during and following an economic downturn, the general assembly enacted legislation that transferred a total amount of over $442 million from various cash funds to the general fund. The money transferred from the cash funds had originally been generated by various state-imposed fees, surcharges, and special assessments, and had, like HPF revenue, been counted as TABOR revenue when first received by the state.

In a lawsuit filed against the state, fee and surcharge paying plaintiffs alleged that "the transfers from the special funds to the general fund represented a tax policy change directly causing a net tax revenue gain, a new tax, or a tax rate increase, without voter approval in violation of [TABOR] because the transferred monies, which [plaintiffs alleged] became general tax dollars as a result of the transfer, would be expended to defray general governmental expenses unrelated to the respective purposes for which

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[13] Section 25.5-5-402.3 (3) (a), C.R.S.

the cash funds were created.[14] The Colorado Supreme Court rejected the claim, stating that "the primary purpose for which the legislature originally imposes a charge is the dispositive criteria in determining whether that charge is a fee or a tax," that "[i]t is undisputed here that, while the monies resided in the special cash funds, they were fees," that "[t]he fact that the fees were eventually transferred to the general fund does not alter their essential character as fees because the transfer does not change the fact that the primary object for which they were collected was not to defray the general cost of government," and that "[a]t most, the transfer of fees to a general fund where, as here, the statutes authorizing assessment of those fees do not contemplate the generation of revenue for general use, incidentally makes funds available to defray the general cost of government," and "does not transform a fee into a tax."[15] Here, the HPF as currently imposed satisfies the tests for classification as a fee for TABOR purposes, and the relevant judicial precedent establishes that even a direct transfer of HPF fees to the general fund would not convert the HPF into a tax. Accordingly, the proposed reduction of HPF revenue, which does not transfer any HPF revenue or cause HPF revenue to be used for any purpose for which it is not already used, clearly would not effect such a conversion and, since TABOR voter approval requirements do not apply to fees, would not require voter approval.

Conclusion

Under current law, the General Assembly may trigger a reduction in the HPF and the resulting revenue by reducing HPF cash fund appropriations by $100 million dollars. If the resulting HPF revenue is insufficient to fully fund all of the purposes for the HPF, the existing HPF revenue would be allocated pursuant to the prioritization in the HPF statute. Under current law, HPF revenue and the federal matching funds must be used first to fully fund hospital reimbursements and incentive payments and the department's administrative costs, before any remaining available revenue is used to fund the expansion of medical benefits or eligibility. The state board is directed to adopt rules reducing medical benefits or eligibility to match available HPF revenue. However, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to

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[14] *Barber,* 196 P.3d at 244 (internal quotations omitted).

[15] *Id.,* at 249-50 and 249 n.13 (internal citations omitted).

insufficient HPF revenue. Finally, the General Assembly may act to reduce HPF revenue without voter approval.