Department of Health Care Policy and Financing

Line Item Description and Department Reference Resource

FY 2018-19 Budget Request

November 2017

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I. LINE ITEM DESCRIPTION

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office Long Bill group of the Department's budget contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determination, client and provider services, utilization and quality review, and information technology contacts. This division is divided into eight subdivisions.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, personal services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department. A description of each line item is presented below.

PERSONAL SERVICES

This line item funds the majority of the Department's expenditures for FTE, temporary staff, and some of its contractors. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through this line item. It excludes expenditures for those FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities.

HEALTH, LIFE, AND DENTAL

This line item funds the Department's health, life, and dental insurance benefits, and is part of the POTS component paid jointly by the State and state employees. The calculated annual appropriation is based upon recommendations contained in the annual Total Compensation Report and associated guidance from the Governor's Office of State Planning and Budgeting (OSPB), and is calculated based upon employee benefit enrollment selections.

SHORT-TERM DISABILITY

This line item, a component of POTS, provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. This benefit is calculated on an annual basis in accordance with OSPB Common Policy instructions.

AMORTIZATION EQUALIZATION DISBURSEMENT

This line item funds the increased employer contribution to the Public Employees' Retirement Association (PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235, which created this line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY

The Salary Survey appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the Total Compensation survey performed annually by the Department of Personnel and Administration. The annual request for this line item is calculated based upon the annual Total Compensation recommendations from the State Personnel Director, along with guidance provided via the OSPB Common Policy Instructions.

MERIT PAY

Formerly known as "Performance Achievement Pay," Merit Pay represents the annual amount appropriated for periodic salary increases for State employees. Salary increases are based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work.

WORKERS' COMPENSATION

This line item provides funding for payments made to the Department of Personnel and Administration (DPA) to support the State's self-insured Worker's Compensation program. Workers' Compensation is a statewide allocation to each Department based upon historic usage. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and Common Policy adjustments. DPA's actuaries determine departmental allocations.

OPERATING EXPENSES

This line item funds the expenses necessary for the Department and its staff to operate. This obligation includes office essentials such as telephones, computers, office furniture, and office supplies as well as requisite travel, both in- and out-of-state, for site visits, public meetings, stakeholder engagement, and training. This line also funds building maintenance and repairs, storage of records, public noticing and postage costs and subscriptions to federal publications.

LEGAL SERVICES

This Common Policy line item funds the Department's expenditures for legal services provided by the Department of Law. The Department is billed based on a blended attorney/paralegal hourly rate developed by the Department of Law.

ADMINISTRATIVE LAW JUDGE SERVICES

This Common Policy line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. Departmental appropriations are based upon historical utilization of these services, by applying the prior year's billable hours to the estimated billable cost for the request year. Adjustments are made based on mid-year reviews by the Department of Personnel and Administration.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

This Common Policy line item is an allocation appropriated to each department based on a shared statewide risk formula for property and liability insurance coverage, also known as the Liability Program and Property Program. Prior to FY 2007-08, the Department did not participate in the Property Program. However, for FY 2007-08, the Department of Personnel and Administration adjusted its policy and began billing the Department for the Property Program portion.

LEASED SPACE

Previously called Commercial Leased Space, this line item was established in FY 2003-04 as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258). The line item is necessary to pay for the Department's obligations for leases of private office space and other facilities that are not State-owned.

CAPITOL COMPLEX LEASED SPACE

This Common Policy line item is appropriated to cover program and overhead costs associated with the maintenance and property management functions provided by the Division of Central Services, Facilities Maintenance for the 31,512 square feet of space the Department occupies at 1570 Grant Street.

PAYMENTS TO OIT

Starting in FY 2014-15, this Common Policy line item combines four OIT-related line items that were previously separated in the Long Bill. This line item funds the Department's allocation for services provided by OIT, including centralized computer services, provision and administration of the Colorado State Network, information technology security, new OIT initiatives, and OIT's internal office expenses.

CORE OPERATIONS

This Common Policy line item resulted from the passage of HB 12-1335, the FY 2012-13 Long Appropriations Bill, and was renamed from COFRS Modernization to CORE Operations in SB 15-234, the FY 2015-16 Long Appropriations Bill. It funds the Department's allocation for services related to the implementation and ongoing support of the new statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures. The new system is needed to meet the State's fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality.

SCHOLARSHIPS FOR RESEARCH USING THE ALL-PAYERS CLAIMS DATABASE

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to fund scholarships for nonprofit and government entities to access and conduct research in the All-Payer Claims Database. The Database was created in 2010 and combines claims data from commercial health plans, Medicare and Medicaid. It is administered by the Center for Improving Value in Health Care.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in FY 2007-08 and contains appropriations for any special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO/FROM OTHER DEPARTMENTS

TRANSFER TO DPHE FOR FACILITY SURVEY AND CERTIFICATION

The Department of Public Health and Environment (DPHE) is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. Federal regulations at 42 C.F.R. § 488 authorizes and sets requirements for both Medicare and Medicaid surveys and certification of health facilities. This line item helps to fund the survey and certification of nursing facilities, hospices, home health agencies, and Home- and Community-Based Services agencies (including alternative care facilities, personal care/homemaking agencies, and adult day services) by paying the Medicaid share. The Department also pays DPHE to maintain and operate the Minimum Data Set resident assessment instrument, which is used for nursing facility case mix reimbursement methodology. However, the Minimum Data Set resident assessment instrument, from which the data is obtained, is not Medicaid funded. The Department contracts with DPHE through an interagency agreement for these functions. Federal financial participation is broken into two categories: 1) expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals expenditures related to long-term care facilities, and 2) expenditures qualifying for a 50% federal financial participation rate to cover POTS and other Common Policies for the FTE that perform these services. While the DPHE FTE is working in the field to survey and inspect the facilities, that FTE qualifies for 75% federal financial participation. After the FTE returns to the office to complete the paperwork associated with the inspection, the FTE time in the office qualifies for 50% federal financial participation. The FTE uses a time reporting sheet that details how each hour of work is spent, so that Medicare and Medicaid funding can be claimed as applicable.

The federal Centers for Medicare and Medicaid Services (CMS) also requires that the State be in compliance with Medicare requirements for home health and licensure for hospice agencies. Facility surveys associated with compliance for these Medicare requirements are also performed by DPHE; however, they are Medicare funded rather than Medicaid funded.

TRANSFER FROM DHS FOR NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income (below 200% of the federal poverty level), first-time mothers with a baby

less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

The trained visiting nurses educate mothers on the importance of nutrition and avoiding alcohol and drugs (including nicotine) and to assist and educate mothers on providing general care for their children and to improve health outcomes for their children. In addition, visiting nurses may help mothers to locate assistance with educational achievement and employment. This type of service is sometimes referred to as "targeted case management," involving a coordinated, ongoing, and personalized strategy for clients with a variety of needs, both medical and non-medical. Each unit of service provided equals 15 minutes and is rated and billed based on that timeframe. In addition to targeted case management, a Department rule change in March 2017 eased physician supervision requirements for nurses, which will allow Nurse Home Visitor Program nurses to bill Health First Colorado for direct services, such as preventive counseling and depression screens. The goals of the program are improvements in pregnancy outcomes and the health and development of their children, as well as long-term economic self-sufficiency of their families.

The Nurse Home Visitor Program received continuation funding in the FY 2013-14 Long Bill, SB 13-230. However, the arrangements for the funding, beginning in FY 2013-14 were changed by HB 13-1117. The program, previously funded through the Department of Public Health and Environment, will be funded going forward through the Department of Human Services. The Nurse Home Visitor Program will continue to provide services in a manner similar to when the program existed at the Department of Public Health and Environment.

TRANSFER TO DPHE FOR PRENATAL STATISTICAL INFORMATION

The Department requires statistical data to evaluate the effectiveness of the Prenatal Plus program that used to be managed by DPHE but is now managed by the Department effective FY 2011-12. DPHE had been measuring the effectiveness of the program by using data supplied by the DPHE Vital Statistics office. The departments determined that it would be more cost-effective to continue to use the Vital Statistics data rather than to create a new tracking system for this purpose, so funding is allocated to reimburse DPHE for this purpose. This line item was newly established as a result of the Department's FY 2011-12 Budget Request DI-8 "Prenatal Plus Administration Transfer."

TRANSFER TO DPHE FOR LOCAL PUBLIC HEALTH AGENCIES

The line item was created through the General Assembly's approval of the Department's FY 2017-18 R-12 Budget Request "Local Public Health Agency Partnerships". The program intends to reduce the fragmentation between medical and public health systems by joining the population-based health work performed by the Local Public Health Agencies (LPHAs) and Regional Care Collaborative

Organizations (RCCOs) through a common funding mechanism. The Department uses state dollars that the LPHAs spend on Medicaid members to draw down a federal match and transfers these funds to the Department of Public Health and Environment. The funds are used for purposes such as hiring community health workers to help Medicaid members navigate between the medical and public health systems and providing LPHAs access to their RCCOs data systems.

TRANSFER TO DORA FOR NURSE AIDE CERTIFICATION

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150(b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (DPHE). The Department provides Medicaid funding for the program and DPHE provides Medicare funding for the program. Pursuant to section 12-38-101, C.R.S., the Colorado State Board of Nursing in DORA oversees regulation of certified nurse aides practicing in medical facilities throughout the state. The regulation of nurse aides is carried out under the Nurse Aide Certification program, which includes a nurse aide training program, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

DORA is required to administer the Nurse Aide Certification program using established standards for the training curriculum to ensure that nurse aides receive federally required training and that nurse aides are tested regularly to assure competency. DORA is also responsible for administering a nurse aide registry program that allows investigations into allegations of abuse by nurse aides, when necessary. The registry also tracks the mandatory criminal background check required for nurse aides per the passage of HB 95-1266.

State funding for this program is comprised of General Fund and fees collected directly from nurse aides. These fees are assessed as part of the required criminal background check. Federal regulations prohibit requiring nurse aides to pay for certification, but requiring non-certified nurse aides to pay the cost of the background check is a permissible exception to these regulations. Many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements. The State funds, consisting of General Fund and reappropriated funds from DORA are used to draw down federal funds.

TRANSFER TO DORA FOR REVIEWS

The Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies (DORA) conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when the Department had a law requiring a sunset review, a specific line item was

established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review.

This line item was established in the FY 2009-10 Long Bill Add-Ons (SB 09-259), beginning with FY 2008-09. The line item name was created to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a type of audit that are performed to provide information to the General Assembly on the effectiveness and efficiencies of particular programs. This information is used by the General Assembly to provide guidance on future legislation or modifications to current legislation. Statutory authority authorizing DORA to conduct these reviews comes from section 24-34-104(8)(a), C.R.S. DORA calculates the anticipated costs for performing particular sunset reviews and notifies the Department by letter so that the costs can be requested in the future year budget submission for the Long Bill.

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

This line item funds a portion of the administrative expenses of the Public School Health Services Program created in SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers. Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. Pursuant to section 25.5-5-318(8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. This line funds the administrative expenses of the Department of Education, including the provision of technical assistance to program coordinators at participating school districts and the review of all local services plans and annual reports.

TRANSFER TO DOLA FOR HOME MODIFICATIONS BENEFIT ADMINISTRATION

This line item includes funding for the Division of Housing to administer the home modification benefit under the Elderly, Blind and Disabled, Spinal Cord Injury, Community Mental Health Supports, and Brain Injury Waivers. Funding ensures that bids for home modifications are correctly structured, and that home modifications are finished timely and meet housing codes.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

Beginning with the FY 2013-14 Long Bill (SB 13-230), this line item, formerly known as "Information Technology Contracts" was entitled "Medicaid Management Information Systems Maintenance and Projects."

The Medicaid Management Information Systems (MMIS) is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The MMIS processes claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from MMIS.

The MMIS is federally required for states that participate in the Medicaid program (Section 1903(r) of the Social Security Act). The Centers for Medicare and Medicaid Services' (CMS) *State Medicaid Manual* identifies the specific types of MMIS costs that are allowable for federal reimbursement.

The Department's new MMIS implemented in March 2017 consists of three interacting systems. Those systems include:

- Colorado interChange - the core system responsible for claims processing;
- Pharmacy Benefits Management System (PBMS) - the system responsible for processing pharmacy claims;
- Business Intelligence and Data Management Services (BIDM) - the system responsible for data analytics

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTS

This funding was adjusted by the FY 2017-18 R-8 "MMIS Operations Adjustment" request to make some technical adjustments and account for a five-month delay in Go-Live of the new MMIS. This also added funding to extend the use of this line item through FY 2017-18, and the line item will be removed from the FY 2018-19 Long Bill. The line was originally funded through the Department's FY 2013-14 R-5 "MMIS Reprocurement" request over four years beginning in FY 2013-14 through FY 2016-17 to procure a new MMIS. This line item was created for the contract costs related to the MMIS reprocurement. The MMIS was reprocured because current federal fiscal agent contracting policies require reprocurement of the MMIS every eight years. The legacy MMIS was highly outdated resulting in significant operational inefficiencies, limitations to the Department's ability to implement policy changes, and risks of losing federal approval and federal financial participation (FFP), making reprocurement an opportunity to acquire a new, modern MMIS to

address these problems. This funding was adjusted by FY 2014-15 S-7, BA-7 "MMIS Adjustments" to align with more detailed business requirements and updated funding needs developed since the original budget request. The new MMIS transitioned from the design, development, and implementation (DDI) stage to the operational stage in March 2017, replacing the legacy MMIS.

FRAUD DETECTION SOFTWARE CONTRACT

On January 23, 2008, the Department submitted BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries," requesting $1,250,000 in total funding to increase efficiencies in Medicaid cost avoidances and provider recoveries. The approved budget amendment allowed the Department to purchase fraud-detection software and also allowed the Department to implement improvements to the Medicaid provider re-enrollment process.

The fraud-detection software utilizes neural network and learning technology to detect fraud, abuse, or waste in the Medicaid program. It also supports such functions as compliance monitoring, provider referrals, and utilization review. Moreover, it provides support to the Department's Program Integrity Section by providing additional research on: potential fraud and abuse; receiving and accessing licensing board data to compare with provider data; looking for known abusive or fraudulent practices using target queries on procedure or diagnosis codes; and, tracking the progress of individual cases, including case hours, investigative cost, and travel expenses related to the Medicaid program.

COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING CONTRACT EXPENSES

The Colorado Benefits Management Systems (CBMS), Operating and Contract Expenses line item was created as a result of the Department's FY 2015-16 S-6, BA-6 CBMS Funding Simplification supplemental request to streamline billing processes related to CBMS. This line item consolidates CBMS funding from line items formerly in the Department's DHS Medicaid-Funded Programs Long Bill group (7), including the former Colorado Benefits Management Systems; HCPF-Only Projects; and CBMS SAS-70 Audit line items. This funding was consolidated to allow the Department to reimburse the Governor's Office of Information Technology (OIT) directly, rather than the previous administratively burdensome and unnecessary process of reimbursing OIT through transactions with the Department of Human Services (CDHS).

The CBMS tracks client data, determines applicant eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. There is no specific authorization in statute that specifically mentions CBMS; however, authorization can be inferred from 25.5-5-101, C.R.S. The OIT currently has oversight of daily operations for the CBMS vendor. All OIT funding for CBMS through this line item is reappropriated from the Department and CDHS. Costs are allocated to the various State and federal

programs participating in CBMS through the federally approved cost-allocation process, primarily determined through polling results of the county departments of human/social services staff according to a federally approved Random Moment Sampling methodology.

A broad range of components are funded from this appropriation including: vendor payments; Department-only projects; computer hardware maintenance and repairs; computer software maintenance and upgrades; non-computer equipment rental; building rental; rental of computers and network equipment; travel expenses; training expenses; telecommunication services; printing and reproduction of paper documents; legal services; freight and shipping charges; data-processing supplies; office supplies; postage; copy supplies; non-capitalized equipment purchases; dues and memberships; registration fees; capital lease principal payments; and capital lease interest payments.

COLORADO BENEFITS MANAGEMENT SYSTEMS, HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item, previously entitled CBMS Modernization Project Personal Service, Operating Expenses and Centrally Appropriated Expenses, provides funding used by the Department, in coordination with funding through the CDHS, to fund state staff who provide user training for county departments of human/social services staff.

HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to build infrastructure allowing for the secure and private exchange of electronic client health information among providers, labs, the Department, and other appropriate health care entities. The initial funding for this line item originated with the Department's FY 2014-15 R-5 Request "Medicaid Health Information Exchange."

Specifically, the Department is installing hardware and software infrastructure that allows Medicaid providers and hospitals to network together their individual electronic health record (EHR) systems. This allows for a client's EHR to be quickly called up and shared with any of the client's providers statewide when appropriate. This enables improved care coordination, better client experiences, better-informed care decisions, more opportunities for preventative care, and advanced analytics to help policy-makers. The Department works closely with the Colorado Regional Health Information Organization (CORHIO), which is the State-Designated Entity (SDE) in charge of coordinating electronic Health Information Exchange (HIE) statewide.

FY 2015-16 R-9 "Personal Health Records and Online Health Education" was approved to increase funding to this line item to implementation additional technology related to HIE. This includes online health education resources and Personal Health Record (PHR) technology, allowing Medicaid clients to securely view their electronic medical information and interact with providers online.

CONNECT FOR HEALTH COLORADO SYSTEMS

This line item was created in the FY 2016-17 Supplemental Appropriations Bill (SB 17-162) and FY 2017-18 Long Bill (SB 17-254). This funding provides federal funds reimbursement to Connect for Health Colorado for allowable systems costs they incur that qualify as certified public expenditures related to the administration of Medical Assistance programs.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

The purpose of Medicaid identification cards is to provide proof of a client's Medicaid eligibility to service providers so that the client can receive medical services from the provider. Currently, if clients cannot show proof of Medicaid eligibility, providers can, at times, refuse to provide services.

Under the medical ID card system, clients are issued plastic Medicaid authorization cards upon a determination of their eligibility for Medicaid. Prior to rendering Medicaid services, providers must verify Medicaid eligibility electronically after viewing the client's plastic card. In the event plastic cards are lost, replacement cards are issued when necessary. The plastic authorization cards have reduced the Department's liability from a one-month guarantee of eligibility to only the exact periods of eligibility. The new cards also allow clients to move on and off covered programs without receiving a new card each time.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards, but, prior to FY 2003-04, there were no specific funds to pay for the production of these cards. Beginning in FY 2003-04, funding for authorization cards for the Old Age Pension State Medical Program's clients was added to the appropriation. Since these clients are not Medicaid eligible, no federal match is available for these funds.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for three Department functions: Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review (PASRR), and Hospital Outstationing.

Disability Determination Services

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services (DHS) to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from DHS to the Department of Health Care Policy and Financing (the Department).

Nursing Home Preadmission Screening and Resident Review (PASRR) Assessments

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this program is 75%.

All admissions to nursing facilities with Medicaid certified beds, regardless of individual payer source, are subject to preadmission screening, and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, that they remain in the nursing facility for the appropriate amount of time, and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

Hospital Outstationing

This line item funds outstationing activities at hospitals which allow hospitals to provide certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the State's medical assistance programs. This line item was created with the passage of HB 09-1293, the "Colorado Health Care Affordability Act," to assist with the anticipated increase in caseload due to the bill.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services (DHS) budget through an interagency transfer and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs

administered by DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, thereby establishing a direct relationship between the Department and the counties performing these functions.

As part of the Department's fiscal note for SB 06-219, the Department and DHS agreed that the allocation and reimbursement methodology would remain the same as prior to July 1, 2006. This included: 1) using the existing federally-approved random moment sampling model performed by DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 2) continuing using a cost-sharing allocation; 3) continuing to utilize the County Financial Management System for counties to have one-stop billing; and, 4) utilizing interagency transfers of General Fund between the Department and DHS pursuant to 24-75-106, C.R.S. in order to maximize Medicaid reimbursement to the counties. Subsequent appropriations for County Administration have been made without including a local share; as a result, the state, county and federal share of the appropriation do not follow the traditional 30% General Fund, 20% local share, and 50% federal funds that were historically seen.

The General Assembly appropriated additional funding to this line item in SB 13-200, which authorized Medicaid expansion under the Affordable Care Act. Additionally, to meet the expected high demand for eligibility determination services, the Centers for Medicare and Medicaid Services (CMS) examined its current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and has confirmed that certain eligibility determination-related costs are eligible for 75% federal financial participation (FFP), which has reduced the state and federal share for certain activities that a reimbursed under this line item. Counties can access the enhanced funding through random moment sampling (RMS) or direct coding.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support an incentive payment structure to counties. The incentive payment structure encourages faster and more accurate application processing and other process improvements in order to create a more efficient and effective eligibility determination process.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item provides for reimbursement to local county departments of human/social services for costs associated with performing Medicaid eligibility determinations for the expansion population categories created in HB 09-1293, the "Colorado Health Care Affordability Act". This funding was included in the County Administration line item, showing up as Cash Funds and Federal Funds; however, the Department's FY 2012-13 S-7 "Hospital Provider Fee Administrative True-up," submitted with the January 3, 2012 Supplemental Budget Request, requested the separation of this funding, thereby establishing this line item to make the budget more transparent, allow for easier tracking of hospital provider fee funds, and to separate funding sources that are allocated based on differing

methodologies. Subsequent appropriations, including those from SB 13-200, have expanded the use of this funding to other populations considered "newly eligible" under the Affordable Care Act.

While the County Administration line item reimburses county departments using a methodology including a random moment time study, a local funding match, and interagency transfers, this line item reimburses in a manner more reflective of the expansion of the Department's programs under HB 09-1293. Prior to FY 2014-15, these funds were distributed twice per state fiscal year based on total County Administration expenditures and each county's percentage of newly eligible clients funded by the Hospital Provider Fee relative to total Medicaid. Beginning in FY 2014-15, these funds are blended with the regular county administration appropriation and distributed periodically through the normal county reimbursement methodology. By blending the two appropriations together, the Department is able to reduce the administrative burden of additional payment while assuring the counties receive funding in a timely manner.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support infrastructure grants to counties. The infrastructure grants provide counties one-time funding to improve the eligibility determination process. The Hospital Provider Fee program was repealed effective July 1, 2017 and replaced with the Colorado Healthcare Affordability and Sustainability Enterprise in SB 17-267, "Sustainability of Rural Colorado". As such the contracts and programs administered through this line are now paid through the Enterprise funding.

MEDICAL ASSISTANCE SITES

This was a new line item in FY 2014-15 funded through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" and will initially fund a review of eligibility assistance and determination sites in addition to funding Medical Assistance (MA) sites for their Medicaid eligibility determination activities.

This line item will fund MA sites to conduct Medicaid eligibility determination on location. MA sites offer additional points of contact for Medicaid eligibility determination and eligibility workers are stationed at places such as schools, clinics and hospitals in order to assist clients. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet and support the Department's aim to have "no wrong door" in determining client eligibility. Previously, MA sites were unfunded for their eligibility determination activities.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services

(CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – Medicaid Funded Programs appropriations.

Funding for administrative case management includes reimbursement for staff and operating costs associated with State supervision and county administration of programs that protect and care for children, including out-of-home placement, subsidized adoptions, child care, and burial reimbursements. Medicaid funding for these costs was identified through a contingency based contract held between the Governor's Office of State Planning and Budgeting and Public Consulting Group, Inc.

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. Also similar to the County Administration appropriation, DHS has agreed to provide additional General Fund spending authority if necessary, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with this funding.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department functions: the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker. Prior to FY 2008-09, each of these functions was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office long bill group into a more programmatic format. As a result of HB 08-1375, the FY 2008-09 Long Bill, 46 line items were consolidated into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated budget items were the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker, which were combined into one line item entitled "Customer Outreach". The purposes of the funding is described as follows.

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) Program

The Department is required to ensure Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program outreach and case management services in a manner consistent with the federal regulations set forth at 42 CFR §§ 441.50-441.61. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services for children. The services include, but are not limited to:

- Contacting eligible clients to provide in-depth explanation of the program and its importance within 60 days of eligibility being established;
- Offering assistance and information to eligible clients and helping to overcome barriers which might impede access to services;
- Clarifying the role of primary care providers, dentists, and the managed care/prepaid health plans;
- Emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician;
- Maintaining periodic contact with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed;
- Initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring EPSDT clients as needed to those agencies and resources;
- Assisting clients with the program and managed care information process; and,
- Referring applicants to the enrollment broker at the time of Medicaid application.

Only administrative and outreach services are funded by this budget item. Services funded by this budget item are contracted primarily by county health department staff but may include other local outreach providers such as hospitals and community-based organizations. The funding for medical services provided through the EPSDT Program remain in the Department's Medical Services Premiums Long Bill group.

Enrollment Broker

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-005. The vendor contracted to serve as the enrollment broker is charged with providing unbiased choice counseling to assist eligible Health First Colorado and Child Health Plan Plus (CHP+) clients to choose available health plans and a primary care medical provider (PCMP). If a client chooses a health plan or a PCMP, the vendor will enroll the client in the plan or with the PCMP. The enrollment broker also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. The enrollment broker performs this work under the name of Health First Colorado Enrollment. As of January 1, 2013, the enrollment broker vendor provides enrollment services for the CHP+ program.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) for the implementation and administration of a centralized eligibility vendor model. The line item was the result of the recommendation by The Blue Ribbon Commission for Health Care Reform (the "208 Commission") created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal suggested creating a

single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility. This line was moved from the Executive Director's Office (C) Information Technology Contracts and Projects Long Bill group into the Executive Director's Office (D) Eligibility Determinations and Client Services in the FY 2016-17 Long Bill (HB 16-1405).

The Centralized Eligibility Vendor streamlines navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, creates expedited eligibility for medical only cases, and improves outreach and enrollment in both programs. These changes ensure easier, more reliable, and timely eligibility and enrollment processes, making the programs more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. In addition, the entity modernizes the current eligibility determination process by providing technology that is not currently available in every county, such as an automated customer contact center and an electronic document and workflow management system. This provides a central repository for applications and related documents. The Centralized Eligibility Vendor also provides electronic systems that aid in managing the online application for benefits. This entity enhances and complements the current multiple county-level process.

CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

This line item was created in the FY 2016-17 Supplemental Appropriations Bill (SB 17-162) and FY 2017-18 Long Bill (SB 17-254). This funding provides federal funds reimbursement to Connect for Health Colorado for allowable eligibility determination and customer service costs they incur that qualify as Certified Public Expenditures related to the administration of Medical Assistance programs.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Acute Care Utilization Review, Long-term Care Utilization Review, External Quality Review, Drug Utilization Review and Mental Health External Quality Review were combined into one line item titled "(E) Utilization and Quality Review Contracts: Professional Services Contracts" within Long Bill group (1) Executive Director's Office.

Acute Care Utilization Review

Acute Care Utilization Review budget item includes the performance of prospective reviews for specified services to ensure that requests for benefits, services and supplies are a covered benefit and that they are medically necessary and appropriate. Reviews are conducted prior to the delivery of services and supplies, and include the following categories: audiology, pediatric behavioral therapy, diagnostic imaging, durable medical equipment (DME), speech therapy, inpatient out-of-state admissions, medical services including transplant and bariatric surgeries, physical and occupational therapy, pediatric long-term home health (LTHH), private duty nursing, certain office administered drugs, and vision.

The Department contracts with an independent contractor to perform these reviews. The reviews ensure that members receive the right services and supports at the right time, for the right amount and duration, and in the right setting. Requiring prior authorization improves the quality of care for members while decreasing the amount of services and supplies that are not medically necessary and are duplicative. This results in decreased costs for Department. Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 C.F.R. §433.15 (6)(i), the Department receives enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization as defined under Section 1152 of the Social Security Act.

Long-Term Care Utilization Review

Long-term care utilization reviews include performing prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reevaluation of services. In addition, the Single Entry Point (SEP) agencies (case management agencies and community-centered boards) perform pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community-based long-term care programs, as well as annual continued stay reviews of these clients. The SEP agencies and other contractors perform the following functions with funding from this budget item:

- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Pre-Admission Screening and Resident Review (PASRR Level I) to identify clients who need Level II screening;
- Administration of the Hospital Back-Up (HBU) Program, which provides cost-effective alternatives for clients who have extended acute hospitalizations by permitting transfer to nursing facilities capable of providing care;

- Assessments for the Children's Extensive Support (CES) waiver which provides Medicaid benefits, services and support for children with developmental disabilities or delays and require special services and provide an alternative to institutional placement;
- Assessments for Private Duty Nursing which provides eligible clients with skilled nursing services in a home setting;
- Data management; and,
- Training for case managers.

The Department's contractor maintains a long-term care database and performs prior authorization reviews for long-term care clients. The results of the prior authorization reviews are transmitted electronically to the Department's fiscal agent. The contractor also conducts reviews for the Level II PASRR Program.

The Department receives enhanced federal funding for many activities performed in this line item. Under Section 1903(a)(2)(C) of the Social Security Act and 42 C.F.R. § 433.15(9), the Department receives enhanced federal financial participation of 75% for funds expended to conduct preadmission screening and resident review activities. If a contractor qualifies as a qualified improvement organization under Section 1152 of the Social Security Act, the Department may seek enhanced federal financial participation of 75% for the performance of medical and utilization review activities other than preadmission screening and resident review.

External Quality Review

This budget item provides funding to validate performance improvement projects (PIPs), conduct compliance site reviews, conduct satisfaction surveys, collect and validate Healthcare Effectiveness Data and Information Set (HEDIS) measures and other performance measures for managed-care organizations and fee-for-service providers, and complete other encounter data audits. In addition to creating reports for these activities Health Services Advisory Group, Inc. also creates annual Technical Reports of activities and recommendations that is required by the Centers for Medicare and Medicaid Services (CMS).

The Department is permitted to receive an enhanced federal financial participation (FFP) rate of 75% for funds expended for performance of external quality review or related activities when they are conducted by an external quality review organization as defined in 42 C.F.R. § 438.320. Additional requirements for the enhanced FFP rate can be found in 42 CFR § 438.370, 42 CFR § 438.364, and 42 CFR § 433.15(b)(10).

Drug Utilization Review

This budget item funds the Department's drug utilization review program established pursuant to 42 C.F.R. § 456.703. The purpose of the program is to ensure appropriate drug therapy while permitting sufficient professional prerogatives to allow for individualized drug therapy. The program consists of both prospective and retrospective reviews, the application of explicit predetermined standards, and an educational program. Pursuant to 25.5-5-506(3)(b), C.R.S., the Department submits an annual report to the Health and Human Services Committees of the General Assembly that contains:

- Information on the prospective and retrospective drug review program;
- Steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards;
- Summary of the educational interventions used and an assessment of the effect of these educational efforts on quality of care; and,
- Estimate of the cost savings generated as a result of the drug use review program.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item funds various audit contracts managed by the Department. Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Nursing Facility Audits, Hospital and Federally Qualified Health Clinics Audits, Single Entry Point Audits, Payment Error Rate Measurement Contract, and Nursing Facility Appraisals were combined into one line item titled "(F) Provider Audits and Services: Professional Audit Contracts" within Long Bill group (1) Executive Director's Office. The budget item Colorado Indigent Care Program Auditor was later added as a result of HB 09-1293 "Health Care Affordability Act," and the budget item Disproportionate Share Hospital (DSH) Audits was added as a result of the Department's FY 2010-11 DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures."

Nursing Facility Audits

This budget item funds statutorily required audits of costs reported by Medicaid nursing facilities for rate setting purposes. The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial

and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient-related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes.

Hospital and Federally Qualified Health Centers Audits

This budget item funds a Department contract with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers (FQHCs), and rural health centers that participate in the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and participation in meetings with providers to resolve problems. The annual rates of reimbursement are based on the results of these audits and are set to cover the reasonable and necessary costs of an efficiently run hospital, FQHC, and rural health center, per federal and State law.

Single Entry Point Audits

This budget item funds annual audits of single entry point (SEP) agencies provided through a contractor. The scope of work has been limited to reviews of cost reports. To the extent that funds allowed, on-site audits are conducted for agencies that posed the highest risk. In FY 2006-07, the appropriation to this line was increased in order to increase the accuracy of SEP agency billing and potentially increase recovery of improper payments.

Community Mental Health Center Audits

This budget item funds annual audits of the Community Mental Health Centers (CMHC) which are nonprofit or publicly operated clinics that provide mental health services in the community. Specifically, the BHOs contract with the 17 CMHCs to provide mental health services to Medicaid clients in their assigned service area. The Colorado Department of Human Services also contracts with the CMHCs to provide mental health services to indigent persons (i.e., non-Medicaid-eligible individuals).

Regional Center Cost Reporting and Auditing

This funding allows the Department to ensure that regional centers receive proper compensation for the services they provide to some of the Department's most acute and vulnerable clients. Additionally, this ensures that the Department would remain in compliance with

CMS, as the cost reports would ensure regional centers are properly compensated according to their actual costs. This helps to meet one of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" by ensuring the regional centers are accurately compensated.

Payment Error Rate Measurement Project Contract

This budget item funds the Payment Error Rate Measurement Project, which was established in response to the federal Improper Payments Information Act of 2002 and was the culmination of three separate federal pilot programs collectively referred to as the Payment Accuracy Measurement Projects. The federal Improper Payments Information Act of 2002 requires the Department to: conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments; estimate the amount of improper payments made; and, report on those estimates. The Improper Payments Information Act of 2002 defines an improper payment as "any payment made that should not have been made or that was made in an incorrect amount including overpayments and underpayments." The definition further states that these payments "include any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and, any payment that does not account for credit for applicable discounts."

In August 2006, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule stating that federal contractors would be hired to calculate national error rates and review states' fee-for-service and managed care payments for Medicaid and State Children's Health Insurance Programs. Under the rule, each state is required to calculate its state-specific eligibility error rates and measure improper payments once every three years, so that all states are reviewed on a rotating basis, with 17 states reviewed per federal fiscal year. Due to the three-year cycle, Colorado completed the eligibility and payment error reviews in FY 2013-14 and will do so again in FY 2016-17.

Under the Payment Error Rate Measurement project, reviews are conducted in three areas: fee-for-service, managed care, and eligibility for both Medicaid and Children's Basic Health Plan. The claims review is conducted by federal contractors, whereas the eligibility review is conducted by the states. The results of these reviews are used to produce national program error rates as well as state-specific program error rates.

Nursing Facility Appraisals

This budget item funds nursing facility appraisals, which occur once every four years. The Department contracts with an independent firm to conduct these appraisals, with the underlying result being the determination of "fair rental value." Fair rental value, or appraised value, means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental

(property) value determination is used in the process of rate setting, which is governed by statute at 25.5-6-201, C.R.S. The per-diem rate paid to nursing facilities is based in part on the fair rental value of the facility.

Colorado Indigent Care Program Auditor

This budget item funds an auditor for the Colorado Indigent Care Program due to the passage of HB 09-1293 "Heath Care Affordability Act." Prior to this passage of this bill, the providers were paid using certification of public expenditures in order to draw federal matching funds. The Department currently contracts with a certified public accounting firm to perform federally mandated cost and rate data audits for hospitals, federally qualified health clinics, and rural health centers that participate in Medicaid. The certified public accounting firm establishes reimbursement rates, reviews contracts, calculates final cost settlements, rebases calculations, consults and assists on cost report interpretations, and meets with providers to resolve discrepancies. Prior to the passage of HB 09-1293, the Department did not perform such audits for providers participating in the Colorado Indigent Care Program. However, due to HB 09-1293, reimbursements for providers participating in the program are to be increased to 100% of cost, requiring similar audits to be conducted for the Colorado Indigent Care Program providers.

Through this budget item, the Department will utilize two types of audits to ensure proper payment of hospital fee funds to Colorado Indigent Care Program providers. The first are desk audits to: analyze cost reports to determine the accuracy and reasonableness of financial data reported by providers; identify problem areas that warrant additional review; and, obtain information for use in planning a site audit if deemed necessary. Second are on-site audits that will focus on specific payment issues that are potentially material in nature and a more detailed verification of data than the desk audit.

Disproportionate Share Hospital Audits

This budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures" (November 2, 2009 FY 2010-11 Budget Request). This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

DSH payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients. These payments assist in securing the hospitals' financial viability and preserving access to care for Medicaid and low-income clients,

while reducing the shift in costs to private payers. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

Primary Care Fund Audits

This budget item provides funding for compliance audits of the data submitted by Primary Care Fund applicants as a result of R-14 "Primary Care Fund Audits" (November 1, 2014 FY 2015-16 Budget Request). This funding is used to hire a contractor for a compliance audit of the data submitted by Primary Care Fund applicant providers to verify the accuracy and validity of the data. Qualified providers must serve a medically underserved population and/or area of Colorado and funds are allocated to each qualified provider based on the number of medically indigent patients served in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for Primary Care Funds. This budget line allows for one-third of the providers, or thirteen providers, to be audited each fiscal year to assure correct reporting of unduplicated patient counts and that patients are correctly categorized by payment source, by provider. For more information regarding the Primary Care Fund, please see the Primary Care Fund Program section of this document.

Managed Care Organization Audits

This budget item provides funding for Managed Care Organization Audits as a result of the FY 2015-16 R-15 "Managed Care Organization Audits" Budget Request. This funding is used to hire an auditing firm to perform audits on financial reports and encounter data from physical and behavioral health managed care organizations that contract with the Department. Prior to the passage of this funding, the Department did not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics. This budget item allows for the Department's contractor to:

- Conduct a thorough review of current managed care contract language to identify weaknesses and recommend appropriate changes to specific language.
- Use selected algorithms on claims data of managed care plans to identify outlier populations that could be at risk of overpayment.
- Test identified outlier populations to ensure compliance with regulations for allowable medical expenses.
- Tie financial reports to supporting information to ensure reporting accuracy in accordance with standards established by the American Institute of Certified Public Accountants.
- Audit of administrative expenses to ensure reported expenses are allowable and accurate.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, established by HB 91S2-1030 and authorized in 25.5-4-302, C.R.S., is operated by a contractor under supervision of the Department. The contractor pursues recoveries on a contingency fee basis and recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. Since FY 2003-04, the contractor has charged a contingency fee of 10.9%, with the remainder of the recoveries acting as an offset to expenditure in the Medical Services Premiums line.

(H) INDIRECT COST RECOVERIES

INDIRECT COST ASSESSMENT

This line item resulted from the passage of SB 13-230, the FY 2013-14 Long Appropriations Bill. It was created to separately identify the overhead costs associated with the operation of general government functions. Indirect cost recoveries are intended to offset these overhead costs that otherwise would have been supported by the General Fund, from cash and federally funded sources. Recoveries from cash and federally-funded programs are calculated for statewide overhead costs by the Office of the State Controller.

(2) MEDICAL SERVICES PREMIUMS

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, individuals with disabilities, adults, and children. Medical services are grouped into the following categories, each of which includes several programs: acute care, community-based long-term care, and long-term care. Additional expenditure is incurred for insurance, service management, and financing payments. For a program-level description of each of these categories of services, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-1, "Request for Medical Services Premiums."

To calculate the funding need for the Medical Services Premiums Line, the Department must forecast Medicaid caseload. The caseload presentation is included in the budget request as a separate exhibit. For a detailed narrative of the caseload forecast, please see the "Medicaid Caseload" Section included in this budget submission.

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health and substance abuse services throughout Colorado through managed-care providers contracted by the Department. The Behavioral Health Organizations (BHOs) are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category that is covered by the BHO contract. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Behavioral Health Community Program."

BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a Behavioral Health Organization to receive mental health or substance abuse services or enrolled Medicaid clients to receive mental health or substance abuse services not covered by the Behavioral Health Organizations. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Behavioral Health Community Program."

(4) OFFICE OF COMMUNITY LIVING

In 2012, Governor Hickenlooper issued Executive Order D 2012-027, establishing the Office of Community Living within the Department. The Office is charged with better aligning services and supports so that people with long-term services and supports needs, and their families, do not have to navigate a complicated and fragmented health care system. HB 13-1314, "Transfer Developmental Disabilities to HCPF" transferred funding from the Department of Human Services to the Department effective March 2014; this Long Bill group was established with the FY 2014-15 Long Bill (HB 14-1336).

The Office of Community Living Long Bill group of the Department's budget contains the administrative and programmatic funding for services and supports for persons with Intellectual and Developmental Disabilities and their families. Funding extends to FTE, operations support for a standalone case management system, and services and supports for eligible individuals and their families.

<u>(A) DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES</u>

(1) ADMINISTRATIVE COSTS

PERSONAL SERVICES

This line item funds the Department's expenditures for FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities. It was created as part of HB 13-1314 "Transfer Developmental Disabilities to HCPF", which transferred the administration of long-term services for persons with intellectual and developmental disabilities to the Department. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through the Executive Director's Office, (A) General Administration POTS appropriations.

OPERATING EXPENSES

In addition to funding telephones, computers, office furniture, and employee supplies associated with the Division's staff, this line also supports a number of annual costs such as in- and out-of-state travel, records storage, postage costs, and subscriptions to federal publications.

COMMUNITY AND CONTRACT MANAGEMENT SYSTEM

This line funds licensing, reporting functions and some limited IT support the Community and Contract Management System (CCMS), currently known as the DDDWeb, which is used to tracking client demographics, waiting list information, and bill for services for people with intellectual and developmental disabilities. CCMS is used for the purpose of authorizing and billing for services for the state funded programs, including the Family Support Services Program (FSSP) and State Supported Living Services.

SUPPORT LEVEL ADMINISTRATION

Service providers assisting HCBS-SLS and HCBS-DD waiver clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level evaluations.

CROSS-SYSTEM RESPONSE FOR BEHAVIORAL HEALTH CRISES PILOT PROGRAM

This line exists to act as a mechanism to transfer funds from the Developmental Disabilities Services Cash Fund created in Section 25.5-10-207 (1), C.R.S. to the Cross-system Response for Behavioral Health Crises Pilot Program Fund created in Section 25.5-6-412(7), C.R.S.

CROSS-SYSTEM RESPONSE FOR BEHAVIORAL HEALTH CRISES PROGRAM SERVICES

In FY 2014-15, the General Assembly passed HB 15-1368, legislation that created the Cross-System Response for Behavioral Health Crises Program Cash Fund. The pilot program supports collaborative approaches to provide a cross-system response to behavioral health crises for individuals with intellectual and developmental disabilities and a mental health or behavioral disorder. The pilot program coordinates services among Medicaid state plan services, Medicaid school-based health services, home- and community-based waiver services, and the capitated mental health care system. The Department oversees multiple pilot sites representing different geographic regions of the state.

The bill required that the pilot program will begin by March 1, 2016, and operate until March 1, 2019. By July 1, 2017, and every July 1 thereafter, the Department must conduct a cost analysis of 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. The

bill also establishes the Cross-System Response for Behavioral Health Crises Pilot Program Fund in the Department. The pilot program repeals on July 1, 2019.

(2) PROGRAM COSTS

ADULT COMPREHENSIVE SERVICES

Funding supports the HCBS-DD waiver, which provides services and supports to persons with intellectual and developmental disabilities, allowing them to continue to live in the community, yet within a 24-hour care model. Services provided under this waiver include day habilitation, prevocational, residential habilitation, supported employment, dental, vision, behavioral services, non-medical transportation, and specialized medical equipment and supplies.

ADULT SUPPORTED LIVING SERVICES

This line provides funding for the HCBS-SLS waiver and the State Supported Living Services option.

The HCBS-SLS waiver provides supported living in the home or community to persons with intellectual and developmental disabilities. Services include day habilitation, homemaker, personal care, respite, supported employment, dental, vision, assistive technology, behavioral services, home accessibility adaptation, mentorship, non-medical transportation, personal emergency response systems, professional therapeutic services, specialized medical equipment and supplies, and vehicle modification.

The State Supported Living Services option provides the same service array as the HCBS-SLS waiver, but is available to individuals who do not meet Medicaid eligibility requirements. State Supported Living Services are locally administered by the Community Centered Boards. Individuals receiving services must not need 24-hour program support. Services are funded with General Fund only.

CHILDREN’S EXTENSIVE SUPPORT SERVICES

The HCBS-CES waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's intellectual or developmental disability. Services include homemaker, respite, vision, adapted and therapeutic recreation equipment, assistive technology, community connector, home accessibility adaptation, professional therapeutic services, specialized medical equipment and supplies, vehicle modifications, and parent education.

CASE MANAGEMENT

This line funds 20 Community-Centered Boards (CCBs) to provide case-management, utilization review/quality assurance/supports intensity scale (UR/QA/SIS Case Management is provided for the three HCBS waivers, the State Supported Living Services delivery option, the State Supported Family Support Services Program, and the Family Support Loan Fund. Waiver services are delivered through community providers, including CCBs and two state-operated regional centers. Targeted Case Management is billed fee-for-service rates.

FAMILY SUPPORT SERVICES

The Family Support Services line provides financial support for families who have children, including adult children, with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The primary purpose of the Family Support Services Program is to keep families together in the family home. In order to qualify, a family must have an eligible child living at home or be interested in facilitating a child’s return to the home. Examples of services include medical and dental expenses, additional insurance expenses, respite care and childcare, special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services.

PREVENTIVE DENTAL HYGIENE

This line item supports outreach services to match individuals needing dental care with dentists willing to provide pro-bono dental care. Funding also goes to train clients receiving developmental disability services and staff about preventive dentistry and to educate both populations about how to access dental care.

ELIGIBILITY DETERMINATION AND WAITING LIST MANAGEMENT

This line provides reimbursement to Community-Centered Boards (CCBs) for administrative functions, including determination of intellectual and developmental disability and Pre-Admission Screening and Resident Reviews (PASRR) to clients throughout the State. Reimbursement for PASRR is only for Level II screenings, which ensures that individuals meet federal criteria for appropriateness of care delivered in a Nursing Facility, as well as determining if they need specialized services. In addition, CCBs are reimbursed for management of the waiting list for the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver.

(5) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department budget consists of the Colorado Indigent Care Program, the Primary Care Fund Program, the Children's Basic Health Plan, and other Safety Net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program is presented below.

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides funding to hospitals and clinics that have uncompensated costs from treating underinsured or low-income uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. For FY 2014-15, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; the Primary Care Fund Program; and, Pediatric Specialty Hospital. These line items allow providers to receive partial compensation for uncompensated costs due to services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, the Colorado Indigent Care Program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the program increased from 185% to 200% of the federal poverty level effective February 1, 2006 due to the expansion populations created under HB 05-1262. On July 1, 2006, the financial eligibility requirement was further increased to 250% of the federal poverty level per SB 06-044. The program contracts directly with hospitals and community health clinics to provide specific services to eligible individuals. By statute, providers are required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and, 3) any other medical care as financing allows. Providers are required to provide on-site eligibility and co-payment determinations. To determine eligibility, providers assign a rating to applicants based on their total income and assets. Nearly all clients are required to pay a minimal annual co-payment, which varies according to services received and client rating. For all client ratings except the N-rating (0-40% of the federal poverty level), annual co-payments cannot exceed 10% of the family's total income and equity in assets. The annual co-payment for clients with an N-rating cannot exceed $120.

The majority of the program is supported by two sources of federal financial participation: Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limit (UPL). Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for federal

matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and cash funds to draw down these federal funds, although the contribution of General Fund dollars to the state match is minimal relative to more innovative sources of state funds. Prior to FY 2009-10, the State utilized certification of public expenditures for all publicly-owned facilities (seen as cash funds in the budget) to draw down matching federal funds. Beginning in FY 2009-10, the use of certification has been replaced with fees assessed on hospital providers. Any provider who participates in the program is qualified to receive funding from the DSH Allotment and the Medicare UPL. See the “Safety-Net Provider Payments” line item for more detail about funding mechanisms.

As required by HB 04-1438, the Department must include in the annual Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. This information can be found in Exhibit K in the Department’s November 1, 2014 FY 2014-15 Budget Request.

SAFETY NET PROVIDER PAYMENTS

The Safety Net Provider Payments line item was added to the Indigent Care Program Long Bill group following the passage of SB 03-258, the FY 2003-04 Long Bill. The Department’s FY 2003-04 DI-6 “Change Methodology for Financing the Indigent Care Program and Disproportionate Share Hospital Through Proposed Safety Net Funding Allocation” submitted with the November 1, 2002 Budget Request requested the consolidation of the following line items into the new Safety Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could more easily be understood by Department staff, the General Assembly, and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved, providing increased overall payments to qualified providers.

Prior to FY 2009-10, the Safety Net Provider Payments line item was composed of four payments: Low-Income, Bad Debt, High-Volume, and Medicaid Shortfall. However, HB 09-1293 combined the Low-Income, Bad Debt, High Volume, and Medicaid Shortfall payments into two more broadly-based supplemental payments to CICP providers: the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment. A summary of the rules related to the reimbursement of Safety Net providers under these two payments is given in the following matrix.

Payment Type	Public Hospitals	Private Hospitals
CICP Disproportionate Share Hospital Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital federal funds limit imposed by federal law.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share of payments is from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share of payment is from Disproportionate Share Hospital federal funds.
CICP Supplemental Medicaid Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share is from the federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share is from the federal Medicaid matching rate for Colorado.

Under the distribution model, CICP hospital providers are reimbursed up to 100% of uncompensated costs associated with treating indigent clients funded in sum by two separate payment calculations (CICP Disproportionate Share Hospital Payment and CICP Supplemental Inpatient Hospital Medicaid Payment). Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital or Upper Payment Limit for inpatient hospital services funds. Both of these allocation types have limits that restrict the amount of federal match available.

Under the Disproportionate Share Hospital payments, the total federal amount made available is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type.

The Upper Payment Limit for inpatient hospital services is determined on a hospital-by-hospital basis and aggregated by hospital type: state-owned public hospitals, non-state owned public hospitals, and private-owned hospitals. Total inpatient hospital expenditures cannot exceed the available aggregated Upper Payment Limit by type. The CICP Supplemental Inpatient Hospital Medicaid Payment is funded by assessed provider fees and federal matching funds under the available Upper Payment Limit for inpatient hospital services.

CLINIC-BASED INDIGENT CARE

The Clinic Based-Indigent Care line item was created in FY 2002-03 utilizing the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment because the hospital is privately owned. Being privately owned, the certification of public expenditures for uncompensated Medicaid costs is not allowed. Instead, General Fund is required to draw down the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to participating clinics. The $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to participating clinics is based on a percentage of uncompensated indigent care costs relative to uncompensated costs reported by all recipients as reported in the Colorado Indigent Care Program Annual Report, increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005, to provide funding to the State's only pediatric specialty hospital, The Children's Hospital, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In FY 2004-05, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% should be appropriated to the General Fund.

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers serving indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other Department criteria. The fund was authorized under Section 24-22-117 (2)(b), C.R.S., and distributes funds generated from Amendment 35 (Tobacco Tax) to the providers based on the portion of medically indigent or uninsured patients they served relative to the total number of medically indigent or uninsured clients served by all qualified providers. To be a qualified provider, an entity must:

- Accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge;
- Serve a population that lacks adequate health care services;
- Provide cost-effective care;
- Provide comprehensive primary care for all ages;
- Screen and report eligibility for the Medical Assistance Program, Children's Basic Health Plan, and the Indigent Care Program; and,
- Be a federally qualified health center per Section 330 of the federal Public Health Services Act **or** have a patient base that is at least 50% uninsured, medically indigent, a participant in Children's Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 185% of the federal poverty level (FPL). The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. A dental benefit, offered in a capitated managed care environment, was added for children in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes under 185% FPL. To participate in the plan, families with incomes over 156% FPL (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. All State expenditures for benefits are matched currently with 88% Title XXI federal funds up to the federal allocation available. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund and the Healthcare Affordability and Sustainability Fee Fund. However, there is no federal financial participation on the annual enrollment fees collected from families. Based on a memorandum of understanding with the Centers for Medicare and Medicaid Services, Colorado's

administrative expenditures are matched at the normal 88% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures.

Until FY 2010-11, the Children's Basic Health Plan consisted of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in FY 2000-01, per Supplemental Bill SB 01-183, the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs. In the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental Costs.

In November 2004, the voters of Colorado approved Amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The legislation provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% FPL effective July 1, 2005. The legislation also provided funding for cost-effective marketing, which began April 1, 2006. Funding was also provided to remove the Medicaid asset test, which became effective July 1, 2006.

In 2007, the Colorado Legislature passed SB 07-097, which expanded eligibility in the Children's Basic Health Plan to children and pregnant women with family incomes up to 205% FPL. Eligibility in the Children's Basic Health Plan was further expanded to 225% of the FPL in 2008 with the passage of SB 08-160. This eligibility expansion was suspended in SB 09-211 due to budget constraints.

Governor Ritter signed HB 09-1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee to increase eligibility in Medicaid and the Children's Basic Health Plan, as well as increase hospital reimbursement. As part of the Act, eligibility in the Children's Basic Health Plan was increased to 250% FPL on May 1, 2010.[1]

During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility

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[1] The Hospital Provider Fee program was repealed effective July 1, 2017 and replaced with the Colorado Healthcare Affordability and Sustainability Enterprise in SB 17-267, "Sustainability of Rural Colorado". As such the contracts and programs administered through this line are now paid through the enterprise funding.

for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation (FFP) rate for their expenditures. Beginning October 1, 2015, the Department will receive an additional 23 percentage point FFP, which increases the match to 88.00%. The Department has received approval from the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients enrolled in the Children's Basic Health Plan. Auxiliary administrative functions are contracted out separately to various vendors for professional services such as actuarial analysis, claims audit, and quality assurance. The actuarial analysis is used to update capitation rates and project claims that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services collect Health Plan Employer Data and Information Set (HEDIS) quality data. Beginning in FY 2012-13, the Department also administers, analyzes, and reports results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as required by the Children's Health Insurance Program Reauthorization Act of 2009.

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

This line item was created during the Department's Supplemental Hearing on January 19, 2011, by the Joint Budget Committee (JBC) Staff as the combination of the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items. The costs of medical and dental services provided to eligible children and medical premiums for prenatal and delivery services for pregnant women enrolled in the Children's Basic Health Plan are funded through this line item beginning in FY 2010-11.

(6) OTHER MEDICAL SERVICES

The Other Medical Services section of the Department's budget contains funding for programs not administered by the Department through the Medicaid or Indigent Care programs. Some of the line items receive federal Medicaid funding but are administered by other departments, Commissions, or hospitals. This long bill group also contains funding for the Old Age Pension State Medical Program and the Medicare Modernization Act State Contribution Payment. A description of each program is presented below.

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical and dental care for non-Medicaid-eligible individuals receiving Old Age Pension grants. This program is 100% State-funded and is not a federal entitlement. Eligible recipients are over the age of 64 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the constitution and supplemental General Fund appropriations to ensure adequate funding.

The Old Age Pension program was established in 1936 by an amendment to the State constitution, creating Article XXIV. This article was amended in 1956 to add the Old Age Pension Health and Medical Care Program and Fund in Section 7. Old Age Pension benefits specified in Article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits.

Both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S., was transferred to the Department from the Department of Human Services, effective July 1, 2003. Beginning in FY 2003-04, this line item was placed in the "Other Medical Services" Long Bill group. The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The program is administered by the Advisory Commission on Family Medicine in the Department of Health Care Policy and Financing (Senate Bill 13-010). Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education, however, beginning in FY 1994-95, federal regulations allowed a federal financial participation rate of 50%. Since federal Medicaid funds were involved, a line item

appropriation to the Department was established. Also, effective July 1, 2013, a privately-owned hospital that receives Family Medicine Residency Training program payments is eligible to receive additional funds for the development and maintenance of family medicine residency training programs in rural areas.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of Denver Health and Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the legislation allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses Denver Health and Hospital Authority for Graduate Medical Education in two ways. First, fee-for-service payments to Denver Health and Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, Denver Health and Hospital Authority also receives lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Costs incurred by Denver Health and Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums line item. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority" line item.

STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of the University of Colorado Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the bill allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses the University of Colorado Hospital Authority for Graduate Medical Education in three ways. First, fee-for-service payments to University of Colorado Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, lump sum payments are also received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Third, the University of Colorado Hospital Authority receives funding for one of nine family medicine residency training programs administered by the Commission on Family Medicine, namely A.F. Williams Family Residency. Costs incurred by the University of Colorado Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums and Other Medical Services; University of Colorado Family Medicine Residency Training Programs line items. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority" line item.

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT

This line item is used to reimburse the federal government for what the federal government determines is the State's obligation of prescription drug costs for Medicaid clients who are also eligible for Medicare. On January 1, 2006, the Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit, replacing Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the obligation of states to cover prescription drugs for this population, the Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. This is known as the "clawback" payment. For calendar year 2006, states were to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passed, the 90% factor was reduced, or "phased down," by 1.67% each year, until it reached 75% in 2015, where it remains today and ongoing.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

This line item was created with the approval of the Department's S-9, BA-7 "Public School Health Services Administrative Claiming" during the FY 2010-11 budget cycle. The Public School Health Services Program uses Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers.

The line item contains all administrative funding for the program excluding the Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System (MMIS). Funding for this line consists of a transfer of spending authority from the "(6) Other Medical Services; Public School Health Services" line item. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

PUBLIC SCHOOL HEALTH SERVICES

The Public School Health Services program began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. The Department pays for claims processing, personnel, and contracting costs. The Department of Education provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. The costs incurred by the two departments for administration are deducted from the federal matching funds. Pursuant to 25.5-5-318 (8) (b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT TRAINING GRANT PROGRAM

Pursuant to Section 25.5-5-208, C.R.S., this program grants funding from the Marijuana Tax Cash Fund to organizations to train health professionals on providing services related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. Specifically, the funding is used for the following:

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

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department’s budget is for Medicaid funding for services provided or administered by the Department of Human Services (DHS). Programs include services for persons with developmental disabilities, high-risk (substance abuse) pregnant women, individuals with mental health needs, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. DHS also receives the Department’s share of the costs to support the Colorado Benefits Management System (CBMS) and other information technology support, as well as operations costs separately accounted for but related to the other groups of clients mentioned above. Medicaid funds for these programs are transferred from the Department to DHS as reappropriated funds. Although the funds are considered reappropriated from the perspective of DHS, the funding sources for these transfers from the Department are General Fund, federal funds, and cash funds.

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the DHS appropriations into 18 separate line items to improve expenditure tracking and reconciliation. A description of each of the line items currently within the Department’s budget follows.

All funding requests in this Long Bill group originate with DHS, and any inquiries related to the Department’s Budget Request should be directed to DHS. The Department of Health Care Policy and Financing is a financing agency for these appropriations, meaning that the Department must validate the DHS funding request is for a Medicaid-allowable purpose as outlined by the federal Centers for Medicare and Medicaid Services (CMS). This Department also performs general oversight of the Medicaid-funded programs to ensure adherence to federal regulations for use of the Medicaid funds.

(A) EXECUTIVE DIRECTOR’S OFFICE – MEDICAID FUNDING

The Executive Director’s Office is responsible for the general policy of the Department of Human Services (DHS) and contains staff and associated resources for implementing policy. This appropriation in the Department’s budget includes Medicaid funding for two sections in the DHS budget: General Administration and Special Purpose. Because the Executive Director’s Office includes a wide range of elements, the authorizations in the Colorado Revised Statutes are also varied. The main authorization is 24-1-120, C.R.S.

General Administration includes the DHS Executive Director and associated administrative staff, including the Department’s budget staff, the Public Information Officer, the Legislative Liaison, and the Division of Field Administration that includes the County Commissioner Liaison. These staff members are FTE at DHS, but several of them also perform services related to Medicaid, so part of their salaries and related expenses are reimbursed by the Department.

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING

This line item includes Medicaid funding for expenses associated with the DHS Information Systems but specifically excludes CBMS funding. The Office of Information Technology is responsible for developing and maintaining the major DHS centralized computer systems, including systems that link to all counties in the State. Not all of these systems support Medicaid functions, and, therefore, not all receive Medicaid funding. The Office supports centralized databases and provides support and training to users, including county staff and private social services providers. The Office of Information Technology Services also helps set policies and strategic directions for de-centralized information technology systems that are operated by individual divisions within DHS.

(C) DIVISION OF CHILD WELFARE – MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located under the Deputy Executive Director of the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for and protecting their children. Although the Administration line item was created as a separate line item in the budget for DHS in FY 2000-01, the separate line for the Department titled "(D) Division of Child Welfare: Administration" was added to the Department's budget in FY 2005-06. Prior to that fiscal year, both administration and services were in a blended appropriation titled "Division of Child Welfare – Medicaid Funding." The child welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of human/social services.

The Division of Child Welfare has two staff who are responsible for oversight of the county work to enroll the children in the Child Welfare system for Medicaid services and who administer the Children's Habilitation Residential Program (CHRP) waiver. The Medicaid funding in this administration line item pays for the staff salaries related to these workers that provide Medicaid-oversight work.

CHILD WELFARE SERVICES

The Child Welfare Services line item supports funding for counties to deliver Medicaid associated services for children and families. The line item provides Medicaid funding for the Children's Residential Habilitation Program (CHRP) Medicaid waiver; out-of-home placement in psychiatric residential treatment facilities; and therapeutic services for children in residential child care facilities.

(D) OFFICE OF EARLY CHILDHOOD – MEDICAID FUNDING

During the 2013 Legislative Session, the General Assembly passed HB 13-1117 "Concerning Alignment of Child Development Programs." The legislation was signed into law by the Governor on May 7, 2013. One result was the creation of the Office of Early Childhood at the Department of Human Services. The early childhood system in Colorado includes four system sectors that address the needs of children, including early learning, child health, child mental health, and family support and parent education. Research confirms that these areas, along with prenatal health, are interrelated and that it is difficult if not impossible to separates children's emotional, behavioral, and learning needs from their prenatal and child health and wellness or from the involvement and support of their families.

DIVISION OF COMMUNITY AND FAMILY SUPPORT, EARLY INTERVENTION SERVICES

Early Intervention Services Case Management previously existed at DHS under Services for People with Disabilities as Community Services for People with Developmental Disabilities. The case management of these services is aimed at families who have infants and toddlers through age two, with developmental disabilities or developmental delays that have been identified at a young age. Therefore, HB 13-1117 has repositioned this service under the Office of Early Childhood to improve the delivery of services to very young children.

(E) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees.

Previously, the Department's share of the funding for SAVE was included in the Department's Medical Services Premiums line item, and costs related to Medical Assistance Sites checking immigration status for clients presenting for medical care at those sites are still charged to Medical Services Premiums.

(F) BEHAVIORAL HEALTH SERVICES – MEDICAID FUNDING

COMMUNITY BEHAVIORAL HEALTH ADMINISTRATION

This line item funds the Medicaid portion of Personal Services and Operating Expenditures for oversight of the mental health services provided by the Department of Human Services (DHS). Colorado provides mental health care to a larger population than just Medicaid clients, but this line item is prorated from the total state expenditures for mental health care to represent only the Medicaid portion. There is no specific statutory reference for Mental Health Administration, but a reference may be inferred from 24-1-120, C.R.S.

Personal Services for the staff in this administrative line item include salaries and associated expenditures. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

MENTAL HEALTH TREATMENT SERVICES FOR YOUTH

HB 99-1116 created the Child Mental Health Treatment Act to improve the probability that children with significant mental health needs receive treatment. This legislation was passed to help mitigate parents' difficulty in navigating the various governmental systems including child welfare, mental health, law enforcement, juvenile justice, education, and youth corrections in seeking help for their children. Often these situations resulted from a court action of dependency and neglect that caused parents to give up custody of their children to the local departments of human/social services. The Child Mental Health Treatment Act set up a framework for getting mental health treatment for these children without resorting to the dependency and neglect action. However, during the evaluation process for admission to the residential treatment center, if it is determined that the child is a victim of child abuse, the case is referred to child welfare services.

HIGH-RISK PREGNANT WOMEN PROGRAM

This line item provides Medicaid funding for prenatal and postpartum substance abuse treatment services for women at risk of a poor birth outcome due to alcohol or substance abuse. The High-Risk Pregnant Women Program, also called "Special Connections," is a statewide voluntary alcohol and drug treatment program for pregnant women who are at risk of poor birth outcomes due to substance abuse-related disorders. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in DHS.

MENTAL HEALTH INSTITUTES

The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 in Denver, and the Colorado Mental Health Institute, established in 1879 in Pueblo. The institutes provide inpatient psychiatric hospital services to citizens of Colorado having a major illness such that the individual cannot be expected to function and/or be treated in the community. Both locked and unlocked treatment units are provided, with a wide variety of assessment and treatment services offered to patients. Services have included: individual, group, and family therapy; treatment goal-setting; work therapy; community-readiness skills; medication and health education; education programs; pastoral services; substance abuse education and treatment; and, discharge and aftercare planning. The Fort Logan location does not have an inpatient treatment program for substance abuse.

Funding for the institutes comes from a variety of sources such as disability payments, Medicare, Medicaid, third-party insurers or insurance companies, counties, school districts, and other State Departments (such as the Department of Corrections or the Department of Education). These institutes also transfer a portion of their revenues to other offices in DHS that provide support for operations of the institutes. Such supporting operations include facilities management and accounting functions in the Office of Operations and computer functions in the Office of Information Technology. The Department pays for the services provided to Medicaid clients at the institutes as well as the Medicaid portion of the functions in the Office of Operations and Office of Information Technology that relate to Medicaid services at the institutes.

(G) SERVICES FOR PEOPLE WITH DISABILITIES – MEDICAID FUNDING

REGIONAL CENTERS

The State operates three regional centers that provide direct support for adults with developmental disabilities. These are individuals who have significant needs and for whom adequate services and support are not available in the Community-Centered Board (CCB) system to safely meet their needs. The regional centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional centers serve adults in community group homes that provide services for between four and eight people. The majority of regional center beds are operated under the same comprehensive Home- and Community-Based waiver program that supports most community-based residential services. The regional center campuses also house Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID).

The Department provides funding for Personal Services, Operating Expenses, capital outlay for patient needs, leased space, residential incentive allowance, and the purchase of services. Funding has recently been allocated through the budget process to address staffing, wait-lists, and Medicaid waiver changes.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with regional centers of the Department of Human Services (DHS). The line item was added through the FY 2003-04 Supplemental Bill (HB 04-1320) to reflect historic department practice.

(H) ADULT ASSISTANCE PROGRAMS, COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING

This line item was created to support funding of the State Ombudsman program of the Department of Human Services (DHS), which manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. This program provides liaison services between DHS and its clients who are being served by the Division of Aging and Adult Services. The programs provided for the elderly are administered through the county departments of human/social services or through regional Area Agencies on Aging. This program also provides statewide advocacy for residents in long-term care facilities. The advocate can investigate complaints made by or on behalf of residents in the long-term care facilities.

The types of services provided under this program include a nutrition program, a caregiver program, a senior employment program, the long-term care ombudsman program mentioned above, and other supportive services. Because Medicaid pays for services in long-term care facilities to clients who are categorically eligible for Medicaid, the possibility exists that clients in those facilities may need someone to intervene on their behalf when the need arises. Therefore, Medicaid pays a small contribution to the overall costs of the State Ombudsman Program.

(I) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

The Division of Youth Corrections is under the direction of the Deputy Executive Director for Children, Youth, and Families at the Department of Human Services (DHS). The Division of Youth Corrections provides management and oversight to state-operated and private-contract residential facilities, as well as community-based alternative programs, that serve youth between 10 and 20 years of age who: have demonstrated delinquent behavior; are detained while awaiting adjudication; or are committed to the Division of Youth Corrections after adjudication. Facilities for youth offenders include intensive secure units, medium care units, staff secure units, and non-secure community residential programs. Only residents in non-secure, community residential programs would qualify for Medicaid. Other youth in secured, locked facilities have their medical care paid entirely through State General Fund.

The Division is currently organized into Administration, Institutional Programs, and Community Programs; Medicaid funding is provided only within the Community Programs section. Within the Community Programs section, the Medicaid funding covers a portion of Personal Services (includes POTS and indirect costs), a portion of Purchase of Contract Placements (mental health services), and a portion for a Managed Care Pilot Project.

(J) OTHER

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS

This line item was created in the FY 2009-10 Long Bill (SB 09-259). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, including common costs, overhead costs, or joint costs.

DEPARTMENT OF HUMAN SERVICES INDIRECT COST ASSESSMENT

This line item was created in the FY 2017-18 Long Bill (SB 17-254). The line item funds the Medicaid share of costs for various Indirect Cost Assessment lines for CDHS departmental or statewide overhead costs associated with the operation of general government functions.

II. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2017 that affects Department policies and procedures.

HB 17-1045 (Young, Lambert) Extend Home Care Allowance Grant Program

The bill modifies the repeal date of the home care allowance grant program. The program will repeal when the reviser of statutes receives notice that there is a consumer-directed service delivery option available for homemaker, personal care, and medical support services for individuals who are receiving home-based and community-based services pursuant to the supported living services waiver. The bill requires the Executive Director of the Department of Human Services and the Executive Director of the Department to notify the reviser of statutes when the triggering event occurs.

HB 17-1060 (Thurlow, Tate) Reporting Requirements by Health Care Policy & Financing To General Assembly

The bill repeals, adds an exemption to section 24-1-136 C.R.S, or puts expiration dates in statute for the following reports: Children's Access to Health Care Report, Medical Assistance Client Fraud Report, Medical Homes for Children Report, All Payers Claims Database Report, School-based Substance Abuse and Intervention Program Report, Colorado Indigent Care Report, Senior Dental Program Report, Medicaid Management Information System Roll-forward Report, Medicaid Provider Rate Review Committee Report, Strategic Plan to Eliminate the Waitlist for IDD Waivers Report.

HB 17-1078 (Landgraf, Coram) Transfer Funds from the Family Support Loan Program

The bill repeals the Colorado Family Support Loan Fund and transfers any money remaining in that fund to a new fund created in the family support services program. The new Family Support Services Fund may be used for expenses relating to the termination and wrap up of the Colorado Family Support Loan Fund, and to provide services under the family support services program to support families caring for a family member with intellectual and developmental disabilities.

HB 17-1126 (Danielson, Michaleson Jenet, Crowder) Medicaid Appeal Review Legal Notice Requirements

The bill requires the administrative law judge hearing Medicaid appeals to review the legal sufficiency of the notice of action from which the recipient is appealing at the commencement of the appeal hearing if the notice of action concerns the termination or reduction of an existing benefit. If the notice is legally insufficient, the judge shall advise the appellant that he or she may waive the defense of insufficient notice and proceed to a hearing on the merits or may ask the judge to decide the appeal based on the judge's finding of

insufficiency. The judge shall advise the appellant that a legally sufficient notice may be issued in the future and that the state may recoup benefits from the appellant. The provisions of the bill apply to hearings conducted on and after a certain date.

HB 17-1139 (Michaelson Jenet, Landgraf, Martinez-Humenik, Kefalas) Medicaid Provider Compliance Billing Safety Rules

The bill subjects a provider of Medicaid services to a civil monetary penalty if the provider improperly bills or seeks collection from a Medicaid recipient or the estate of a Medicaid recipient. The provider is also liable for a refund to the recipient of any amount unlawfully received from the recipient, including statutory interest, and for all amounts submitted to a collection agency in the name of the recipient. If, within 30 days, a provider voids the bill, returns any amounts unlawfully received, and makes every effort to resolve the collection action for the recipient, the provider is not subject to the penalties outlined in the bill. A provider is not subject to the penalties outlined in the bill if a person knowingly misrepresents his or her Medicaid coverage status to the provider and the provider submits documentation relating to the misrepresentation. A provider may appeal the imposition of a civil monetary penalty. In addition, the bill allows the Department to require a corrective action plan from any provider who fails to comply with rules, manuals, or bulletins issued by the department, the medical services board, or the Department's fiscal agent or from a provider whose activities endanger the health, safety, or welfare of a Medicaid recipient.

HB 17-1143 (Landgraf, Crowder) Audits of Medicaid Client Correspondence

The bill directs the Office of the State Auditor to conduct or cause to be conducted an audit of client correspondence, including letters and notices, sent to clients or potential clients in Medicaid programs. The audits will be conducted in 2020 and 2023 and thereafter at the discretion of the State Auditor.

HB 17-1280 (Michaelson Jenet, Young, Gardner) Disability Trusts 21st Century Cures Act Language

The bill conforms Colorado statutory language relating to the creation of a disability trust to the language established in the federal '21st Century Cures Act'. Specifically, it clarifies that the individual who is the beneficiary of a disability trust can also be the person who establishes such trust.

HB 17-1343 (Young, Moreno) Implement Conflict-free Case Management

The bill implements conflict-free case management for persons with intellectual and developmental disabilities who are enrolled in home- and community-based services under Colorado's Medicaid program. The bill contains time frames for the implementation of conflict-free case management in Colorado. Initially, the Department shall determine the options for community-centered boards to

become compliant with conflict-free case management when serving persons with intellectual and developmental disabilities who are enrolled in home- and community-based services. Conflicted community-centered boards are required to develop a business continuity plan to transition to providing either case management services or services and supports to these persons. The bill includes a date by which all persons receiving home- and community-based services will be served through a system of conflict-free case management.

HB 17-1351 (Pettersen, Rankin, Jahn & Crowder) Study Inpatient Substance Use Disorder Treatment

The bill requires the Department, with assistance from the Department of Human Services' Office of Behavioral Health, to prepare a written report for committees of the General Assembly relating to residential and inpatient substance use disorder treatment options under the Medicaid program, the cost of treatment, and the potential impact on other state and county programs and services if residential and inpatient substance use disorder treatment options were effective. The Departments' report shall also include recommendations relating to the implementation of residential and inpatient substance use disorder treatment, better coordination of substance use disorder services among state agencies, and necessary changes to state law to implement treatment.

HB 17-1353 (Young, Lundberg) Implement Medicaid Delivery & Payment Initiatives

The bill authorizes the Department to continue its implementation of the Medicaid care delivery system, referred to as the Accountable Care Collaborative (ACC). The bill defines the goals of the ACC and the Department's implementation of the ACC, including, in part, establishing primary care medical homes for Medicaid clients, providing regional coordination and accountability, and integrating physical and behavioral health care delivery. The Medical Services Board is required to promulgate rules implementing the ACC. The bill authorizes the Department to implement performance-based payments for Medicaid providers and creates related reporting requirements.

SB 17-011 (Lambert, Lawrence) Study Transportation for People with Disabilities

The bill creates a technical demonstration forum of eight members to study and document how advanced technologies can improve transportation access for people with disabilities. The executive director of the Department shall serve as vice-chair of the forum.

SB 17-091 (Moreno, Crowder, Ginal) Allow Medicaid Home Health Services in the Community

Under current law, for some clients, home health services under the Medicaid program may only be provided in the client's residence. The bill removes the location restriction for home health services to comply with changes to federal Medicaid rules that allow for services to be delivered in the community as well as the residence.

SB 17-121 (Crowder, Lundberg, Danielson, Landgraf) Improve Medicaid Client Correspondence

The bill requires the Department to engage in an ongoing process to improve Medicaid client letters and notices that concern eligibility for or the denial, reduction, suspension, or termination of a benefit. The bill adds requirements for notices significantly revised or created after January 1, 2018. If sufficient state and federal appropriations are available, on and after July 1, 2018, the Department shall make available electronically a client's information concerning household composition, assets, and income sources and amounts, if relevant to the determination for which the client correspondence was issued. The Department shall provide information concerning Medicaid client communications improvements as part of its annual presentation to its legislative committee of reference.

SB 17-267 (Sonnenberg, Guzman, Becker J., Becker K.) Sustainability of Rural Colorado

The bill places several requirements on the Department. It requires executive branch agencies to submit FY 2018-19 budget requests to OSPB that include requests that would lower the agencies FY 2017-18 budget by two percent. It also creates the Colorado Healthcare Affordability and Sustainability Enterprise (enterprise) as a type 2 agency and government-owned business within HCPF for the purpose of participating in the implementation and administration of a Colorado healthcare affordability and sustainability program on and after July 1, 2017, and creates a board consisting of 13 members. The bill requires the Department to implement delivery reform incentive payments program (DSRIP) no earlier than October 1, 2019 and within 120 days of the enactment of the federal "Advancing Care of Exception Kids Act" to seek any federal waiver necessary to fund, in cooperation with hospitals that meet the specified requirements, the implementation of an enhanced pediatric health home for children with complex medical conditions.

SB 17-295 (Lundberg, Young) Revise Medicaid Fraud Reporting

The bill updates the Department's annual reporting on efforts to detect and prosecute Medicaid client fraud and the Attorney General's annual reporting on Medicaid provider fraud. The bill requires the Department to annually submit a single, comprehensive report on client and provider fraud in the Medicaid program, including information received annually from the Attorney General. The bill adds the Joint Budget Committee to the legislative committees receiving the report and requires that the report include additional cost and savings information.