Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

S09- Provider Enrollment Fee Collection and Costs
BA09- Provider Enrollment Fee Collection and Costs

Dept. Approval By: Josh Block 1/4/16

OSPB Approval By: 1/4/16

X	Supplemental FY 2015-16
	Change Request FY 2016-17
	Base Reduction FY 2016-17
X	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request Amount	FY 2016-17 Base Request	FY 2016-17 Budget Amendment	FY 2017-18 Continuation Amount
Total of All Line Items Impacted by Change Request	Total	$32,784,833	$1,180,463	$34,937,013	$119,280	$121,943
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,823,649	$0	$7,198,178	$0	$0
	CF	$1,919,380	$1,180,463	$2,089,729	$119,280	$121,943
	RF	$293,350	$0	$293,350	$0	$0
	FF	$23,748,454	$0	$25,355,756	$0	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request Amount	FY 2016-17 Base Request	FY 2016-17 Budget Amendment	FY 2017-18 Continuation Amount
01. Executive Director's Office - MMIS Maintenance and Projects	Total	$32,784,833	$1,180,463	$34,937,013	$119,280	$121,943
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,823,649	$0	$7,198,178	$0	$0
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Letternote Text Revision Required? Yes ____ No X **If Yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and CORE Fund Number: FF: Title XIX (1000), CF: Provider Enrollment Fees (NEW FUND)

Reappropriated Funds Source, by Department and Line Item Name:
N/A

Approval by OIT? Yes ____ No ____ **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests $1,180,463 cash funds for FY 2015-16, $119,280 cash funds for FY 2016-17, and $121,943 cash funds for FY 2017-18 for the screening costs associated with provider enrollment into the Medicaid program funded by revenue collected from provider enrollment application fees.

Current Program

- Each provider of Medicaid services must enroll with the state to be certified. Providers are divided into three risk categories; Limited, Moderate, and High risk.
- Screening requirements for limited risk providers include license verification, National Provider Identifier (NPI) verification, Office of Inspector General exclusion check, and information verification on the owners/controlling interests of the provider. Moderate risk providers require site visits in addition to the above mentioned procedures. High risk providers require the screening measures explained above, as well as a full criminal background check for all individuals with ownership in the provider of five percent (5%) or more.

Problem or Opportunity

- Pursuant to federal regulations under 42 CFR § 455.460, the provider enrollment application fee must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government, however, the revenue is not currently included in the Department's budget.
- This revenue is non-exempt Taxpayer Bill of Rights (TABOR) state revenue.

Consequences of Problem

- Underutilizing funds from the provider enrollment application fees collected prevents the Department from fully complying with federal regulation. Improperly using the fee may result in federal disallowance of funding related to screening costs, as well as an under-calculation of TABOR revenue.

Proposed Solution

- The Department requests the creation of the Medicaid Provider Enrollment Fee Cash Fund.
- The Department would utilize the Medicaid Provider Enrollment Fee Cash Fund to fund provider screening costs, with any remaining funds being remitted to the Center for Medicaid and Medicare Services (CMS), as per federal regulation.

Department Priority: ***S-9, BA-9***
Request Detail: ***Provider Enrollment Fee Collection***

Summary of Incremental Funding Change for FY 2015-16	**Total Funds**	**Cash Funds**
Provider Enrollment Fee Collection and Costs	$1,180,463	$1,180,463

Summary of Incremental Funding Change for FY 2016-17	**Total Funds**	**Cash Funds**
Provider Enrollment Fee Collection and Costs	$119,280	$119,280

Summary of Incremental Funding Change for FY 2017-18	**Total Funds**	**Cash Funds**
Provider Enrollment Fee Collection and Costs	$121,943	$121,943

Problem or Opportunity:

Federal regulations at 42 CFR § 455.460 mandate that an enrollment fee be collected for institutional providers enrolling in the Medicaid program who are not already enrolled in Medicare, or Medicaid or Children's Health Insurance Programs in other states; however, the revenue from the provider enrollment fees is not accounted for in the State's budget. Pursuant to the federal regulation, the Department must use the revenue from the provider enrollment fees collected to pay for screening costs associated with provider enrollment to the extent moneys are available. Federal Medicaid funds cannot be used to pay for the screening costs unless costs exceed the revenue collected from the fees. If the amount of the provider enrollment fees collected by the Department exceeds the cost of the screening program, the excess amount must be remitted to federal government. The revenue that is being collected is non-exempt Taxpayer Bill of Rights (TABOR) revenue.

The federal regulation at 42 CFR § 455.414 requires states, beginning March 25, 2011, to complete revalidation of enrollment for all providers, regardless of provider type, at least every five years. States are required to complete the revalidation process of all provider types by March 24, 2016. The Centers for Medicare and Medicaid Services (CMS) allowed the Department to postpone implementation of this requirement because the Department was procuring a new Medicaid Management Information System

(MMIS) to avoid costly system changes in both the new and current MMIS. The Department implemented the new provider enrollment functionality in September 2015, and has since began collection of fees from providers. Providers who are enrolled in Medicaid as of July 1, 2015, must re-validate before March 24, 2016, and at least every five years thereafter. States are not required to rescreen these same providers so long as the providers have been screened by Medicare or another state's Medicaid program or CHIP. No application fee is required for providers that the Department is not required to rescreen.

Federal regulations at 42 CFR §§ 455.410 and 455.450 require that providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment. Each provider is given a categorical risk level of limited, moderate, or high. The risk level is based on the calculated risk of fraud, waste, and abuse of the provider and provider type. Each of the risk types require the following screening procedures:

- Limited risk providers require license verification, National Provider Identifier (NPI) verification, Office of Inspector General exclusion check, and information verification on the owners/controlling interests of the provider.
- Moderate risk providers require a site visit pre- and post-validation in addition to the above mentioned procedures. These site visits are unannounced in order to ensure that the providers are not committing fraud, waste, or abuse. The site visits will be performed by the interChange vendor.
- High risk providers require the screening measures explained above, including the site visits, as well as fingerprinting and a criminal background check for all individuals with ownership in the provider of 5% or more.

If these procedures are not followed, including proper accounting of fees collected and utilization of the revenue from the provider enrollment fees collected for screening costs, the Department is at risk of disallowance from CMS. If a provider is improperly enrolled in Medicaid, CMS may disallow federal funds for expenditures made to that provider.

The Department has submitted a request to CMS for a hardship exception providing justification to waive the fee for all institutional providers, but that request has not yet been approved or denied. Of the 64 counties in Colorado, 53 are designated at a shortage or as an underserved area. The Department is concerned that the application fee may adversely impact beneficiary access as the cost of the fee may deter providers from applying to become or continue as a Medicaid provider, which could further decrease access to services in these underserved areas.

Proposed Solution:

The Department requests $1,180,463 cash funds for FY 2015-16, $119,280 cash funds for FY 2016-17, and $121,943 for FY 2017-18 for the screening costs associated with provider enrollment into the Medicaid program. In addition, the Department requests for the Joint Budget Committee to sponsor legislation for the creation of a new cash fund with the recommended title of "Medicaid Provider Enrollment Fee Cash Fund" to accurately account for the new provider enrollment fee revenue and expenditure.

Additionally, the Department requests that any interest and income derived from investments and deposit of moneys in the fund be credited to the fund, and that the enabling statute prohibit transfers out of the fund for other State purposes. Federal regulation at 42 § CFR 455.460 requires that revenue collected from fees be used to pay screening costs. The moneys from the cash fund would solely be used to cover the Department's screening costs, except that unspent revenue from fee collections must be remitted to the federal government. All moneys from fee collection in the cash fund must only be used for purposes of intended use of the funds.

Finally, the Department requests to apply the "(I)" notation to appropriation of these cash funds to the line item to designate the inclusion of these funds in the line item as informational only due to the federal restrictions for the collection and use of these funds. Federal regulation requires use of the cash funds to pay for provider screening costs to the extent the cash funds are available, thus there is no limit on the expenditure of such moneys except as limited by the ability to collect fees.

Because this is a new program and because the request to waive the application fee is still pending approval, the Department is not presently requesting a reduction of General Fund. Although the cash funds from the provider enrollment fees will be used to offset currently appropriated costs, there is not enough information to predict how much expenditure will be offset in the current year with precision. If the General Fund appropriation is reduced, the Department would risk being underappropriated in the current year, and unable to fulfill its contractual obligations to its vendors. Although this may lead to an overappropriation in the current year, the Department notes that any excess funding will be rolled forward,[1] and the Joint Budget Committee can use any excess funding from the roll-forward to offset future year obligations, once more information has been obtained about actual fees paid.

Anticipated Outcomes:

The Department is meeting its performance goals by ensuring that the Department complies with federal regulation and thus reduces the risk of disallowance. The Department's customer strategy focuses on improving health outcomes and member experience while reducing the growth rate of costs. The Department is meeting this goal with this request by attributing provider screening cost to federally mandated fee collections, rather than General Fund. Additionally, the Department is maintaining current standards of providers, reducing the amount of fraud, waste, and abuse within the Medicaid program through the screening of providers. Creating the Medicaid Provider Enrollment Fee Cash Fund and using the fee to cover all screening costs associated with providers enrolling in the Medicaid program would allow the Department to comply with federal law enacted in 2011. Creating this cash fund would also provide a clear accounting of the revenue for TABOR reporting purposes and for ease of reporting collections and expenditures for federal reporting purposes. Collection and utilization of this fee as federally prescribed avoids repercussions from the federal government for non-compliance.

Assumptions and Calculations:

Detailed calculations for this request are included on the attached appendix.

[1] Pursuant to section 25.5-4-211(1), C.R.S.

Tables 1.1-1.3 row B, provide the incremental requests for FY 2015-16, FY 2016-17 and FY 2017-18. The Department requests the funding to be included in the Medicaid Management Information System Maintenance and Projects line item.

The actual and projected enrollment application fee per provider by calendar year (CY) are provided in table 3 of the appendix. The methodology for determining the enrollment application fee per provider is established in 42 CFR § 424.514(d) which prescribes that the fee will be adjusted each calendar year by the percentage change in the consumer price index (CPI). CPI forecasts are obtained from the Bureau of Labor Statistics.

Table 2 is a summary of the revenue from the provider enrollment fee projections. The Department identified the number of in-state only institutional providers shown in table 2 row A for the calculations of the revenue from fee collection because federal regulations at 42 CFR § 455.460 require that only one application fee be collected for a Medicaid enrolling provider. Consequently, if providers are enrolled in another state's Medicaid program preceding application as a Colorado provider, it is presumed that the other state would have collected the application fee and conducted the required screening. Given the complexities of determining whether a provider should be assessed a fee, the Department does not have sufficient information to further delineate the number of providers that will be required to pay the enrollment fee. Some providers would not be required to pay the fee because they are already enrolled as Medicare providers, or Medicaid or CHIP providers in another state, but that information is not readily available to the Department. Therefore, Department has projected revenue collection for FY 2015-16 based on the maximum number of providers that could be impacted. The Department will request adjustments to funding in this line as needed once the Department has sufficient information and data upon which to accurately make revenue and expenditures projections.

The Department anticipates that there will be minimum enrollment in FY 2016-17 and FY 2017-18. Primarily only new providers will be enrolling during those fiscal years, since provider revalidation for all current providers must be complete in FY 2015-16. Subsequent revalidation is required at least every five years, therefore, the Department is expecting another mass re-enrollment in FY 2020-21. By then the Department should have sufficient information to make accurate projections for an FY 2020-21 budget request to account for the anticipated increased revenue collection and screening costs.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

Collection of the provider enrollment application fee is a federal mandate that is unaccounted for in the Department's budget. The Department received new data in that it was notified by CMS that re-validation and re-enrollment of Medicaid provider is required in FY 2015-16 by March 24, 2016 which was earlier than anticipated given the Department's request for a waiver and the ongoing implementation of the new MMIS system. Therefore, the Department has determined that required fee collection will have a substantive impact including TABOR revenue implications and increases in provider screening expenditures in FY 2015-16 and ongoing.

Table 1.1 FY 2015-16 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$32,759,633	$6,817,349	$1,919,380	$293,350	$23,729,554	FY 2015-16 Long Bill (SB 15-234)
B	**Incremental Request**	**$1,180,463**	**$0**	**$1,180,463**	**$0**	**$0**	**Table 2 Row C**
C	FY 2015-16 Total	$33,940,096	$6,817,349	$3,099,843	$293,350	$23,729,554	Row A + Row B

Table 1.2 FY 2016-17 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$34,937,013	$7,198,178	$2,089,729	$293,350	$25,355,756	November 2, 2015 FY 2016-17 Request
B	**Incremental Request**	**$119,280**	**$0**	**$119,280**	**$0**	**$0**	**Table 2 Row C**
C	FY 2016-17 Total	$35,056,293	$7,198,178	$2,209,009	$293,350	$25,355,756	Row A + Row B

Table 1.3 FY 2017-18 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$34,937,013	$7,198,178	$2,089,729	$293,350	$25,355,756	November 2, 2015 FY 2016-17 Request
B	**Incremental Request**	**$121,943**	**$0**	**$121,943**	**$0**	**$0**	**Table 2 Row C**
C	FY 2017-18 Total	$35,058,956	$7,198,178	$2,211,672	$293,350	$25,355,756	Row A + Row B

Table 2: Provider Enrollment Fee Revenue Estimate					
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**Source**
A	Maximum Number of Providers Required to Pay the Enrollment Fee	2,133	213	213	Total number of In-state Institutional Providers
B	Projected Average Monthly Providers Required to Pay the Fee	305	18	18	FY 2015-16: Row A divided by 7 months of enrollment from September 2015 thru March 2016; FY 2016-7 and FY 2017-18: Row A divided by 12 months of enrollment.
C	CY 2015 Fee	$553	N/A	N/A	Table 3 Row F
D	Number of Months of Fee Collection	4	N/A	N/A	Includes calendar year 2015 months from the implementation starting in September 2015 through December 2015.
E	**Estimated CY 2015 Fee Collection**	**$674,028**	**N/A**	**N/A**	**Row B * Row C * Row D**
F	CY 2016 Fee	$554	$554	N/A	Table 3 Row G
G	Number of Months of Fee Collection	3	6	N/A	FY 2015-16 includes January thru March 2016; FY 2016-17 include July 2016 through December 2016.
H	**Estimated CY 2016 Fee Collection**	**$506,435**	**$59,001**	**N/A**	**Row B * Row F * Row G**
I	Projected CY 2017 Fee	N/A	$566	$566	Table 3 Row H
J	Number of Months of Fee Collection	N/A	6	6	FY 2016-17 includes January through June 2017; FY 2017-18 includes July through December 2017.
K	**Estimated CY 2017 Fee Collection**	**N/A**	**$60,279**	**$60,279**	**Row B * Row I * Row J**
L	Projected CY 2018 Fee	N/A	N/A	$579	Table 3 Row I
M	Number of Months of Fee Collection	N/A	N/A	6	FY 2017-18 includes January 2018 through June 2018.
N	**Estimated CY 2017 Fee Collection**	**N/A**	**N/A**	**$61,664**	**Row B * Row L * Row M**
O	**Total Projected Revenue Collection by Fiscal Year**	**$1,180,463**	**$119,280**	**$121,943**	**Sum of Row E, H, K, and N**

Table 3: Provider Enrollment Fee Projections				
Row	**Calendar Year**	**Fee Amount**	**Consumer Price Index Percentage Increase**	**Source**
A	2010	$500	1.00%	The provider enrollment fee is federally mandated under 42 CFR 424.514 (d) (2). The fee for CY 2010 was $500. Each subsequent calendar year fee amount is adjusted by the percentage change in the Consumer Price Index (CPI). CPI forecasts are obtained from the Bureau of Labor Statistics.
B	2011	$505	3.54%	
C	2012	$523	1.66%	
D	2013	$532	1.80%	
E	2014	$542	2.10%	
F	2015	$553	0.20%	
G	2016	$554	2.20%	
H	2017	$566	2.30%	
I	2018	$579		

Table 1.1 FY 2015-16 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$32,759,633	$6,817,349	$1,919,380	$293,350	$23,729,554	FY 2015-16 Long Bill (SB 15-234)
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C	FY 2015-16 Total	$33,940,096	$6,817,349	$3,099,843	$293,350	$23,729,554	Row A + Row B

Table 1.2 FY 2016-17 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$34,937,013	$7,198,178	$2,089,729	$293,350	$25,355,756	November 2, 2015 FY 2016-17 Request
B	**Incremental Request**	**$119,280**	**$0**	**$119,280**	**$0**	**$0**	**Table 2 Row C**
C	FY 2016-17 Total	$35,056,293	$7,198,178	$2,209,009	$293,350	$25,355,756	Row A + Row B

Table 1.3 FY 2017-18 Summary of Incremental Change							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
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B	**Incremental Request**	**$121,943**	**$0**	**$121,943**	**$0**	**$0**	**Table 2 Row C**
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K	**Estimated CY 2017 Fee Collection**	**N/A**	**$60,279**	**$60,279**	**Row B * Row I * Row J**
L	Projected CY 2018 Fee	N/A	N/A	$579	Table 3 Row I
M	Number of Months of Fee Collection	N/A	N/A	6	FY 2017-18 includes January 2018 through June 2018.
N	**Estimated CY 2017 Fee Collection**	**N/A**	**N/A**	**$61,664**	**Row B * Row L * Row M**
O	**Total Projected Revenue Collection by Fiscal Year**	**$1,180,463**	**$119,280**	**$121,943**	**Sum of Row E, H, K, and N**

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