

**Schedule 13**

**Funding Request for the FY 2015-16 Budget Cycle**

**Department of Health Care Policy and Financing**

PB Request Number SBA-10

**Request Titles**

S-10 Provider Fee Analytics  
BA-10 Provider Fee Analytics

Dept. Approval By:	Josh Block		<input type="checkbox"/>	Supplemental FY 2014-15
			<input type="checkbox"/>	Change Request FY 2015-16
			<input type="checkbox"/>	Base Reduction FY 2015-16
OSPB Approval By:			<input checked="" type="checkbox"/>	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Supplemental Request	Base Request	Governor's Revised Request	Budget Amendment
	<b>Total</b>	<b>\$6,151,808</b>	<b>\$1,000,000</b>	<b>\$5,481,508</b>	<b>\$1,000,000</b>	<b>\$1,000,000</b>
	FTE	-	-	-	-	-
Total of All Line Items	GF	\$2,225,315	\$0	\$1,918,265	\$0	\$0
	CF	\$727,500	\$500,000	\$727,500	\$500,000	\$500,000
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$3,198,993	\$500,000	\$2,835,743	\$500,000	\$500,000

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Supplemental Request	Base Request	Governor's Revised Request	Budget Amendment
	<b>Total</b>	<b>\$6,151,808</b>	<b>\$1,000,000</b>	<b>\$5,481,508</b>	<b>\$1,000,000</b>	<b>\$1,000,000</b>
	CF	\$727,500	\$500,000	\$727,500	\$500,000	\$500,000
01. Executive Director's Office - General Professional Services and Special Projects	FF	\$3,198,993	\$500,000	\$2,835,743	\$500,000	\$500,000
	GF	\$2,225,315	\$0	\$1,918,265	\$0	\$0

Letternote Text Revision Required?      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Cash or Federal Fund Name and CORE Fund Number: CF: Hosptial Provider Fee (24A0) FF: Title XIX Reappropriated Funds Source, by Department and Line Item Name: N/A Approval by OIT?                              Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required: <input checked="" type="checkbox"/> Schedule 13s from Affected Departments: N/A Other Information: N/A	<b>If Yes, describe the Letternote Text Revision:</b> Cash funds are from the Hospital Provider Fee.
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#### ***Cost and FTE***

- Beginning in FY 2014-15, the Department requests \$1,000,000 total funds, \$500,000 cash funds to fund research, audits, and external consulting necessary for the proper management of the Medicaid expansion population and other Hospital Provider Fee funded populations. This includes the completion of a post implementation review of the Modified Adjusted Gross Income conversion (MAGI).

#### ***Current Program***

- Several Medicaid populations in Colorado (MAGI Adults, MAGI Parents above 60% FPL, and the Disabled Buy-in Program), a hospital supplemental payment program, and administration related to supporting the populations and supplemental payment program are funded with the Hospital Provider Fee, which was created by the Colorado Health Care Affordability Act, HB 09-1293. FY 2015-16 expenditure for these populations, administration, and supplemental payments is estimated to be over \$2.8 billion total funds, including over \$640 million in cash funds.

#### ***Problem or Opportunity***

- The Hospital Provider Fee program is a multibillion dollar program that is both relatively new and has endured many changes with Medicaid expansion. The Department has needs for analysis and research critical to the proper management of the provider fee program, but has no existing funding source for these activities. Complex analysis necessary for maintaining compliance with state and federal statute is often delayed because the Department does not have the ability to respond quickly to these needs.
- Federal scrutiny of the Department has significantly increased since the implementation of the Hospital Provider Fee model and the Affordable Care Act.
- The Department anticipates that this increase in scrutiny is a permanent change from the federal government.

#### ***Consequences of Problem***

- Failure to provide funding and resources for projects, research, and audits means the Department is unable to quickly respond to areas of concern. Without the right resources to properly calculate payments and perform post-payment reviews, the Department is at a significant risk of having federal funds disallowed, which would result in increased costs to the State. Providers are also at risk of having to payback funding if federal funding is retrospectively determined to be unavailable.

#### ***Proposed Solution***

- The Department requests \$1,000,000 total funds, \$500,000 cash funds to research, audit, and hire external consulting as needed for proper management of the Medicaid expansion population. This funding source would make timely responses and quick turnaround for research projects possible. Post implementation review of major systems and eligibility changes is critical to ensure that Medicaid services are being funded appropriately.



**COLORADO**  
Department of Health Care  
Policy & Financing

FY 2014-15 and FY 2015-16 Funding Request | January 2, 2015

John W. Hickenlooper  
Governor

Susan E. Birch  
Executive Director

**Department Priority: S-10, BA-10**  
**Request Detail: Provider Fee Analytics**

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Provider Fee Analytics	\$1,000,000	\$0

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Provider Fee Analytics	\$1,000,000	\$0

***Problem or Opportunity:***

The Department is in need of ongoing funding to ensure that expenditures made for populations funded by the Hospital Provider Fee meet federal requirements.

The Colorado Health Care Affordability Act, HB 09-1293, created several Medicaid populations in Colorado (MAGI Adults, MAGI Parents/Caretakers above 60% FPL, continuous eligibility for eligible children, and the Disabled Buy-in Program), a hospital supplemental payment program, and administration related to supporting the populations and supplemental payment program are funded with the Hospital Provider Fee. Colorado then expanded Medicaid under the Affordable Care Act (ACA) in SB 13-200, which further expanded eligibility, but also allowed the state to replace state funding with federal funding due to higher federal match rates.

These changes have significantly increased the financial and accounting complexity needed to maintain compliance with federal regulations. Although the Department performs studies and audits throughout the year to ensure systems, eligibility determination, rate setting, and financing are all operating correctly and in compliance with federal and state regulations, the Department is limited in what it can do by its current staffing and contractor funding level. As a result, the Department needs to increase its resources in several major areas to ensure compliance and prevent the disallowance of federal funds.

**FMAP Claiming and Population Identification**

The ACA included provisions that required states to standardize their income eligibility determination criteria for Medicaid and the Children's Basic Health Program. Implementation of MAGI in October 2013 changed

the calculation of the Federal Poverty Level (FPL) used in determining applicants' eligibility and brought the state into compliance with the standardization requirements of the ACA. Because Medicaid is a needs-based program, the conversion affects who would be eligible for Medicaid services as well as how those services would be funded. The converted calculation may affect the source of state funds needed and the federal funds rate when the converted FPL moves a client between the traditional and expansion populations.

Of particular interest, MAGI Parents/Caretakers with an FPL above 68% are in the expansion population and receive 100% federal match, and those with an FPL below 68% are in the traditional population with a standard federal match. The assumption prior to the implementation of MAGI was that clients would move between the traditional and expansion populations with their newly calculated FPL, but the net movement would be negligible. Since October 2013, the Department has observed that clients have disproportionately moved from the expansion population to the traditional population. Such changes create a significant increase in General Fund expenditure. The substantial magnitude of the changes seen after October 2013 warranted review of the conversion implementation. This MAGI analysis cannot be completed without additional funding, but must be completed this fiscal year.

The Department has hired an actuary to perform a study to better understand the changes that occurred with the MAGI conversion to determine if any changes are warranted. Due to the complexity and volume of data, this project is requiring over 400 work hours and cannot be completed without additional funding. Completion of this study is crucial to validating the threshold between traditional and expansion populations for parents/caretakers, confirming that the correct FMAP is being applied to the appropriate clients, and thus ensuring proper use of funding sources.

The MAGI conversion is only one of many issues that the Department is investigating related to proper FMAP claiming. It is clear that the Department will face a significant amount of scrutiny from the federal government to ensure that it is correctly using federal funds; even though the higher FMAP rates phase down over time, the Department will still be entitled to 90% federal funds for these populations after the phase down is complete. It is of paramount importance that the Department is proactive in identifying any issues that could cause the loss of federal funding, but the Department is currently constrained with what it can do by existing resources.

#### Disproportionate Share Hospital Payments

The Hospital Provider Fee Program funds a supplemental payment program, which includes disproportionate share hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. States are required to submit an independent certified DSH audit and an annual report. The Department attempts to respond appropriately to the findings of the DSH audits, but the volume of work needed has exceeded the Department's staff and contractor capacity. The most recent audit recommendations suggested collecting data on low income utilization rate (required by CMS), out-of-state DSH payments, patient days at the revenue code level, Medicare crossover data from hospital records to use for uncompensated care cost calculations, and updating the uniform cost report manual. The ability to respond to audit findings is dependent on available resources and timing of the budget cycle.

## Provider Fee Modeling and Data Collection

The accuracy of the hospital provider fee model depends critically on the accuracy of data submitted by the hospitals. The Department contracts with a third party to collect and analyze the data for accuracy. In recent years, however, the complexity of the model and the scrutiny from CMS has increased to the point where the Department does not have the resources to adequately respond to questions. The Department's current appropriations are not sufficient to allow for the level of independent data collection and verification that is required, particularly because the Department's contractors are responsible for the accuracy of the data. If the Department does not have sufficient funding, the contractor would continue to be limited in what it can do.

This scrutiny is occurring at a national level; on March 18, 2013, CMS issued State Medicaid Director's Letter #13-003 (SMDL #13-003), which discussed the accountability of the federal and state governments for the integrity of the investment of tax dollars in the Medicaid program. CMS expressed its desire to include a periodic process that would review state expenditures, claims information, and audit results to identify overall performance. Starting in 2013, CMS required the State to submit an annual upper payment limit (UPL) demonstration. This is to better the understanding of the variables surrounding rate levels, supplemental payments, and total providers participating in the programs, and the funding supporting the payments in the UPL demonstration. Additional support towards data integrity would help ensure the annual UPL demonstration is accurate and is able to provide valuable findings.

## Payment Reform

The Department's ability to make supplemental payments to hospitals is dependent on the payments it makes through the fee-for-service program. The UPL is calculated based on fee-for-service payments, and so any movement away from fee-for-service will decrease the UPL and therefore reduce supplemental payments to hospitals. Federal regulations do not provide for an easy solution to this problem; however, it is likely that CMS would grant a demonstration waiver allowing the Department to retain UPL room even if payments are transitioned away from fee-for-service. The process, however, is extraordinarily complex and would require multiple years of work to determine the requirements for such a waiver. The Department cannot absorb this workload and does not currently have the resources necessary to hire a contractor to perform the needed research.

### ***Proposed Solution:***

The Department requests \$1,000,000 total funds and \$500,000 cash funds in FY 2014-15 and future years to fund projects related to the Medicaid expansion authorized under HB 09-1293 and SB 13-200. The current year funding would be used to study the effects of the MAGI implementation and increase the Department's accuracy in claiming federal funds for expansion populations; implement mandatory data collection related to DSH payments; perform the required annual UPL demonstrations required by CMS; and explore payment reform options related to hospital payments. The need for funding is ongoing.

Section 25.5-4-402.3(4)(b)(VI)(B), C.R.S., states that the provider fee may be used for costs related to implementing and maintaining the provider fee, including personal services, operating, and consulting

expenses. From 2009 to present, Colorado has seen several phases of expansion in the Medicaid program, either implementing the Hospital Provider Fee program or incorporating changes required by ACA that directly affect the program. With frequent changes being made to Medicaid, it is important that the Department's understanding of the provider fee program remains relevant in order to maintain and efficiently manage the program. The Department is limited in its ability to pursue corrective actions and analyses that would illuminate information critical to forecasting the magnitude and needs of these expansion populations. This funding source would promote research and audits to maintain a relevant understanding of the program, preserve and confirm compliance with state and federal statute, and ensure continual improvement of the provider fee program.

***Anticipated Outcomes:***

The Department would use the available funding for in depth research and external consulting to maintain and continuously improve the provider fee program. These funds would allow the Department to hire external consultants for review of populations, utilization, rates, perform audits on systems, and ensure a well-managed program. A separate funding source would greatly improve response rates and turnaround time to issues and questions that naturally arise with programs of such magnitude. These projects would help lower the probability of future federal deferrals and recoupments from providers.

The Department anticipates that the completion of the MAGI analysis would either validate that the implementation of the MAGI conversion is working as intended, or would demonstrate a need for revisions to the criteria being used for eligibility determinations and population financing. Should revisions be needed, the Department would work with CMS to determine the appropriate actions and would complete the changes through the budget process.

***Assumptions and Calculations:***

The provider fee model allows for funding for costs related to maintaining the provider fee, including personal services, operating, and consulting expenses, per section 25.5-4-402.3(4)(b)(VI)(B), C.R.S. Because these expenses are built into the provider fee model, the Department assumes that there is sufficient cash fund revenue to support ongoing ad hoc analysis related to the Medicaid expansion.

The Department assumes \$1,000,000 total funds, \$500,000 cash funds, would be sufficient funding to perform annual pressing needs for complex analysis. The Department's estimate is based on recent experience with needs for complex analysis relating to provider fee modelling, MAGI Adult capitation rate setting and the MAGI Analysis. Costs for specific projects, however, are not yet known; the Department would be required to competitively bid other contracts, and thus, totals are not known at this time. However, given the projected scopes of work, the Department anticipates that the needed projects would require considerable resources.

In the event that funding goes unutilized because bids are lower than anticipated or because work cannot be completed in the fiscal year, unused cash funds would remain in the Hospital Provider Fee Cash Fund and would be used to offset future revenue collection.

***Supplemental, 1331 Supplemental or Budget Amendment Criteria:***

This request meets supplemental and budget amendment criteria because it is in response to a significant workload change.