

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	
	Total	\$6,151,808	\$1,000,000	\$5,481,508	\$1,000,000	\$1,000,000
	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

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		Appropriation	Supplemental Request	Base Request	Governor's Revised Request	
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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	If Yes, describe the Letternote Text Revision: 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, which is estimated to be 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 periodic 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.
- One specific and pressing need is funding of the post MAGI implementation review. The Department is reviewing the MAGI conversion and how this affected the financing for services for specific Medicaid populations. Upon the implementation of MAGI in October 2013, significant changes were seen in Medicaid caseload. In particular, clients eligible for the MAGI Parents/Caretakers category have disproportionately moved from the expansion population (above 68% FPL) to the traditional population (below 68% FPL). Such changes create a significant increase in General Fund expenditure. The magnitude of the changes seen after October 2013 warrant a post implementation review.

Consequences of Problem

- Failure to provide funding and resources for ad hoc projects, research, and audits means the Department is unable to quickly respond to areas of concern. Complex analysis is needed for maintaining the provider fee program, but slow turn around puts tax dollars at risk and results in poor management of the provider fee program.

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. Of this amount, \$82,459 would fund the MAGI analysis in FY 2014-15. 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 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. Studies and audits serve as a means to uncovering inefficiencies and errors and have the potential to improve many aspects of Medicaid. Identifying inefficiencies and problems is most critical with newer and unfamiliar programs to ensure that they are working properly. The provider fee program, introduced by HB 09-1293, is relatively new and has gone through significant changes as Colorado has expanded Medicaid.

The Colorado Health Care Affordability Act, HB 09-1293, created several Medicaid populations in Colorado (MAGI Adults, MAGI Parents/Caretakers 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. This young, multibillion dollar program demands attention and in depth research so the Department may increase its understanding of the needs of the entire program to ensure the State is maximizing available funding and managing the program as efficiently as possible. The Department does perform some research internally, but the ability to respond to immediate needs is limited due to insufficient funding.

As mentioned above, 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 potential for timely response is limited due to funding constraints. 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.

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.

Financial support is necessary for timely responses to audit findings and to perform studies that enhance data integrity for reports and performance analysis. There is also continual need to study the effects of the changes in policy on the Provider Fee Program. Additional expansion and changes to existing populations, including the provider fee program, were introduced with the Affordable Care Act (ACA). 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 affects the way services are funded when the converted FPL moves a client between the traditional and expansion populations, and resulted in major changes to populations in the Hospital Provider Fee program.

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 Department anticipates valuable findings from this analysis, and hopes to perform a similar study after more data has accrued.

The Department can sometimes absorb small unexpected costs with existing resources, but the ability to fund ad hoc projects is limited and often results in postponing other priorities. The consequences of these limitations worsen as Medicaid changes and expands. When the program changes significantly, the necessity for external auditing and studies increases. The Department does not have the ability to respond to these needs in a timely manner due to financial constraints. The provider fee program requires careful attention and complex analysis necessary for maintaining compliance with statute, but responding to these needs with short turnaround is a rare possibility. Postponing of time sensitive projects will continue if financial restrictions are not alleviated.

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.

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, implement mandatory data collection related to DSH payments, and perform the required annual UPL demonstrations required by CMS. Going forward, this funding would be used to support other needed projects on an as-needed basis.

The need for funding is ongoing. The Department would use funding in FY 2015-16 and beyond to continue to fund the DSH data collection and UPL demonstration. Any remaining funding would allow the Department to perform smaller projects and needs as they arise.

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. This funding is permissible under section 25.5-4-402.3 (4)(b)(VI)(B), C.R.S., which 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.

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.

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. This is based on recent experience with needs for complex analysis relating to MAGI Adult capitation rate setting and the MAGI Analysis, and a potential need for 6-10 projects of similar or greater scope annually.

Presently, the Department has only received a bid for the MAGI analysis described above. The totals are based on the estimate provided by the Department's actuary, who estimated that the scope of work would require 406.2 hours at a rate of \$203 hours, for a total of \$82,459. 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 DSH data collection and UPL demonstrations would require consider 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.