MEMORANDUM

JOINT BUDGET COMMITTEE

TO	JBC Members
FROM	JBC Staff
DATE	January 26, 2021
SUBJECT	Comeback Packet 2

Included in this packet are staff comeback memos for the following items:

Health Care Policy and Financing: (Eric Kurtz): Family medicine residence training program *(Tabled Item)*

Health Care Policy and Financing: (Eric Kurtz): Public health emergency end resources *(Tabled Item)*

MEMORANDUM

JOINT BUDGET COMMITTEE

TO Members of the Joint Budget Committee
FROM Eric Kurtz, JBC Staff (303-866-4952)
DATE January 26, 2021
SUBJECT Supplemental Comebacks - Health Care Policy and Financing
1. S8 Family medicine residency training program
2. S10 Public health emergency end resources

S8 FAMILY MEDICINE RESIDENCY TRAINING PROGRAM

	REQUEST	RECOMMENDATION
TOTAL	**$1,204,207**	**$0**
General Fund	353,723	0
Cash Funds	211,050	0
Federal Funds	639,434	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **NO**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: The Department argues this was a technical error and the JBC did not intend to cut the University of Colorado family medicine residency program. As evidence, they cite that footnote 26 regarding intergovernmental transfers between the University of Colorado and the Department of Health Care Policy and Financing still references family medicine placements and was not updated to reflect the elimination of the State University Teaching Hospitals – University of Colorado Hospital Authority line item. The JBC staff notes that it was not just the JBC but the entire General Assembly that voted for the change. Based on a review of what was said and written about the reduction to the line item, the JBC staff admits there is a possibility the General Assembly did not understand that reducing the line item would impact family medicine residencies, but the JBC staff's default assumption is that the General Assembly knew what it was doing. The Department did not present any new information about the family medicine residencies. Therefore, the JBC staff concludes this request does not meet the JBC's supplemental criteria. However, the JBC members are better positioned than the JBC staff to judge whether the reduction to family residencies aligned with their intent or was a "technical error."

STATUS AND REASON FOR COMEBACK:

When the JBC first considered the request Rep. Herrod requested some additional information on the impact of the family medicine program on recruitment and retention of minority practitioners and access to care in underserved minority communities.

In response the Department indicated 22.2 percent of family medicine residents identify a race/ethnicity that is not white/Caucasian. Also, the Department reports the average number of family medicine physicians practicing in urban under-served areas has increased to 10.75 from 2017-2019 compared to 9.4 from 2012 to 2016. The full fact sheet from the Department is attached as an appendix at the end of this document.

The rest of the description below is a repeat of the original staff write-up.

DEPARTMENT REQUEST:

The Department requests $1.2 million total funds, including $379,468 General Fund, to partially restore the FY 2020-21 elimination of the State University Teaching Hospitals line items that impacted family medicine residencies.

The State University Teaching Hospitals line items paid for graduate medical education at the University of Colorado Hospital Authority and Denver Health, but the funding for the University of Colorado Hospital Authority included $1,293,652 total funds that was used for family medicine residencies. The $1,293,652 total funds for family medicine residencies included reappropriated funds from the University of Colorado. The reappropriated funds were added a couple years ago as part of negotiations that resulted in the University of Colorado (CU) sending money appropriated for the School of Medicine to the Department of Health Care Policy and Financing to receive matching federal funds that are then paid to the physicians of CU. The funding in the State University Teaching Hospitals line paid for 36 family medicine residencies. All of the residencies include rural rotations and 6 were specifically rural track residencies.

The reason the University of Colorado Hospital Authority had separate funding from the rest of the family medicine residencies are technical and tie back to federal regulation. The federal Center for Medicare and Medicaid Services (CMS) was questioning the validity of Colorado's payments for graduate medical education. In FY 2008-09 the General Assembly decided the path of least resistance was to separate the funding into a line item that clarified the status of the University of Colorado Hospital as a "unit of government" in its role as a provider of graduate medical education and this successfully resolved the concerns of CMS.

The State University Teaching Hospitals line item for Denver Health did not include any money for family medicine residencies. Denver Health does host family medicine residents, but the University of Colorado Hospital Authority is the sponsoring and organizing entity. Denver Health indirectly benefits from state funds for family medicine residencies through payments from the University of Colorado Hospital Authority.

In addition to eliminating the State University Teaching Hospitals line items, the General Assembly reduced funding for the Commission on Family Medicine by $1,066,098 total funds. The staff recommendation was to reduce the Commission on Family Medicine by $4,000,000 total funds (almost 50 percent). Instead, the JBC chose to reduce the $8.2 million total funds appropriation for the Commission on Family Medicine by 13.0 percent. The $8.2 million total funds has historically paid for 228 residencies.

When the reductions were made the residencies had already been awarded for 2020-21 and so absorbing the reductions by reducing residency placements was problematic, at least in the short term. The Commission is using reserves and proportional operating reductions to continue funding the residencies. In the longer term the number of family medicine residencies could be reduced to absorb the reductions in funding, or sponsoring hospitals and practices could take on the cost. If residencies are reduced it may impact the recruitment and retention of family medicine doctors to the state, although Colorado continues to experience net in-migration, suggesting it is a place people desire to live. Historically, approximately two thirds of the family medicine residents who train in Colorado

remain in Colorado to practice and of those who remain approximately 40 percent practice in rural and underserved communities.

The table below summarizes the funding for family medicine residencies from the two line items and the JBC's reductions to the two line items. The net result was a 24.9 percent decrease. The total funds match the historic residency funding and the FY 20-21 reductions, but the fund sources have been restated to reflect the higher federal match offered through the Families First Coronavirus Relief Act.

Family Medicine Residency Funding				
	TOTAL FUNDS	GENERAL FUND	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Historic Residency Funding				
State University Teaching Hospitals	$1,293,652	$369,520	$197,100	$727,032
Commission on Family Medicine	8,196,518	3,590,075	0	4,606,443
Subtotal - Residency Funding	**$9,490,170**	**$3,959,595**	**$197,100**	**$5,333,475**
FY 20-21 Reductions				
State University Teaching Hospitals	($1,293,652)	($369,520)	($197,100)	($727,032)
Commission on Family Medicine	(1,066,098)	(466,951)	0	(599,147)
Subtotal - Reductions	**($2,359,750)**	**($836,471)**	**($197,100)**	**($1,326,179)**
Percent Reductions	-24.9%	-21.1%	-100.0%	-24.9%

In the supplemental the Department does not propose restoring all of the money in the State University Teaching Hospitals line items, but does request restoring the portion of the line item devoted to family medicine residencies with a reduction proportional to the reduction made to other family medicine residency programs.

The proper way to look at this request is as restoring funds for family medicine residencies in general, rather than specifically for the University of Colorado Hospital Authority. In the request the Department asserts that due to federal regulation the money for the University of Colorado Hospital Authority residencies must flow through State University Teaching Hospitals line item and that without the appropriation the Commission on Family Medicine cannot pay for these residencies. However, the JBC staff believes this is likely an overstatement. The Commission on Family Medicine is currently paying for the University of Colorado Hospital Authority residencies from reserves. Further, it is unclear that current staff at CMS would have the same hyper-technical concerns about Colorado's appropriation structure as the staff at CMS over a decade ago that led to the creation of the State University Teaching Hospitals line items. The Commission on Family Medicine has taken a formal position that they want to allocate the money for family medicine residencies proportionally. If the reduction stays in place, the Commission would attempt to reduce funding for all family medicine residencies, rather than specifically eliminating funding for the University of Colorado Hospital Authority. It is unknown if CMS would object to that approach.

STAFF RECOMMENDATION:

Staff does not recommend the request. The original staff recommendation, which the JBC did not approve, was to reduce the Commission on Family Medicine by $4.0 million total funds plus eliminate the State University Teaching Hospital line items, which included another $1.3 million for family medicine residencies, for a net reduction of $5.3 million total funds for family residencies. The current

net reduction of $2.4 million total funds is significantly less. While the Commission on Family Medicine plays an important role in developing the primary care provider network, particularly in rural and underserved areas, the appropriation pays for teaching, rather than direct services and, therefore, the JBC staff considered it a lower priority than preserving eligibility and benefits. It appears there is more money now than was assumed in May, but more money is not one of the JBC's supplemental criteria.

If the JBC wants to restore funding for the Commission on Family Medicine, the JBC may also want to consider restoring funding for some of the benefit reductions implemented last year, including the increase in member copays, a $1,000 annual cap on the adult dental benefit, stopping implementation of H.B. 20-1384 for wraparound services for at-risk children, and a $1.0 million reduction in the senior dental program. The member copays and $1,000 annual cap on the adult benefit have not yet been implemented due to the extension of the federal public health emergency, so decisions on restoring funding for these benefits will be made in figure setting for FY 2021-22. The H.B. 20-1384 wraparound services for at-risk children was a new program and thus a lower priority. Therefore, if the JBC wants to restore funding in FY 2020-21, the top priority for the JBC staff would be the $1.0 million General Fund for the senior dental program before the funding for family medicine residencies.

If the JBC decides to restore funding for the family medicine residencies, then the dollar amounts need to be updated for the current federal match. To provide the same $1.2 million total funds requested by the Department now requires $330,343 General Fund, rather than the $353,723 that was requested.

S10 PUBLIC HEALTH EMERGENCY END RESOURCES

	REQUEST	RECOMMENDATION
TOTAL	**$8,323,654**	**$55,457**
FTE	1.0	0.6
General Fund	784,231	0
Cash Funds	1,087,562	27,729
Federal Funds	6,451,861	27,728

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made as the Department' understanding of the administrative and fiscal impact of emerging federal pandemic policies develops.

STATUS AND REASON FOR COMEBACK:

When the staff write-up for the Department of Health Care Policy and Financing's supplemental requests was submitted to the JBC, the staff recommendation on *S10 Public Health Emergency End Resources* was pending some additional information about the impact of a recent federal extension of the public health emergency. The staff recommendation that was pending is contained in this memo.

DEPARTMENT REQUEST:

The $8.3 million total funds, including $784,231 General Fund, and 1.0 FTE in the table above reflects the official supplemental request for just the Department of Health Care Policy and Financing. When the impacts on other departments are included, the official request was for $8.4 million total funds with no change in the General Fund. Shortly after the request was submitted the federal government extended the public health emergency, changing the need for resources in several ways. Then on Friday, January 22, 2021, the federal acting Secretary of Health and Human Services sent a letter to governors stating:

> *To assure you of our commitment to the ongoing [COVID] response, we have determined that the [federal public health emergency] PHE will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, [the federal Health and Human Services] HHS will provide states with 60 days' notice prior to termination.*

This is not an official extension of the public health emergency and the current declaration expires April 21, 2021. However, based on the letter the Department agrees with the JBC staff assessment that most of the requested funding does not need to begin until FY 2021-22. The exception is funding for an eligibility overflow processing center, where the Department requested $86,556 total funds and 0.6 FTE to begin the procurement process.

OVERVIEW OF THE ENTIRE ORIGINAL REQUEST

The original proposed funding and FTE were to address expected administrative costs, mostly at the county level, associated with an anticipated surge in eligibility redeterminations when the federal public health emergency ends. During each fiscal quarter the public health emergency is in effect, Colorado qualifies for an additional 6.2 percent federal match, but as a condition of receiving the enhanced match Colorado cannot disenroll anybody from Medicaid until the last day of the month when the public health emergency ends. Based on an executive order the Department sought and received federal permission to implement the same standard for children enrolled in the Children's Basic Health Plan (marketed as the Child Health Plan Plus or CHP+). The Department refers to people who continue on Medicaid or CHP+ despite changes in eligibility status that would normally disqualify them as "locked in." When the public health emergency ends the eligibility status of each person who is locked in must be redetermined, causing a temporary surge in workload for county and state staff involved in eligibility determinations and appeals. The request assumes the redeterminations will need to be completed in three months, in part because the longer people are on Medicaid and CHP+ the higher the cost to the state, but final federal guidance on the time frame for completing the eligibility redeterminations has not yet been issued.

The redeterminations themselves will be automatic through the Colorado Benefits Management System (CBMS), but they still drive a significant workload for county and state officials. Eligibility review packets will be sent to all locked in members with instructions for the members to review the data on file and provide any updates. If members respond with updates, the county must process the new information into CBMS. Once a redetermination is made, either with the existing information on file or with updated information from the member, a notice is sent to members with a pending disenrollment. These members have a right to appeal. When an appeal is filed the Department and counties must do additional research to determine if a case should be reopened as well as track steps

in the hearing process and prepare hearing materials. Appeals can occur at the county level where they are processed through facilitated dispute resolution conferences and/or at the state level where an administrative law judge provides an initial decision.

Independent of the expected surge in redeterminations, counties have been dealing with increases in applications for all types of public assistance, including Medicaid and CHP+, related to the pandemic and the economy. Also, the Department says counties are reporting unusually high employee absentee rates of nearly 9 percent for reasons unrelated to the pandemic plus another 8 percent specifically attributed by counties to COVID and associated issues like child care. The Department says it continues to seek ways to make the eligibility process more efficient and automated to reduce the workload on counties and cites the centralized processing of returned mail as a recent example of an efficiency initiative. However, without additional county resources for the expected surge in redeterminations the Department fears already strained counties will not be able to maintain quality standards for timely processing of applications. The Department expects at least 95 percent of applications to be processed within 45 days[1]. In December 97.4 percent of redeterminations were processed within 45 days, which is down from November when 98.5 percent of redeterminations were processed within 45 days, despite a decrease in redeterminations due to the public health emergency lock in. As recently as August 2019 through April 2020 the timely processing dropped down to 75-80 percent of applications processed within 45 days during a system update and the Department wants to avoid a similar problem in the future.

When counties get behind on timely processing, members must wait to hear if they have coverage. For select services, like emergency hospital visits, Medicaid will retroactively cover costs back to the event that precipitated the Medicaid application, but the person applying does not know the status of coverage until the eligibility determination is made. Some populations, like pregnant adults and children, are presumed eligible and Medicaid will pay for coverage until the eligibility determination is made. However, for most health care services a person cannot get Medicaid coverage until the eligibility determination is made. An illustrative example of a service that might be an urgent need, but Medicaid would not provide retroactive coverage or presumptive eligibility, is behavioral health.

To offset the need for General Fund the Department proposes using money from the Healthcare Affordability and Sustainability (HAS) Fee that is currently appropriated for on-site eligibility determinations at hospitals. The annual appropriation has been in place since 2011, but the Department has been reverting the spending authority, because the federal Centers for Medicare and Medicaid Services (CMS) has yet to approve this form of payment to the hospitals. The money is accounted for in the annual HAS Fee allocation formula, and so repurposing it does not increase the amount hospitals expect to pay for administrative costs. However, if the Department were able to use the money for on-site eligibility determinations at hospitals, then that might be perceived by hospitals as providing a more direct benefit to hospitals than paying for county workload related to a surge in eligibility redeterminations. More than enough of the surge in eligibility redeterminations is related to expansion populations financed with the HAS Fee to justify using the HAS Fee for this purpose. Among the allowable uses of the HAS Fee listed in Section 25.5-4-402.4 (5)(b)(VI)(F), C.R.S., is:

[1] Historically unenforced federal regulations in 42 CFR 435.912(c) and 457.340(d) call for 100 percent of applications to be processed within 45 days.

> *The enterprise's personal services and operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in subsections (5)(b)(IV) and (5)(b)(V) of this section, including but not limited to administrative costs associated with the determination of eligibility for public medical assistance by county departments.*

As part of the request the Department asked for rollforward authority, due to uncertainty about when the supplemental will be approved, whether the public health emergency may get extended again, and how long federal guidance will allow for completion of the redeterminations.

ELIGIBILITY OVERFLOW PROCESSING CENTER

Based on the expected extension of the public health emergency, the only piece of the original request that is still relevant for FY 20-21 is funding to begin the procurement of an eligibility overflow processing center. The fiscal impact of the rest of the request has shifted to FY 21-22 and can be addressed during figure setting. The proposed eligibility overflow processing center would absorb some of the increased workload on counties from the surge in eligibility redeterminations.

The Department recognizes the challenges for counties to quickly train and staff up for a short-term workload spike, as well as regional variations in the capacity and will of local governments for a temporary staff increase. Also, the Department anticipates an ongoing need for periodic support to counties to address eligibility determination backlogs. Based on the patterns from previous economic downturns the Department expects applications for Medicaid and CHP+ to remain high for several years after the overall economy begins to recover. The Department has recently experienced unanticipated events like wildfires, system updates, and health care policy changes that temporarily significantly increased application processing backlogs. In order to address similar types of potential disruptions in the future, and to minimize the need for temporary staff increases at the county level, the Department proposes to handle some of the surge in redeterminations through a centralized backlog support that would be ongoing. The Department would contract with a vendor (most likely a county) or vendors to handle the overflow from counties experiencing backlogs in eligibility determinations.

To begin the process of procuring the eligibility overflow processing center the Department requests $86,556 total funds, including $43,278 state funds, for two new positions (0.6 FTE for FY 20-21). One position would be responsible for managing the contract and stakeholder engagement and the other position would be responsible for training to the processing center and counties using the resource. For FY 21-22 would grow to 2,051,864 total funds, including $562,499 state funds, and 2.0 FTE as the contract costs begin and the costs for the new staff are annualized. As with other components of the request, the Department proposes the state share of costs would come from the HAS Fee. To strengthen the connection between the HAS Fee and the request, the Department proposes the eligibility overflow processing center would be limited to handling applications and redeterminations related to the expansion populations financed from the HAS Fee.

STAFF RECOMMENDATION:

The JBC staff recommends approval of the eligibility overflow processing center portion of the request, with modification to apply the JBC's common policies for new FTE. The rest of the request will be addressed during figure setting. Staff views the proposed eligibility overflow processing center as a critical strategy to minimize the impact on counties of the expected surge in redeterminations, as

well as a promising strategy to maintain timely processing of eligibility determinations for applicants and clients through the end of the public health emergency and beyond. The JBC staff considers the requested 2.0 FTE somewhat generous for the work involved. However, the JBC staff wants to see as much of the surge in redeterminations as possible handled through the overflow processing center and thus supports the full staffing requested by the Department. There are other elements of the overall request, which will be addressed in figure setting, where the JBC staff is less convinced about the value and scale of what the Department proposes and so the JBC staff will be recommending fewer FTE in those areas, which may balance out the moderately generous recommendation for staffing the eligibility overflow processing center.

The table below summarizes the calculation of the staff recommendation. The Department's estimate for the contract assumes the contractor will hire approximately 25 eligibility workers and associated administrative staff and will have a capacity to handle a little over 2,300 determinations per month. For the FTE the Department assumed they would be in place for four months, which seems overly optimistic given recruitment time, but the Department also assumed the pay date shift, which doesn't apply for cash funded FTE, so the staff recommendation ends up in a similar place, after removing benefits for the first year per the JBC's common policy.

Eligibility Overflow Processing Center					
	Monthly	Months	FY 20-21	Months	FY 21-22
Personal Services					
Contract Administrator V	$6,659	3	$19,977	12	$79,908
Training Specialist IV	$5,322	3	$15,966	12	$63,864
Subtotal wages			$35,943		$143,772
PERA	0		$3,918		$15,671
Medicare	0		$521		$2,085
Subtotal Personal Services			$40,382		$161,528
Operating					
On-going (supplies, telephone, software)	$1,350	3	$675	12	$2,700
One-time (computer, cubicle, workstation)	$7,200	NA	$14,400	NA	$0
Subtotal Operating			$15,075		$2,700
Eligibility overflow processing center contract			$0		$1,853,731
TOTAL			**$55,457**		**$2,017,959**
HAS Fee			$27,729		$545,547
Federal Funds			$27,728		$1,472,412

APPENDIX A
COMMISSION ON FAMILY MEDICINE FACT SHEET

COLORADO COMMISSION ON FAMILY MEDICINE

COFM response to JBC Committee Member questions 1-25-2021

During review of the supplemental requests on 1/25/2021, a request for more information regarding the diversity of the residency programs and COFM's contributions to rural access in the state. Below please find a summary of this information. Some is incomplete due to the tight turnaround and will be completed and forwarded once all information is received.

Diversity in Residency programs:

Please consider that residents accepted into Colorado programs are recruited from medical schools across the country. Colorado residency programs are intentionally employing recruitment and interviewing processes that are intended to expand the diversity of their programs, while at the same time being reliant on the populations of medical students those schools are successful and committed to recruiting.

Currently, the composition of the Colorado family medicine programs is as follows (6 of 10 programs reporting):

	% CO resident physicians
Gender-Female	59.8%
Race/ethnicity other than white/caucasian	22.2%
LGBTQI*	6.6%
Rural practice interest	31%
Other- person with disability	<1

*This figure may not be 100% accurate as this question is not asked of residents.

Concerted efforts are being made by all residencies to recruit a more diverse body of resident physicians to their programs:

- *Substantial* revisions of applicant review and interview process
- Recruited at medical schools primarily serving under-represented minorities (URM)
- Provided internal and statewide training on Diversity, Equity, and Inclusion to encompass racial/ethnic, gender identity, rural, etc.

- Work with various workforce pipeline organizations and educational institutions in outreach to students and community members focused on recruitment of healthcare practitioners
- Increase the number of persons of color in Colorado residency programs

Residency programs Increased interviews of medical student persons of color by:

	2013	2014	2015	2016	2017	2018	2019
American Indian	1%	1%	1%	1%	1%	1%	1%
Asian	8%	16%	10%	11%	8%	11%	13%
African American	2%	2%	2%	2%	2%	4%	6%
Hispanic	4%	5%	6%	5%	5%	11%	16%
Caucasian	85%	76%	81%	81%	84%	73%	64%

Rural primary care access and support:

The mission of the Commission on Family Medicine is to help assure access to primary care in rural and underserved communities in the state. Rural access has always been at the heart of the COFM's efforts in Colorado. Recent support has allowed the establishment of 3 of the state's 4 rural training tracks. Rural rotations are required of all Colorado family medicine residents to expose them to the world of practice in a rural environment. As a result of Colorado's investment in rural healthcare access, the family medicine residency programs have produced physicians practicing in rural areas that continue to exceed national rates.

Prior to the rural training tracks being established, the average number of physicians staying in Colorado to practice rural medicine was 4.5. Since the tracks took on their first residents, that number doubled at 9. In addition, the hosts for the rural training tracks indicate that with resident physicians on site, patient care volume rises, physician satisfaction rises, and there is more interaction with the communities.

With the collaborative support of the ten programs, urban underserved areas have also seen a rise in the number of family medicine physicians in practice, averaging 9.4 from 2012 to 2016, and 10.75 from 2017-2019. Over 60% of all residents remain to practice in Colorado, regularly exceeding the national average.

COLORADO COMMISSION ON FAMILY MEDICINE

Helping to assure access to primary care in rural and underserved communities across Colorado.

Value of Resident Physicians to Rural Colorado

Benefits of the Commission's work to rural Colorado are multiple and difficult to quantify. **Over 1/2 of the Commission's funding impacts rural primary care practice either directly or indirectly** through training and practice with our rural training tracks (RTT) and rural rotation sites.; the broad spectrum training the resident physicians receive; the recruitment efforts on behalf of our rural communities as well as all of our programs, the cross organization training they receive with federally qualified health centers, public health, behavioral health, in-hospital and in-clinic care delivery, schools, and with homeless, indigent, and undocumented patients.

Our Rural Training Tracks: Our residents and faculty practice at a sole community rural hospital handling level 3 trauma, obstetrics, inpatient, geriatric, psychology and other routine procedures

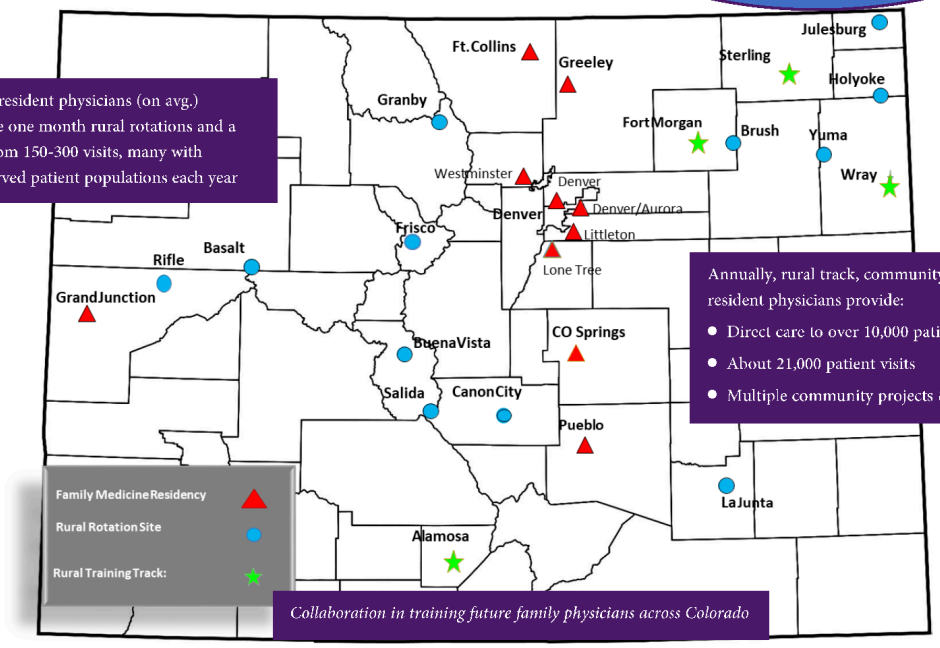
14 RTT resident physicians see:

- 50-60% Medicaid members
- 10-25% Medicare members
- 3-24% uninsured community members

Our Rural Rotation Clinics:

These rural physicians value the residents in their practice as a means to introduce them to rural practice and to keep up on current trends in their field.

Seventy resident physicians (on avg.) complete one month rural rotations and a range from 150-300 visits, many with underserved patient populations each year



Annually, rural track, community based resident physicians provide:

- Direct care to over 10,000 patients
- About 21,000 patient visits
- Multiple community projects & services

Collaboration in training future family physicians across Colorado

Since 1977.