JOINT BUDGET COMMITTEE

# STAFF BUDGET BRIEFING
# FY 2022-23

# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

PREPARED BY:
ROBIN J. SMART, JBC STAFF
ERIC KURTZ, JBC STAFF
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JOINT BUDGET COMMITTEE STAFF
200 E. 14TH AVENUE, 3RD FLOOR • DENVER • COLORADO • 80203
TELEPHONE: (303) 866-2061 • TDD: (303) 866-3472
https://leg.colorado.gov/agencies/joint-budget-committee

# CONTENTS



## ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2020 and 2021 legislative sessions that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy21-22apprept_0.pdf

The online version of the briefing document, which includes the Numbers Pages, may be found by searching the budget documents on the General Assembly's website by visiting leg.colorado.gov/content/budget/budget-documents. Once on the budget documents page, select the name of this department's *Department/Topic*, "Briefing" under *Type*, and ensure that *Start date* and *End date* encompass the date a document was presented to the JBC.

# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

## DEPARTMENT OVERVIEW

The Department helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- **Medicaid** which serves people with low income and people needing long-term care;
- **Children's Basic Health Plan** which provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria;
- **Colorado Indigent Care Program** which defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income; and
- **Old Age Pension Health and Medical Program** which serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, administering grants such as the Primary Care and Preventive Care Grant Program, and housing the Commission on Family Medicine Residency Training Programs.

## DEPARTMENT BUDGET: RECENT APPROPRIATIONS

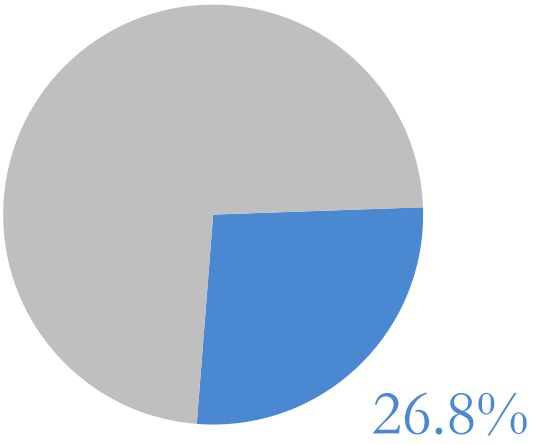
| FUNDING SOURCE | FY 2019-20 | FY 2020-21 | FY 2021-22 | FY 2022-23 * |
|---|---|---|---|---|
| General Fund | $3,001,084,178 | $2,814,512,212 | $3,346,715,726 | $3,995,530,891 |
| Cash Funds | 1,401,230,812 | 1,651,639,211 | 1,595,483,422 | 1,635,634,663 |
| Reappropriated Funds | 93,709,522 | 45,994,354 | 87,674,424 | 92,584,435 |
| Federal Funds | 6,355,609,055 | 7,563,106,406 | 8,249,920,468 | 7,822,349,250 |
| **TOTAL FUNDS** | **$10,851,633,567** | **$12,075,252,183** | **$13,279,794,040** | **$13,546,099,239** |
| | | | | |
| Full Time Equiv. Staff | 544.6 | 557.2 | 601.4 | 672.9 |

*Requested appropriation.

Funding for the Department of Health Care Policy and Financing in FY 2021-22 consists of 25.2 percent General Fund, 12.0 percent cash funds, 0.7 percent reappropriated funds, and 62.1 percent federal funds.

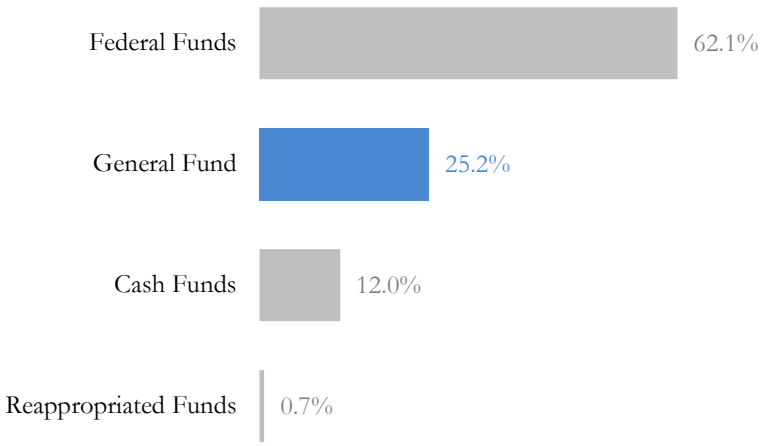
# DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund



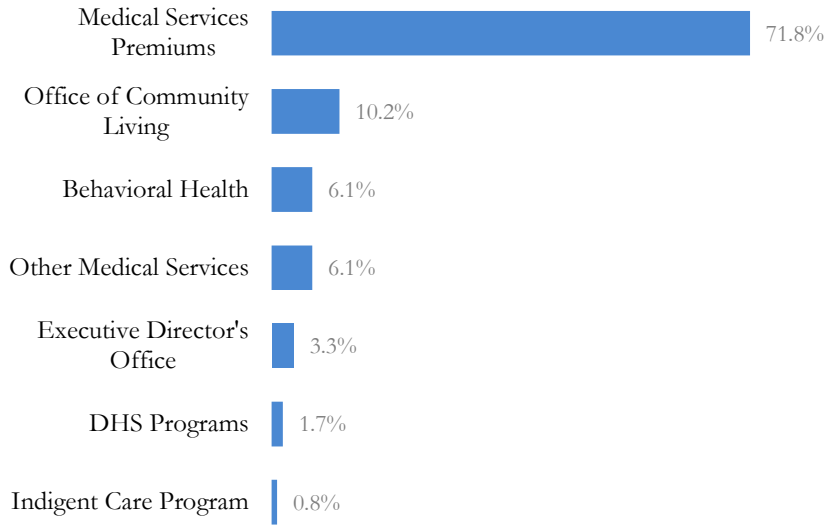

Based on the FY 2021-22 appropriation.

Department Funding Sources



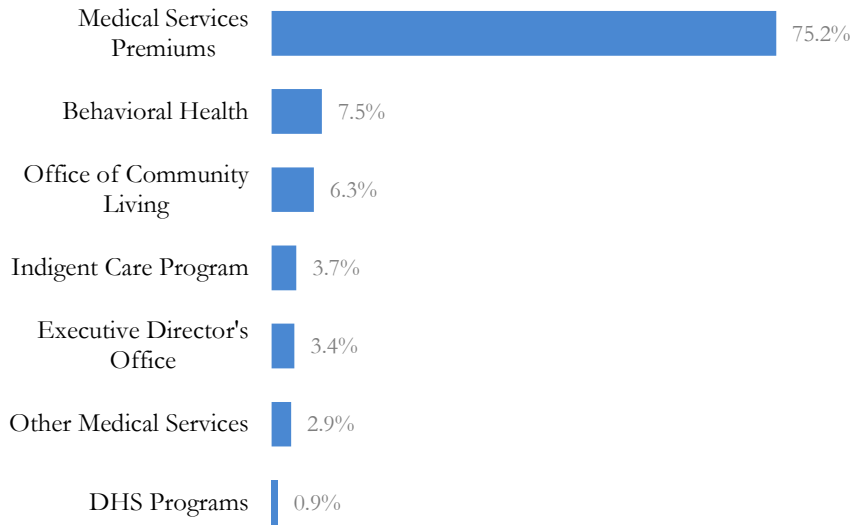

Based on the FY 2021-22 appropriation.

## Distribution of General Fund by Division




Based on the FY 2021-22 appropriation.

## Distribution of Total Funds by Division




Based on the FY 2021-22 appropriation.

# GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 25.2 percent General Fund, 12.0 percent cash funds, 0.7 percent reappropriated funds, and 62.1 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

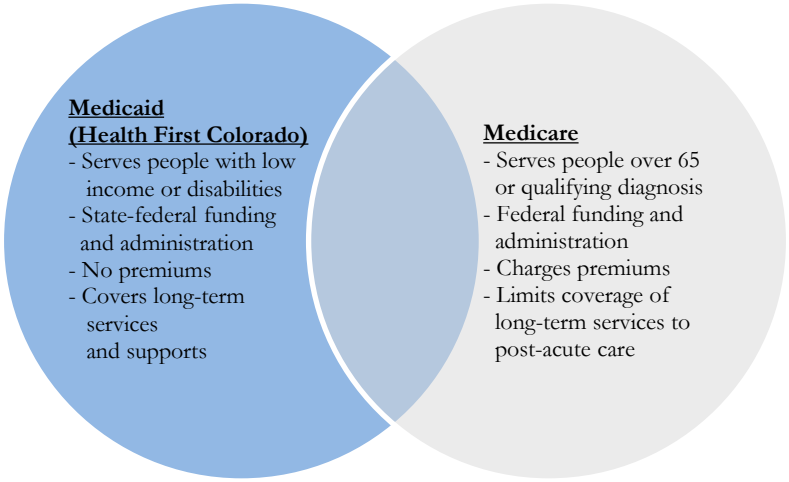
## MEDICAID

Medicaid (marketed by the Department as *Health First Colorado*) provides health insurance to people with low income and people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. The federal government and state government share responsibility for financing, administering, and policy setting for the program.

Medi**caid** is sometimes confused with the similarly named Medi**care** that provides insurance for people who are elderly or have a specific eligible diagnosis regardless of income. The federal government administers Medicare and finances it with a combination of federal funds and annual premiums charged to participants. While the two programs are distinct, they do interact with each other, as some people are eligible for both Medicaid, due to their income, and Medicare, due to their age. For these people (called "dually eligible"), Medicaid pays the Medicare premiums and may assist with copayments, depending on the person's income. In addition, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term services and supports (LTSS) while Medicare coverage for LTSS is generally limited to post-acute care.

Nearly all the Medicaid clients age 65 or older and a portion of the people with disabilities who are on Medicaid are also enrolled in Medicare.

[1] The exception where participants would pay a premium is the voluntary "buy-in" program for people with disabilities whose income is above the standard Medicaid eligibility criteria but below 400 percent of the federal poverty guidelines.




The federal government matches state expenditures for the Medicaid program. The federal match rate, called the Federal Medical Assistance Percentage (FMAP), can vary based on economic conditions in the state, the type of services provided, and the population receiving services.

For state fiscal year 2021-22 the average FMAP for the majority of Colorado Medicaid expenditures is 54.65 percent as a result of a temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act of 2020. The higher federal match is available for services from January 1, 2020 through the last quarter during which a disaster is declared by the federal Secretary of Health and Human Services. Based on the current disaster declaration, the higher federal match would expire at the end of March 2022, but the disaster declaration could be extended.

| Standard Medicaid Federal Match | | | | | |
|---|---|---|---|---|---|
| State Fiscal Year | Ave. Match | Federal Match by Quarter (of state fiscal year) | | | |
| | | Q1 (Jul-Sep) | Q2 (Oct-Dec) | Q3 (Jan-Mar) | Q4 (Apr-Jun) |
| FY 17-18 | 50.00 | 50.02 | 50.00 | 50.00 | 50.00 |
| FY 18-19 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 |
| FY 19-20 | 53.10 | 50.00 | 50.00 | 56.20 | 56.20 |
| FY 20-21 | 56.20 | 56.20 | 56.20 | 56.20 | 56.20 |
| FY 21-22 | *54.65* | 56.20 | 56.20 | 56.20 | *50.00* |
| FY 22-23 | *50.00* | *50.00* | *50.00* | *50.00* | *50.00* |

*Italicized figures are projections.*

For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado receives an enhanced federal match of 90.0 percent. In Colorado the "newly eligible" population includes adults without dependent children with income to 138 percent of the federal poverty guidelines and parents with income from 69 percent to 138 percent of the federal poverty guidelines.[2]

| ACA "NEWLY ELIGIBLE" FEDERAL MATCH | | | | | |
|---|---|---|---|---|---|
| STATE FISCAL YEAR | AVE. MATCH | FEDERAL MATCH BY QUARTER (OF STATE FISCAL YEAR) | | | |
| | | Q1 (JUL-SEP) | Q2 (OCT-DEC) | Q3 (JAN-MAR) | Q4 (APR-JUN) |
| FY 17-18 | 94.50 | 95.00 | 95.00 | 94.00 | 94.00 |
| FY 18-19 | 93.50 | 94.00 | 94.00 | 93.00 | 93.00 |
| FY 19-20 | 91.50 | 93.00 | 93.00 | 90.00 | 90.00 |
| FY 20-21 | 90.00 | 90.00 | 90.00 | 90.00 | 90.00 |
| FY 21-22 | 90.00 | 90.00 | 90.00 | 90.00 | 90.00 |
| FY 22-23 | 90.00 | 90.00 | 90.00 | 90.00 | 90.00 |

Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, if the eligible population and/or the eligible services utilized are greater than expected, then the state and federal government must pay the higher cost, regardless of the initial appropriation. There are exceptions where federal waivers allow enrollment and/or expenditure caps for expansion populations and services. In the event that the State's Medicaid obligation is greater than anticipated, the Department has statutory authority to overexpend the Medicaid appropriation.[3]

After accounting for standard income disregards, Medicaid effectively covers people to 138 percent of the federal poverty guidelines, or $17,774 annual income for an individual and $30,304 annual income for a family of three. The Medicaid eligibility limits are slightly higher for children and pregnant women and if these populations earn income above the Medicaid limits they can still qualify for the Children's Basic Health Plan up to effectively 265 percent of the federal poverty guidelines, or $58,194 annual income for a family of three. In addition, there are special rules for the elderly, people with disabilities, and some smaller populations that are summarized in the table below.

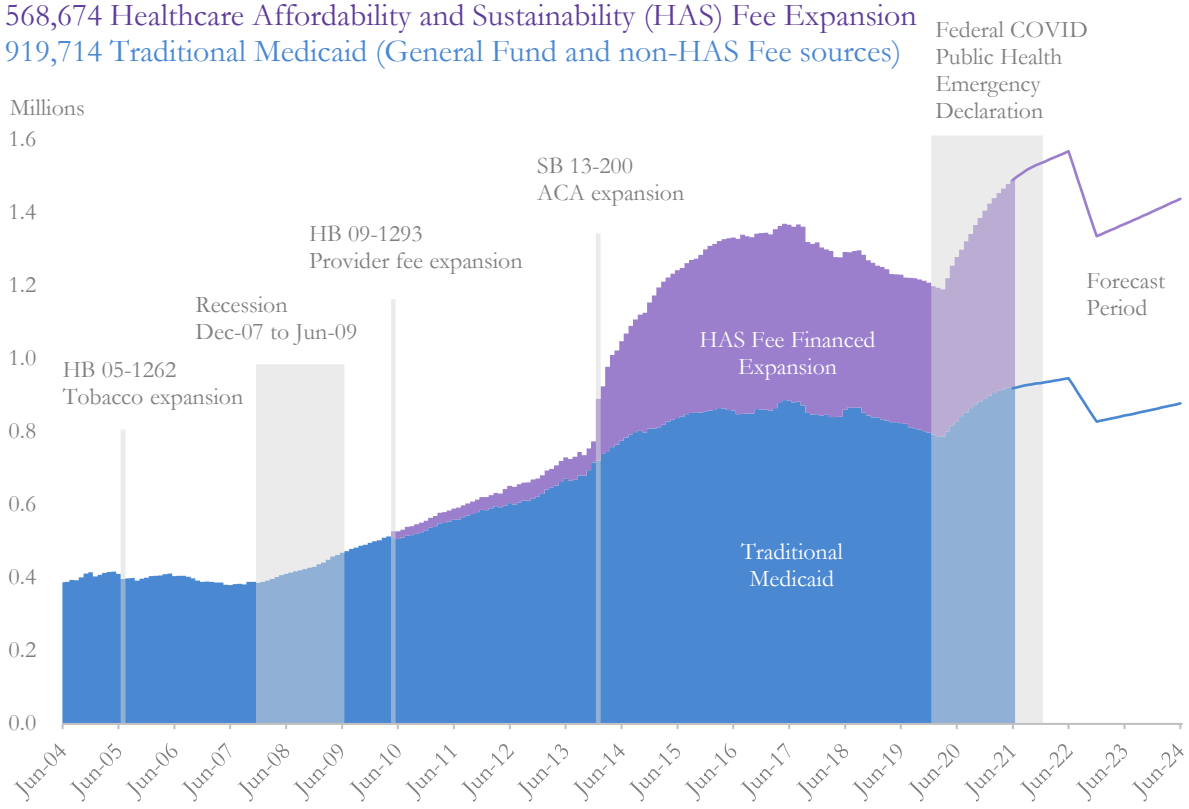
[2] In statute the income limit is 133 percent of the federal poverty guidelines, but with federally mandated standard income disregards, the effective income limit is 138 percent.
[3] See Section 24-75-109 (1)(a), C. R. S.

| Special Medicaid Eligibility Categories | |
|---|---|
| Category | Eligibility Standard |
| Adults 65+ years | Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit<br>100% FPL = assistance with Medicare premiums and coinsurance<br>135% FPL = assistance with Medicare premiums |
| People with disabilities (not otherwise qualified) | 450% FPL = may "buy in" to Medicaid with premiums on a sliding scale based on income |
| Nursing home level of care | 300% of SSI income threshold |
| Breast or cervical cancer | 250% of FPL |
| Former foster children | To age 26 regardless of income |
| Non-citizens | If otherwise qualified for Medicaid = emergency services only |

| Family Size | Federal Poverty Guideline – 2020 | SSI Annual Income Limit |
|---|---|---|
| 1 | $12,880 | $9,528 |
| 2 | $17,420 | $14,292 |
| 3 | $21,960 | |
| 4 | $26,500 | |
| More | add $4,540 each | |

The most significant factor affecting overall Medicaid expenditures is enrollment. Medicaid enrollment is influenced by factors such as the state population and demographics, economic conditions that affect the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. It also matters through which category enrollment occurs. The state match for traditional Medicaid populations (children, people with disabilities, elderly, and very low-income parents) is financed primarily from the General Fund. For recent expansion populations (adults without dependent children and higher income parents) the state match is from a provider fee on hospitals, called the Healthcare Affordability and Sustainability (HAS) Fee, and the state receives enhanced federal funding for 90 percent of the costs.

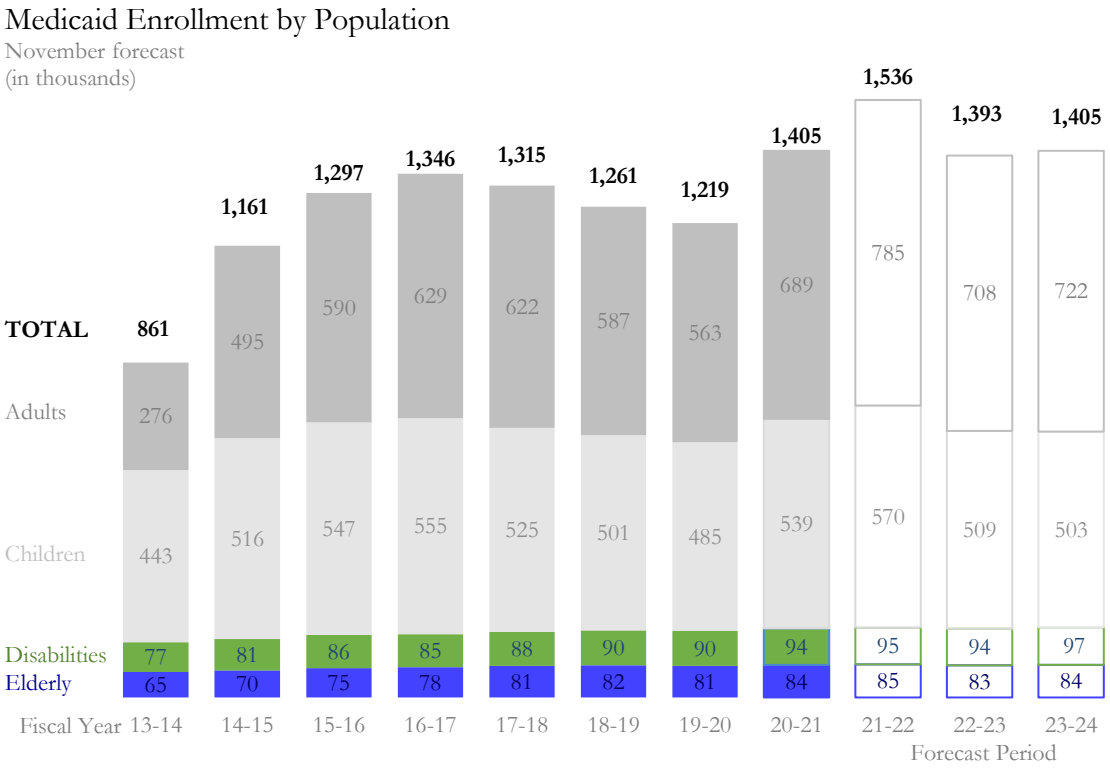
The table below shows enrollment over time separated into traditional populations where the state match is financed primarily from the General Fund and expansion populations where the state match is financed from the HAS Fee and the state receives an enhanced federal match. The chart includes labels for major events, such as eligibility expansions, recessions, and the federal COVID-19 public health emergency declaration. During the federal COVID-19 public health emergency declaration states are not allowed to disenroll people based on income or family size. As a result, the Department projects a large correction to the Medicaid enrollment trend a few months after the emergency declaration expires.



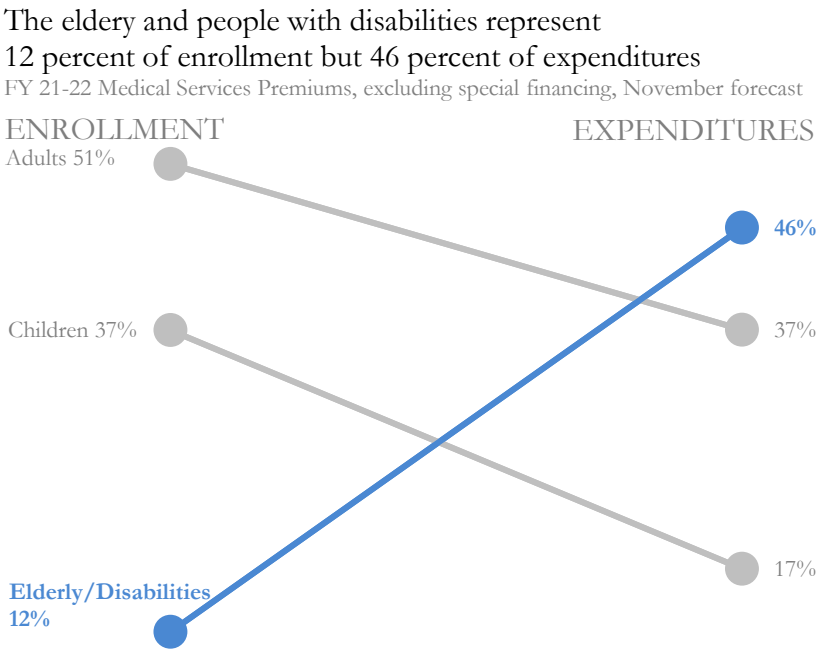

Appropriations for Medicaid are divided into six main components, not including administration: (1) Medical Services Premiums; (2) Behavioral Health Community Programs; (3) the Office of Community Living; (4) the Indigent Care Program; (5) the Medicare Modernization Act State Contribution; and (6) programs administered by other departments. The subsections below discuss each in more detail.

## (1) Medical Services Premiums

Medical Services Premiums is a subset of Medicaid expenditures that pays for physical health care and most long-term services and supports. Medical Services Premiums can be further divided into direct expenditures for services and into special financing. The direct expenditures are driven by the number of Medicaid clients, the costs of services, and the utilization of services. The special financing expenditures are more dependent on state and federal policy parameters. Medicaid serves a large number of low income adults and children.




However, the adults and children are relatively inexpensive compared to the elderly and people with disabilities served by Medicaid. The elderly and people with disabilities represent only 12 percent of the Medicaid enrollment but 46 percent of direct expenditures for services in Medical Services Premiums. This is partly due to higher acuity and medical costs but also to their utilization of long-term services and supports.

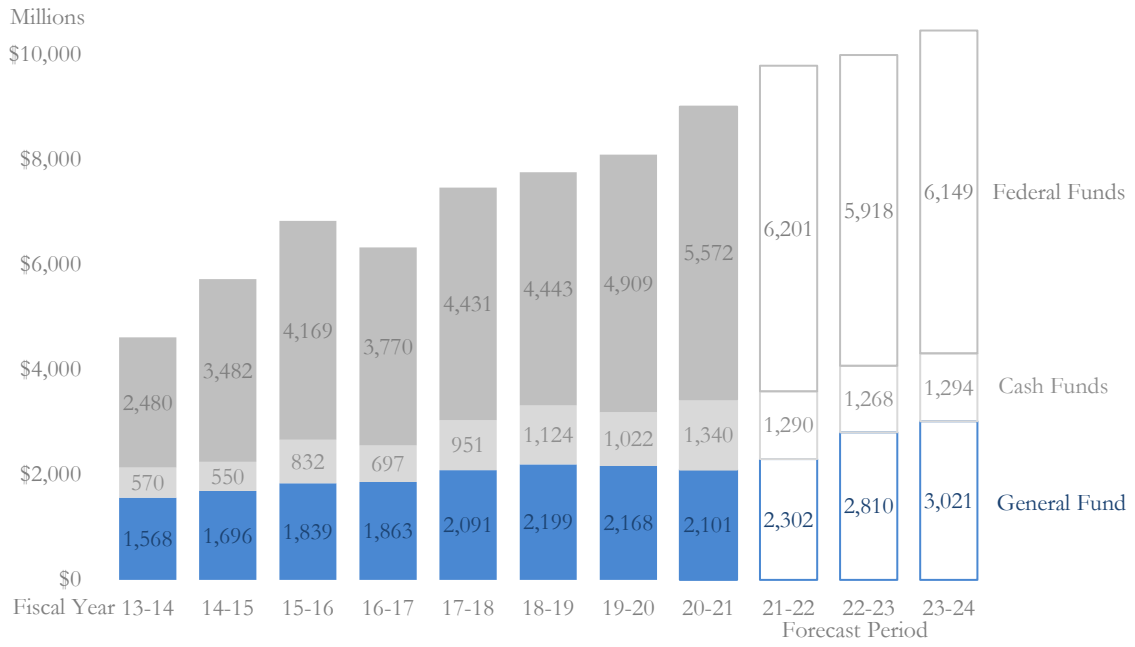


The elderly and people with disabilities are an even more disproportionate share of General Fund expenditures, due to the ways the state and federal government finance different populations and the services they use. For example, for nearly 70 percent of the adult enrollment there is no General Fund cost because they are expansion populations that qualify for an enhanced 90 percent federal match and the state match comes from the HAS Fee. As a result, the elderly and people with disabilities account for 12 percent of Medicaid enrollment but roughly 72 percent of direct General Fund expenditures for services in Medical Services Premiums.

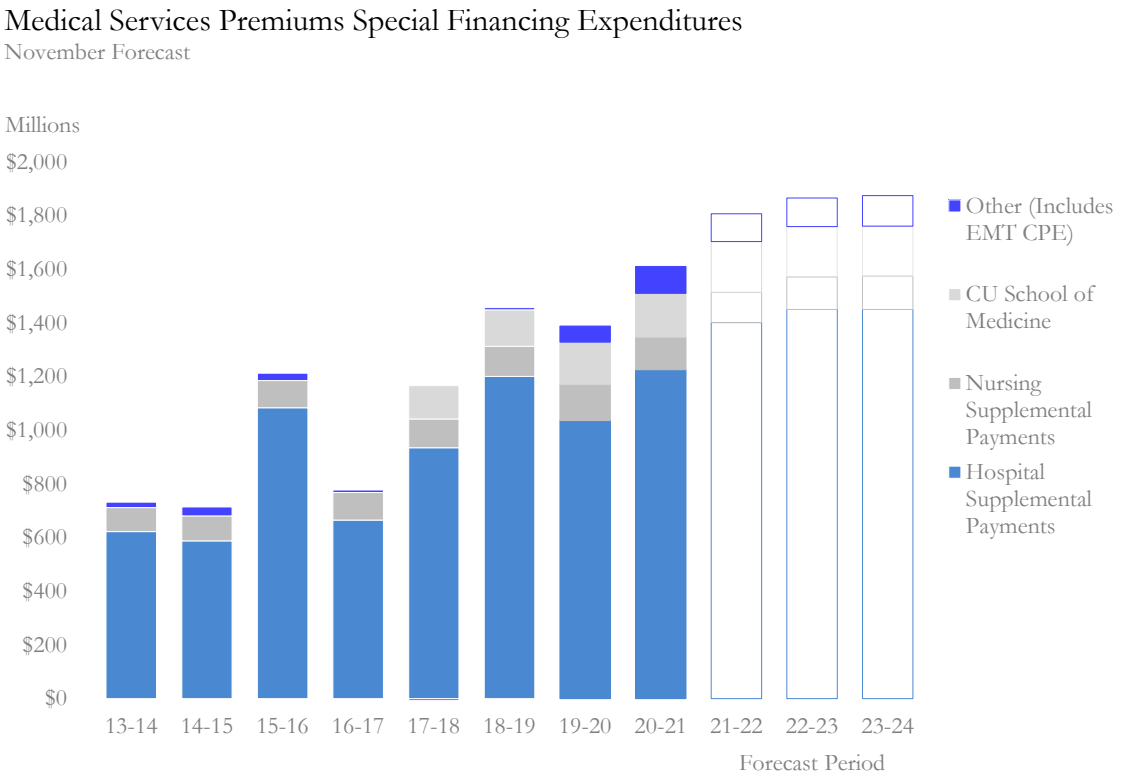
A big piece of why the elderly and people with disabilities are so expensive is their utilization of long-term services and supports. Long-term services and supports in this context includes nursing homes, in-home nursing assistance, in-home therapy services, and a wide variety of home and community assistance that helps people with medical needs stay at home rather than in an institution. The last category might include things like assistance with feeding, bathing, and clothing, transportation, adult day centers, respite care, and hospice. Long-term services and supports are an estimated 31 percent of total funds and 43 percent of General Fund expenditures for direct services in Medical Services Premiums.

When looking at Medical Services Premiums expenditures by fund source it becomes apparent that the General Fund trend is more commensurate with the enrollment of the elderly and people with disabilities than overall enrollment. The dips in General Fund in FY 2019-20 and FY 2020-21 are primarily attributable to the temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act and temporary financing from the HAS Fee authorized by H.B. 20-1386.

Medical Services Premiums Expenditures by Fund Source
November forecast

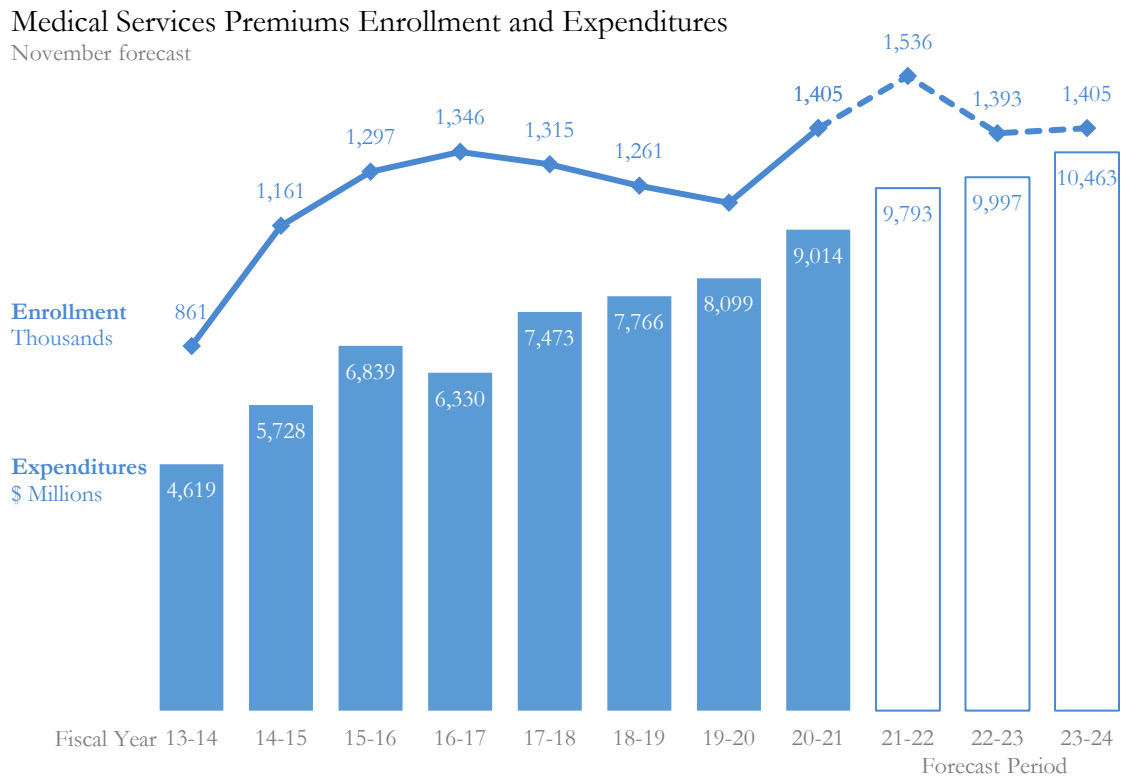


In addition to payments for direct services, the Medical Services Premiums section also includes indirect special financing through provider fees, certified public expenditures, and interagency transfers for providers like hospitals, nursing homes, and the physicians of the University of Colorado's School of Medicine. A portion of the Healthcare Affordability and Sustainability (HAS) Fee, which replaced the Hospital Provider Fee, pays for enrollment expansion, but the majority of the fee matches federal funds in order to make supplemental payments back to hospitals based on the amount of services they provide to low-income clients. Delays in federal approval of Colorado's provider fee plan caused a spike in hospital supplemental payments in state FY 2015-16 and then the legislature limited expenditures in FY 2016-17 when revenue from the provider fee was projected to increase the TABOR refund obligation from the General Fund. The Nursing Facility Fee works in a similar way to the HAS Fee, but to boost payments for nursing homes rather than hospitals. Beginning in FY 2017-18, the General Assembly authorized interagency transfers between the Department of Higher Education and the Department of Healthcare Policy and Financing to increase payments for physicians of the University of Colorado's School of Medicine. Beginning in FY 2019-20 Colorado started certifying public expenditures by local public emergency transportation providers to draw additional federal matching funds for these providers. Federal and state policies setting parameters on these types of special financing influence expenditures more than Medicaid enrollment, utilization, and cost of care patterns.




The chart below puts direct expenditures for services together with special financing and enrollment to show the full picture. As noted previously, enrollment is the most significant factor affecting overall Medicaid expenditures. In FY 2015-16 there was a spike in special financing, noted above, that helps explain why overall expenditures were higher in that year. In FY 2016-17 the Department implemented a new billing system that caused some payment delays and made expenditures shift from

FY 2016-17 to FY 2017-18. From FY 2017-18 through FY 2019-20 the enrollment of expensive populations of the elderly and people with disabilities continued to rise even though overall enrollment declined, helping to explain why expenditures increased when overall enrollment was falling.




## (2) Behavioral Health Community Programs

Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Regional Accountable Entities (RAEs) to provide or arrange for behavioral health services for clients enrolled with each RAE[4]. Each RAE receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services and enrolled with the RAE. The "per-member-per-month" rates paid to each RAE are unique for each Medicaid eligibility category in each geographic region. These rates are periodically adjusted based on clients' actual utilization of behavioral health services and the associated expenditures.

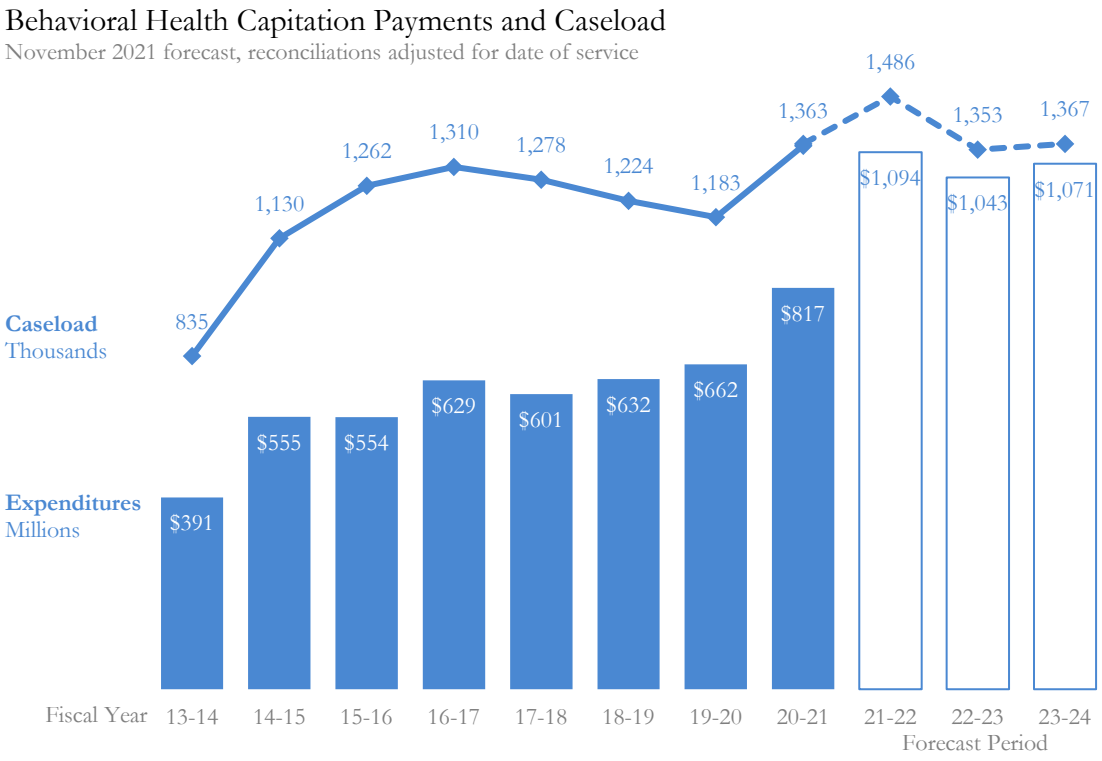
Behavioral health services are primarily supported by the General Fund and federal funds. For adults who are "newly eligible" pursuant to the federal Affordable Care Act the state receives a 90 percent federal match and the state share of costs is financed with the Healthcare Affordability and Sustainability (HAS) Fee. Services for these expansion adults represent a significant portion of total expenditures, but General Fund expenditures are driven more by children (because there are a lot of them) and people with disabilities (because the per capita expenditures are high).

[4] Clients are attributed to RAEs based on the location of their primary care provider, rather than their own address.

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver programs that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. Changes in the federal match rate for various eligibility categories also affect the State's share of expenditures.

There can be lags between when changes in utilization and cost of care are picked up in the behavioral health rates. For example, in FY 2015-16 capitation rates for many eligibility groups went down based on cost of care data from the prior year, helping to explain why overall expenditures decreased that year when overall enrollment increased.

Regarding recent trends, in FY 2017-18 rates went down due to a change in federal managed care rules that limited how much Colorado could pay providers. In FY 2018-19 and FY 2019-20 the reductions in overall caseload were primarily in low utilizers of behavioral health services and the remaining members were higher utilizers, resulting in an increase in rates. In FY 2021-22 the rates came in higher than expected, primarily due to a higher percentage of Medicaid clients utilizing behavioral health services and partly due to an increase in substance use disorder treatment capacity. The projected decrease in FY 2022-23 is related to the expected end of the public health emergency and the federal prohibition on disenrolling Medicaid clients.




With two exceptions, the caseload reported in the graph above is the same as the Medicaid enrollment, since behavioral health is paid per member per month. It is not the same as the number of utilizers of behavioral health services. The first exception is non-citizens, because for this population Medicaid covers emergency health services but not behavioral health. The second exception is elderly adults

who qualify for Medicaid assistance with their Medicare premiums but have too much income to qualify for full Medicaid benefits. For these elderly adults Medicare covers behavioral health under Medicare's policies.

## (3) Office of Community Living

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. Colorado has four Medicaid waivers for individuals who qualify for intellectual and developmental disability services:

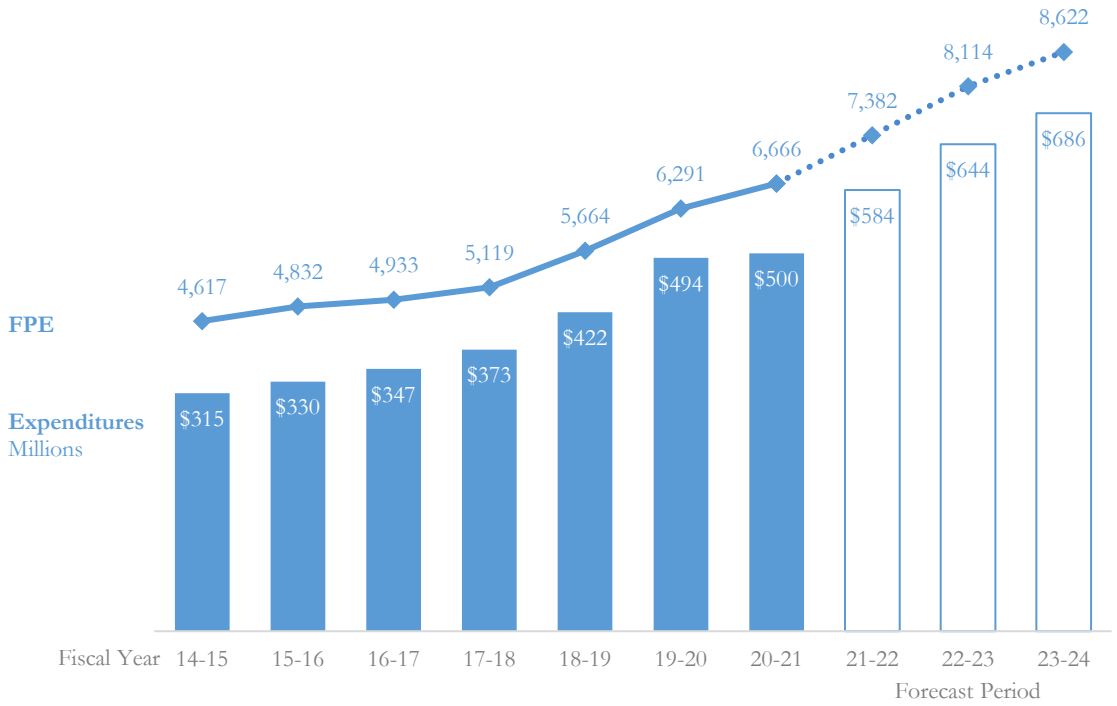
- Adult Comprehensive/Developmental Disabilities waiver (DD waiver) is for individuals over the age of 18 who require residential and daily support services to live in the community.
- Supported Living Services waiver (SLS waiver) is for individuals over the age of 18 who do not require residential services but require daily support services to live in the community.
- Children's Extensive Services waiver (CES waiver or children's waiver) is for youth aged 5 to 18 who do not require residential services but do require daily support services to be able to live in their family home.
- Children's Habilitation Residential Services waiver (CHRP waiver) is for children with intellectual and developmental disabilities and complex behavioral support needs requiring home- and community-based services.

As part of the waivers, Colorado is allowed to limit the number of waiver program participants. Annually, the General Assembly appropriates sufficient funding to ensure no waiting list for the SLS, CES, and CHRP waivers.

The FY 2020-21 average monthly enrollment on the DD waiver was 6,802, up 7.7 percent from the previous fiscal year. As of June 30, 2021, 2,819 individuals were identified as needing DD services as soon as available, a decrease of 4.7 percent from the previous year. While the majority of these individuals receive services through other programs, including the SLS waiver, some may not be receiving the level of services required to meet their needs. New DD waiver enrollments are funded annually for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and individuals transitioning from institutions.

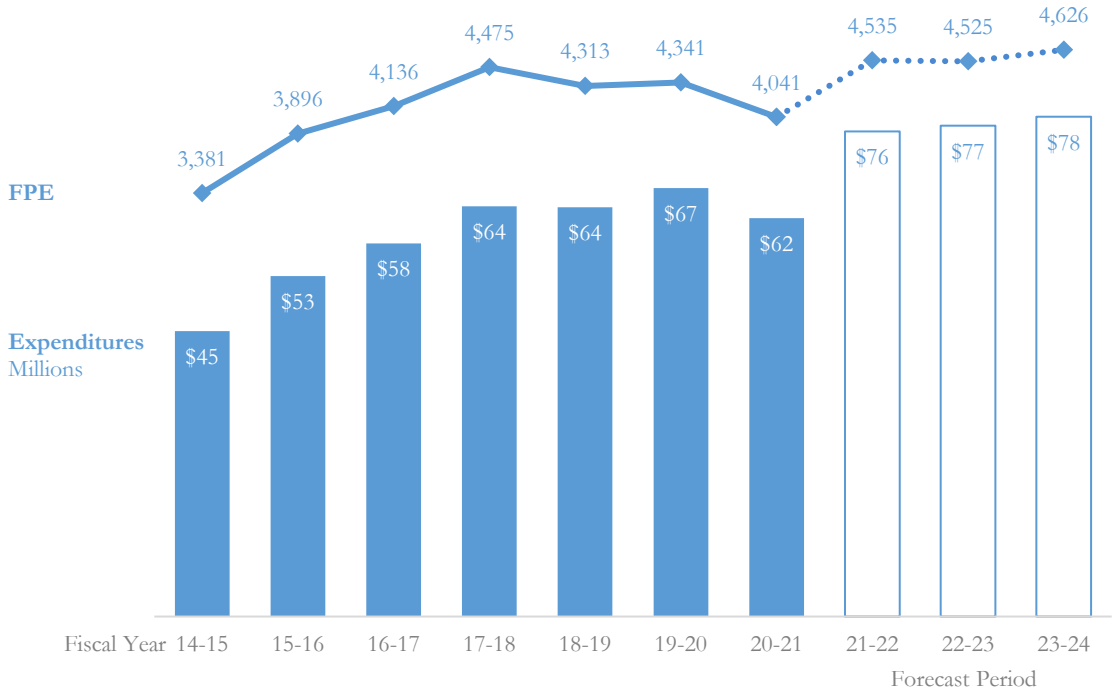
The Comprehensive waiver provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports.

Comprehensive Services



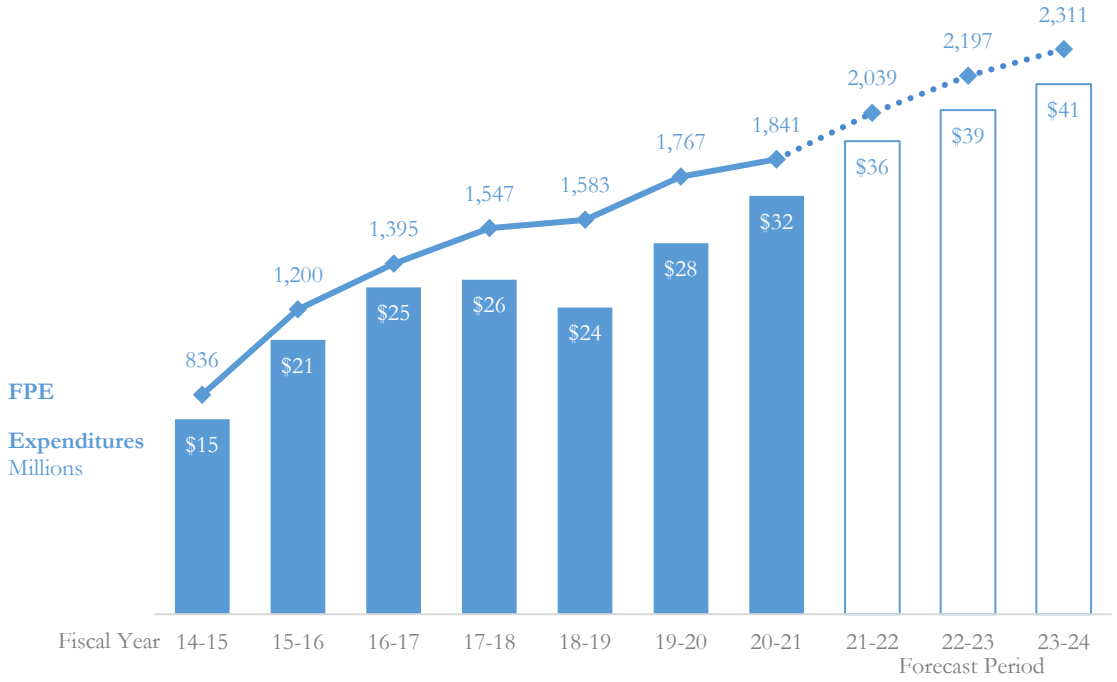

The Supported Living Services (SLS) waiver provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports.

Supported Living Services



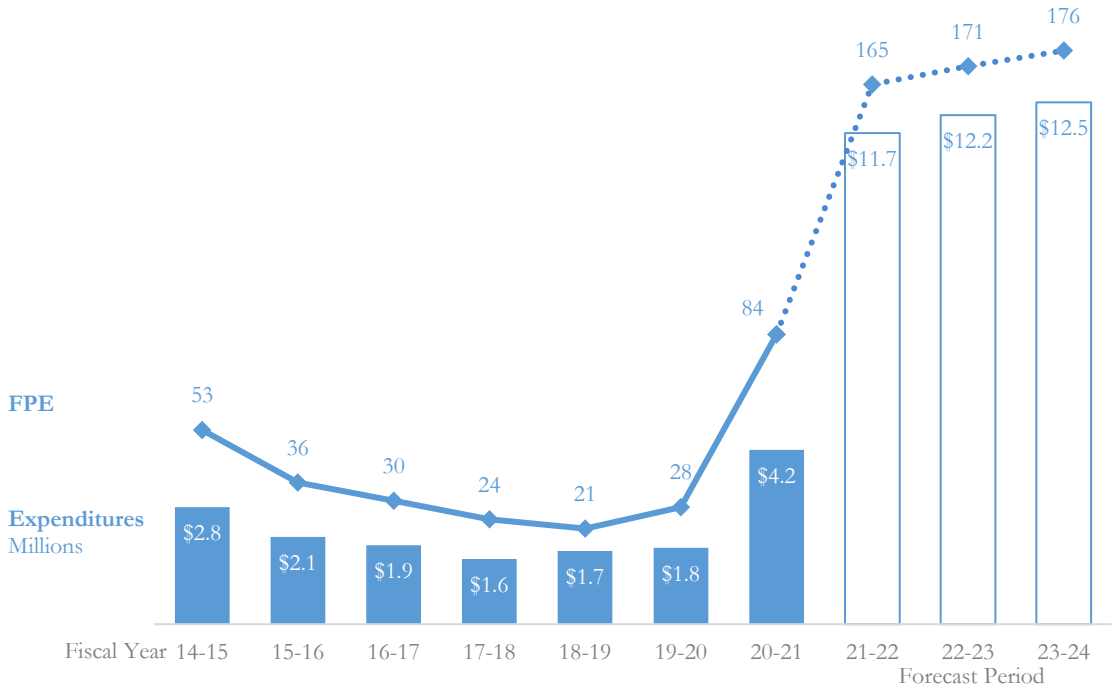
The Children's Extensive Support (CES) waiver provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood.

Children's Extensive Support



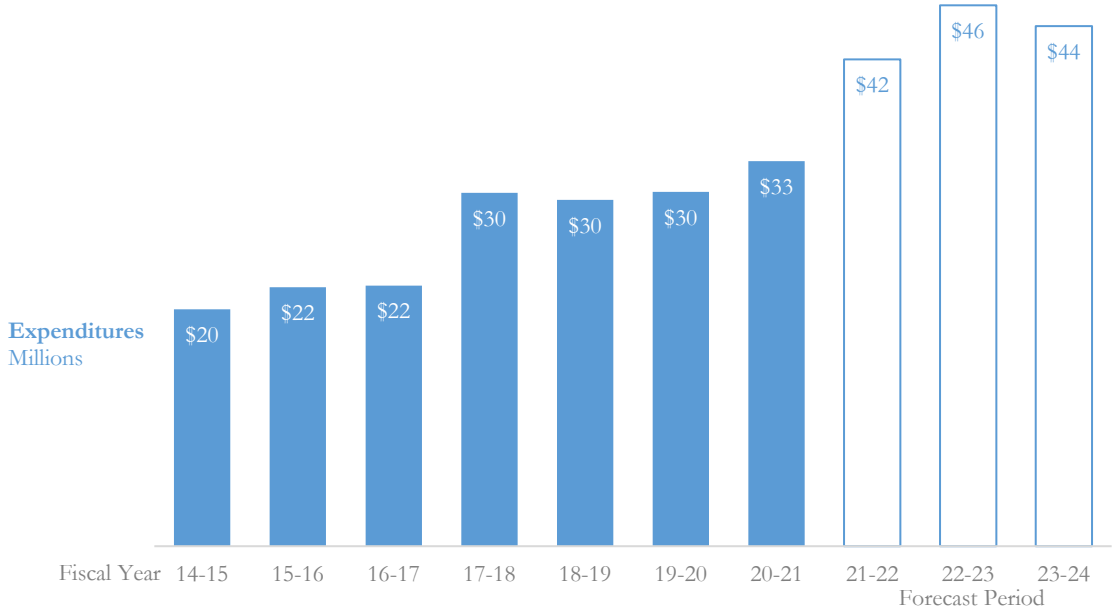

The Children's Habilitation Residential Program (CHRP) waiver provides residential services for children and youth in foster care or at risk of child welfare involvement who have a developmental disability and very high needs that put them at risk for institutional care.

Children's Residential Habilitation

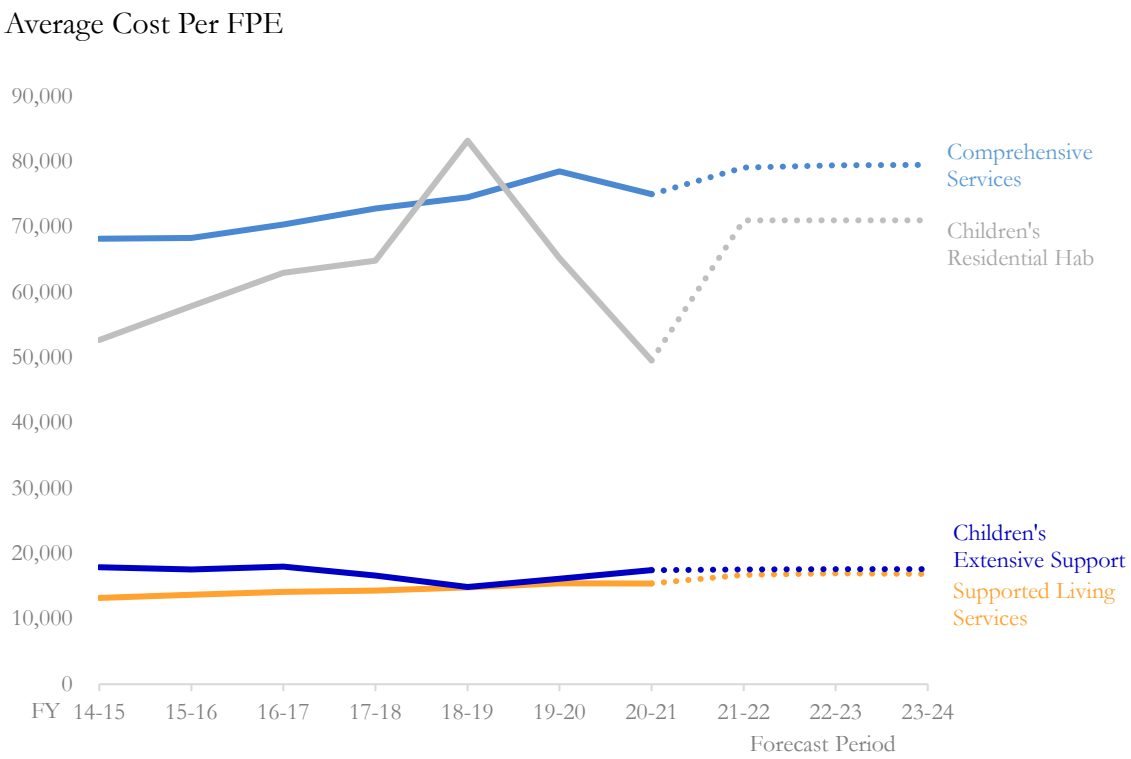



Targeted Case Management (TCM) provides assessment of each client's long-term care needs, the development and implementation of personalized care plans, coordination and monitoring of the delivery of services, and evaluation of the effectiveness of services.

Targeted Case Management



The average number of individuals receiving a billable service at a given time is referred to as Full Person Equivalent (FPE).




## (4) INDIGENT CARE PROGRAM

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Participating providers agree to accept reduced payments, on a sliding scale based on income, from people enrolled in the program. In exchange, the providers receive supplemental Medicaid payments. To qualify for the program people must make less than 250 percent of the federal poverty guidelines and be ineligible for Medicaid or CHP+.

Federal and state policies influence funding more than the number of individuals served, utilization, or the cost of services. The majority of the funding is from federal sources. State funds for the program come from provider fees paid by hospitals and the General Fund.

Most of the money goes to hospitals through the federal Disproportionate Share Hospital program that allows supplemental Medicaid payments to hospitals that serve a high number of indigent clients. Revenue from the provider fee on hospitals serves as the state match. In addition, there is a special pediatric hospital supplemental payment with a state match from the General Fund.

Related to the Indigent Care Program there is a primary care grant program financed with tobacco taxes that serves a similar purpose of paying providers who treat patients regardless of insurance using a sliding fee schedule based on income. The primary care grant program has distinct constitutional payment criteria and there are some eligible providers that do not participate in Medicaid. However,

S.B. 21-212 (Moreno/McCluskie) instructed the Department to align the primary care grant program more closely with the Indigent Care Program such that almost all of the primary care payments now qualify for a Medicaid match. Simultaneously, the General Assembly stopped appropriating General Fund for clinic based indigent care. The net result was a General Fund savings and an increase in payments to providers.

| INDIGENT CARE PROGRAM | | | |
|---|---|---|---|
| | FY 2020-21 ACTUAL | FY 2021-22 APPROPRIATION | FY 2022-23 REQUEST |
| **Hospital Payments** | | | |
| Safety Net Provider Payments | $135,548,026 | $257,909,481 | $261,184,109 |
| Pediatric Specialty Hospital | 10,764,010 | 10,764,010 | 10,764,010 |
| Total Funds | $146,312,036 | $268,673,491 | $271,948,119 |
| General Fund | 4,714,636 | 5,048,321 | 5,382,005 |
| Cash Funds (HAS Fee) | 67,774,013 | 119,466,874 | 133,577,400 |
| Federal Funds | 73,823,387 | 144,158,296 | 132,988,714 |
| | | | |
| **Clinic Payments** | | | |
| Clinic Based Indigent Care | $6,039,386 | $0 | $0 |
| Primary Care Fund | 24,666,536 | 50,703,870 | 50,703,870 |
| Total Funds | $30,705,922 | $50,703,870 | $50,703,870 |
| General Fund | 2,645,251 | 0 | 0 |
| Cash Funds (tobacco tax) | 24,666,536 | 25,373,115 | 25,373,115 |
| Federal Funds | 3,394,135 | 25,330,755 | 25,330,755 |
| | | | |
| **Total Indigent Care** | **$177,017,958** | **$319,377,361** | **$322,651,989** |
| General Fund | 7,359,887 | 5,048,321 | 5,382,005 |
| Cash Funds | 92,440,549 | 144,839,989 | 158,950,515 |
| Federal Funds | 77,217,522 | 169,489,051 | 158,319,469 |

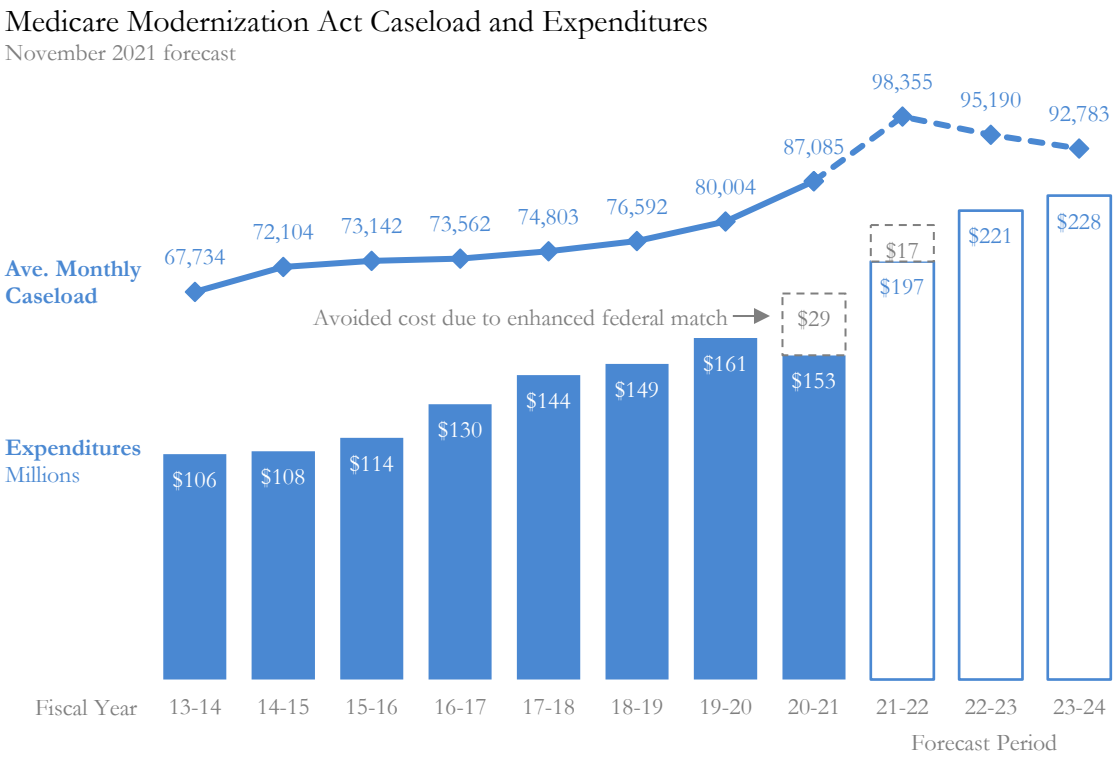
Appropriations prior to FY 2020-21 are not comparable due to technical changes to the format of the appropriations.

## (5) MEDICARE MODERNIZATION ACT

The federal Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid in Medicaid, as estimated by a federal formula.

The state's obligation is influenced by the number of people dually eligible for Medicare and Medicaid and estimates in the federal formula of drug prices and utilization. Expenditures have been growing faster than caseload due to increasing prices for pharmaceuticals.

This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes. The end of the temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act explains a significant portion of the projected increase in the MMA obligation in FY 2022-23. The MMA payment is typically made from the General Fund with rare exceptions when Colorado used alternate fund sources.

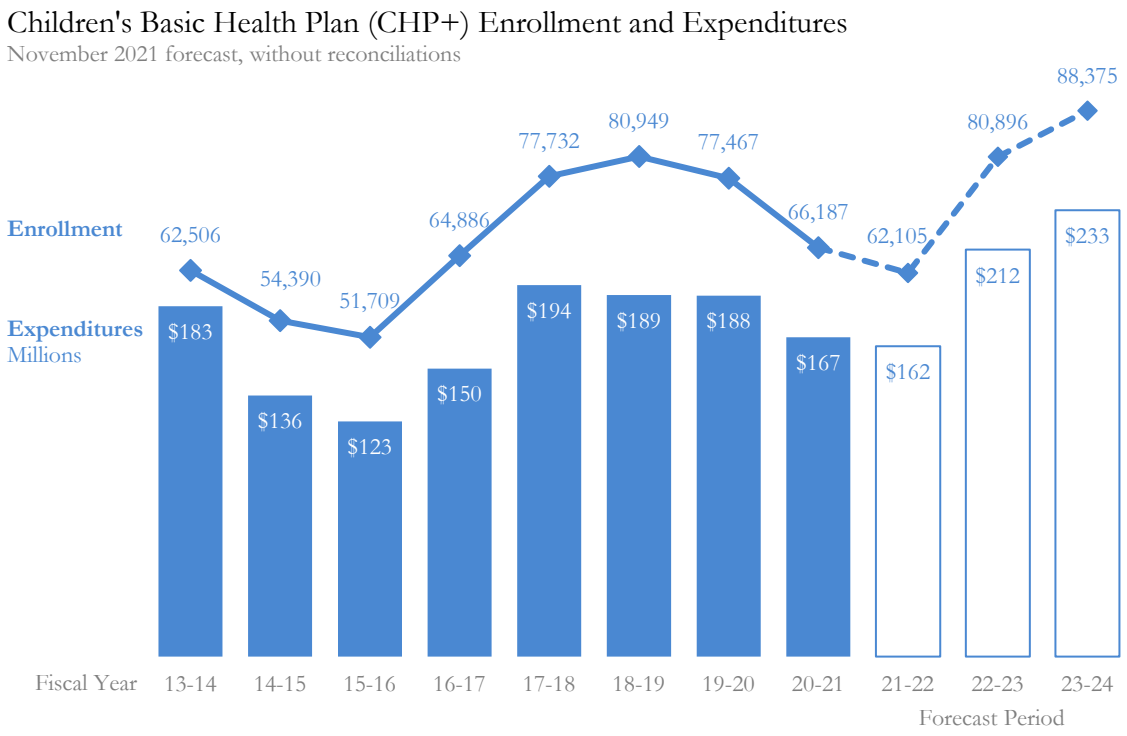



## CHILDREN'S BASIC HEALTH PLAN

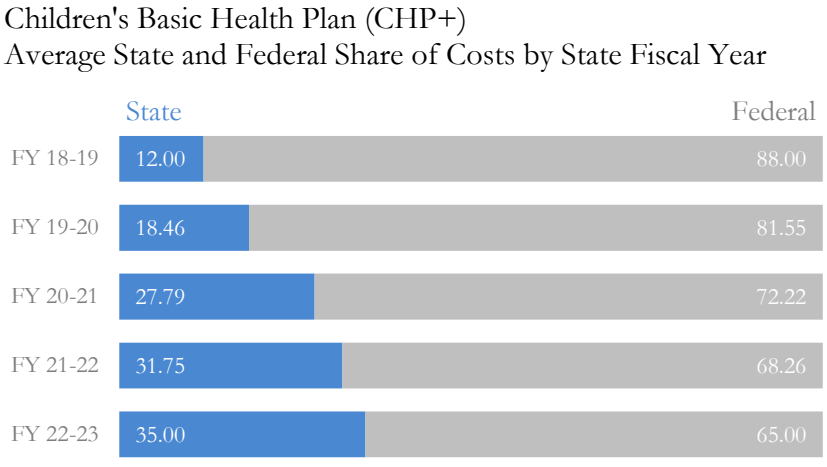
The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with more income than the Medicaid eligibility criteria allow, effectively to 265 percent[5] of the federal poverty guidelines or $58,194 annually for a family of three. Annual membership premiums vary based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines. Coinsurance costs are nominal.

Historically, enrollment in CHP+ has been highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. Sometimes when Medicaid enrollment decreases CHP+ enrollment increases, and vice versa, as people transition between the two programs. In addition, CHP+ has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations.

[5] In statute the income limit is 250 percent of the federal poverty guidelines, but with federally mandated standard income disregards, the effective income limit is 265 percent.




Federal funds match state funds for program costs not covered by member contributions. The federal match rate for CHP+ is derived from the standard FMAP for Medicaid. Federal policies provided a temporary boost to the match rates for federal fiscal years 2015-16 through 2019-20. The expected standard federal match rate for Colorado for federal fiscal year 2020-21 through federal fiscal year 2026-27 is 65 percent, but the temporary increase in the federal match rate for Medicaid authorized by the federal Families First Coronavirus Response Act plays through the formula that determines the federal match rate for CHP+ to provide an increase.




CHP+ typically receives roughly $15 million in revenue from the tobacco master settlement agreement distribution formula and some of the state match for higher income children and pregnant adults comes from the HAS Fee. Any remaining state match comes from the General Fund.

# SUMMARY: FY 2021-22 APPROPRIATION & FY 2022-23 REQUEST

| DEPARTMENT OF HEALTH CARE POLICY AND FINANCING | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| FY 2021-22 APPROPRIATION: | | | | | | |
| S.B. 21-205 (Long Bill) | 13,259,364,597 | 3,424,327,111 | 1,551,766,954 | 97,905,609 | 8,185,364,923 | 581.9 |
| Other Legislation | 20,429,443 | (77,611,385) | 43,716,468 | (10,231,185) | 64,555,545 | 19.5 |
| **TOTAL** | **$13,279,794,040** | **$3,346,715,726** | **$1,595,483,422** | **$87,674,424** | **$8,249,920,468** | **601.4** |
| FY 2022-23 REQUESTED APPROPRIATION: | | | | | | |
| FY 2021-22 Appropriation | $13,279,794,040 | 3,346,715,726 | $1,595,483,422 | $87,674,424 | $8,249,920,468 | 601.4 |
| R1 Medical Services Premiums | (34,349,234) | 203,211,855 | 39,321,653 | (785,199) | (276,097,543) | 0.0 |
| R2 Behavioral health | 17,894,411 | 23,043,372 | 5,181,553 | 0 | (10,330,514) | 0.0 |
| R3 Child Health Plan Plus | 37,398,301 | 11,373,603 | 5,647,506 | 0 | 20,377,192 | 0.0 |
| R4 Medicare Modernization Act | 27,863,762 | 27,863,762 | 0 | 0 | 0 | 0.0 |
| R5 Office of Community Living | 36,542,346 | 41,134,323 | 956,424 | 0 | (5,548,401) | 0.0 |
| R6 Value-based payments | 22,850,574 | 7,403,648 | (7,197) | 0 | 15,454,123 | 9.6 |
| R7 Utilization management | (3,011,223) | (1,512,985) | 116,559 | 0 | (1,614,797) | 0.0 |
| R8 County administration | (590,849) | 461,138 | 1,936,919 | 0 | (2,988,906) | 5.9 |
| R9 OCL Program enhancements | 2,452,715 | 1,872,153 | 0 | 0 | 580,562 | 0.0 |
| R10 Provide rates | 104,434,828 | 41,327,629 | 5,966,149 | 0 | 57,141,050 | 0.0 |
| R11 ACC and CHP accountability | (1,048,141) | (351,127) | 0 | 0 | (697,014) | 2.0 |
| R12 Convert contracts to FTE | (339,518) | (155,265) | (60,722) | 370,586 | (494,117) | 23.2 |
| R13 Compliance FTE | (4,678,266) | (2,393,350) | 108,434 | 0 | (2,393,350) | 10.8 |
| R14 MMIS True up and administration | (56,079,142) | (10,347,479) | (2,753,052) | 0 | (42,978,611) | 12.5 |
| R15 All-Payer Claims Database | 200,000 | 200,000 | 0 | 0 | 0 | 0.0 |
| R16 Urban Indian Health | 48,025 | 48,025 | 0 | 0 | 0 | 0.0 |
| R17 SBIRT training | (250,000) | 0 | (250,000) | 0 | 0 | 0.0 |
| Annualize prior year budget actions | 109,575,600 | 91,856,728 | (35,116,696) | 5,159,407 | 47,676,161 | 5.1 |
| Federal match for HCBS | 412 | 210,225,626 | 19,002,579 | 0 | (229,227,793) | 0.4 |
| Centrally appropriated items | 4,033,590 | 1,990,296 | 121,808 | 56,734 | 1,864,752 | 0.0 |
| Human Services | 3,018,914 | 1,509,455 | 0 | 0 | 1,509,459 | 0.0 |
| NP Equity officers | 216,966 | 0 | 0 | 108,483 | 108,483 | 2.0 |
| Transfers to other state agencies | 141,804 | 53,758 | 0 | 0 | 88,046 | 0.0 |
| Tobacco forecast | (20,676) | 0 | (20,676) | 0 | 0 | 0.0 |
| **TOTAL** | **$13,546,099,239** | **$3,995,530,891** | **$1,635,634,663** | **$92,584,435** | **$7,822,349,250** | **672.9** |
| **INCREASE/(DECREASE)** | $266,305,199 | $648,815,165 | $40,151,241 | $4,910,011 | ($427,571,218) | 71.5 |
| Percentage Change | 2.0% | 19.4% | 2.5% | 5.6% | (5.2%) | 11.9% |

## DESCRIPTION OF INCREMENTAL CHANGES

**R1 MEDICAL SERVICES PREMIUMS:** The Department requests a net decrease of $34.3 million total funds, including an increase of $203.2 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. *See the issue brief "Forecast Trends" for more information.*

**R2 BEHAVIORAL HEALTH PROGRAMS:** The Department requests a net increase of $17.9 million total funds, including an increase of $23.0 million General Fund, for projected changes in caseload,

per capita expenditures, and fund sources for behavioral health services. *See the issue brief "Forecast Trends" for more information.*

**R3 CHILD HEALTH PLAN PLUS:** The Department requests an increase of $11.4 million total funds, including $5.6 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. *See the issue brief "Forecast Trends" for more information.*

**R4 MEDICARE MODERNIZATION ACT:** The Department requests an increase of $27.9 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. *See the issue brief "Forecast Trends" for more information.*

**R5 OFFICE OF COMMUNITY LIVING:** The Department requests a net increase of $36.5 million total funds, including an increase of $41.1 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the issue brief "Forecast Trends" for more information.*

**R6 VALUE-BASED PAYMENTS:** The Department requests an increase of $22.9 million total funds, including $7.4 million General Fund, and 9.6 FTE for the planning and implementation of three alternative payment models, including shared savings for pharmacy prescribers, bundled payments in maternity care, and partial capitation payments to primary care providers. The Department indicates that funding is for the implementation of an evidence-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget). *See the issue brief "Value-based Payments" for more information.*

**R7 UTILIZATION MANAGEMENT:** The Department requests a net decrease of $3.0 million total funds, including a decrease of $1.5 million General Fund, to expand and strengthen utilization management measures in the Medicaid program. The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**R8 COUNTY ADMINISTRATION:** The Department requests a net decrease of $0.6 million total funds, including an increase of $461,138 General Fund, and 5.9 FTE to:

- Address county administration funding issues;
- Increase funding for pay-for-performance though the County incentives Program allocation;
- Hire addition staff to provide proper fiscal and programmatic oversight of county administrative-related activities; and
- Reduce the amount of time it takes to conduct on-site compliance reviews of all 64 counties.

The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**R9 OFFICE OF COMMUNITY LIVING (OCL) PROGRAM ENHANCEMENTS:** The Department requests an increase of $2.5 million total funds, including $1.9 million General Fund, to:

- Increase rates and expand benefits for services offered through the Home- and Community-based (HCBS) waivers;
- Increase provider bed capacity; and
- Create additional opportunities for care in the community.

The Department indicates that funding is for the implementation of both evidence-informed and theory-informed programs as defined in S.B. 21-284 (Evidence-based evaluation for budget). *See the issue brief "Provider Rates" for more information concerning rate adjustments.*

**R10 PROVIDER RATES:** The Department requests an increase of $104.4 million total funds, including $41.3 million General Fund, for changes to provider rates. The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget). *See the issue brief "Provider Rates" for more information.*

| R10 PROVIDER RATE ADJUSTMENTS | | | | | |
|---|---|---|---|---|---|
| RATE | CHANGE | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| Across the board rate adjustment | 0.5 percent increase | $32,230,602 | $11,432,806 | $1,499,074 | $19,298,722 |
| Targeted rate increases | | | | | |
| Durable medical equipment | Rebalancing (between 80 and 100 percent) | $1,596,720 | $798,360 | $0 | $798,360 |
| Massage therapy | 34.5 percent increase | 27,293 | 13,647 | 0 | 13,646 |
| Non-emergent medical transport | Increase rates below 60.8 percent up to 60.8 percent | 22,816,821 | 7,393,642 | 4,014,769 | 11,408,410 |
| Emergency medical transport | Increase rates below 50 percent up to 50 percent | 8,298,520 | 1,948,546 | 453,943 | 5,896,031 |
| Non-medical transport | Increase rates below 70 percent up to 70 percent | 3,046,513 | 1,523,256 | 0 | 1,523,257 |
| Speech therapy | Rebalancing (between 70 percent and 100 percent) | 1,134,728 | 567,364 | 0 | 567,364 |
| Home- and community-based services | Maintain $15/hr wage through remainder of FY 2022-23 | 33,373,436 | 16,686,725 | 0 | 16,686,711 |
| SUBTOTAL TARGETED RATE INCREASES | | $70,294,031 | $28,931,540 | $4,468,712 | $36,893,779 |
| Changes to member contributions | | | | | |
| Changes to copayments | Increase from $6 to $8 | ($26,920) | ($5,275) | ($1,637) | ($20,008) |
| Personal needs allowance | Increase from $152.00 to $383.33 | 1,937,115 | 968,558 | 0 | 968,557 |
| SUBTOTAL CHANGES TO MEMBER CONTRIBUTIONS | | $1,910,195 | $963,283 | ($1,637) | $948,549 |
| **TOTAL PROVIDER RATE ADJUSTMENTS** | | **$104,434,828** | **$41,327,629** | **$5,966,149** | **$57,141,050** |

**R11 ACC AND CHP+ ACCOUNTABILITY:** The Department requests an increase of $210,178 total funds, including $52,409 General Fund, and 2.0 FTE to increase oversight of the Accountable Care Collaborative (ACC) and the Child Health Plan Plus (CHP+). In addition, the Department requests a net reduction of $1,258,319 total funds, including a reduction of $403,536 General Fund, to true up appropriations for the contract administration of CHP+ with expected expenditures. The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

| R11 ACC & CHP+ ACCOUNTABILITY | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| ACC Oversight | $104,818 | $52,409 | $0 | $52,409 | 1.0 |
| CHP+ Oversight | 105,360 | 0 | 36,876 | 68,484 | 1.0 |
| **Subtotal** | **$210,178** | **$52,409** | **$36,876** | **$120,893** | **2.0** |
| | | | | | |
| CHP+ Contract admin true-up | (1,258,319) | (403,536) | (36,876) | (817,907) | 0.0 |
| | | | | | |
| **Total** | **($1,048,141)** | **($351,127)** | **$0** | **($697,014)** | **2.0** |

**R12 CONVERT CONTRACTS TO FTE:** The Department requests a net decrease of $0.3 million total funds, including a decrease of $0.2 million General Fund, and 23.2 FTE to repurpose funding from contractor resources to hire FTE. The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**R13 COMPLIANCE FTE:** The Department requests a net decrease of $4.7 million total funds, including a decrease of $2.4 million General Fund, to expand and strengthen operational compliance and program oversight and accountability. The Department indicates that funding is for the implementation of an evidence-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**R14 MMIS TRUE-UP AND ADMINISTRATION:** The Department requests a decrease of $56.1 million total funds, including $10.3 million General Fund, and 12.5 FTE to accurately reflect current costs associated with operating the Medicaid Management Information Systems (MMIS) and current federal match rates. *See the issue brief "Medicaid Management Information Systems" for more information.*

**R15 ALL-PAYER CLAIMS DATABASE:** The Department requests an increase of $200,000 General Fund to partially restore funding for the All-Payer Claims Database Scholarship Program. The funding was eliminated in FY 2020-21 as part of budget balancing reductions. The Department indicates that funding is for the implementation of a theory-informed practice as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**R16 URBAN INDIAN HEALTH:** The Department proposes short-duration state-only payments to Urban Indian Health Organizations equal to the estimated General Fund savings from a provision of the American Rescue Plan Act that temporarily grants a 100 percent federal match for services to Medicaid clients by Urban Indian Health Organizations. Denver Indian Health and Family Services is the only Urban Indian Health Organization in Colorado. The proposed funding is intended to: (1) address current gaps in clinical operations and guarantee long-term sustainability for the providers; and (2) address health care disparities that are exasperated by the pandemic, including lower vaccination rates in under-resourced communities. In January the Department will submit a corresponding supplemental requesting funds in FY 2021-22. The Department indicates that funding is for the implementation of an evidence-informed program as defined in S.B. 21-284 (Evidence-based evaluation for budget).

| R16 URBAN INDIAN HEALTH | |
|---|---|
| FISCAL YEAR | GENERAL FUND |
| FY 2021-22 | $70,825 |
| FY 2022-23 | 48,025 |
| **Cumulative Total** | **$118,850** |

**R17 SBIRT TRAINING:** The Department proposes a $250,000 reduction in Marijuana Tax Cash Fund revenues devoted to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) training program, reducing the total funding for FY 2022-23 to $500,000. According to the Department, the Office of State Planning and Budgeting's September forecast projects Marijuana Tax Cash Fund revenue more than 20 percent below the FY 2021-22 budget and there has been no formal evaluation or return on investment calculated for the SBIRT training program. The request would not change the funding for SBIRT services, which are still covered under Medicaid. It only impacts the SBIRT training program, which primarily[6] provides grants to train professionals to deliver SBIRT services. The Department indicates that funding is for the implementation of an evidence-informed program as defined in S.B. 21-284 (Evidence-based evaluation for budget).

**ANNUALIZE PRIOR YEAR BUDGET ACTIONS:** The request includes adjustments for out-year impacts of prior year legislation and budget actions, summarized in the table below. The titles of the annualizations begin with either a bill number or the relevant fiscal year. For budget decisions made in the Long Bill, the title includes a reference to the priority number the Department used in that year for the initiative, if relevant. If there is no reference to a bill number or priority number, then the change was initiated by an action other than a bill or request from the Department.

The largest General Fund increases are for the annualization of the following:

- S.B. 21.213 (Use of increased Medicaid match) that captured the benefit to certain cash funds provided by a temporary increase in the federal match rate and converted that benefit to General Fund relief;
- Addition of 667 waiting list enrollments onto the Home- and Community-based Services Comprehensive Waiver for individuals with intellectual and developmental disabilities;
- A 2.5 percent increase in rates paid to most community providers;
- S.B. 21-194 (Maternal health providers) that places new requirements on health providers and insurers, expands public health insurance coverage, and implements other initiatives related to maternal and perinatal health; and
- FY 2021-22 R18 Behavioral health program adjustments that decreased incentive payments that are based on provider service performance and quality metrics by 25 percent and to lower estimates of provider capacity and consequent utilization for the Substance Use Disorder benefit.

The largest decrease in General Fund is for the second year of FY 2021-22 R23 Behavioral health claims and eligibility process that integrated eligibility determinations, claims processing, and data reporting for various behavioral health programs statewide.

[6] Pursuant to statute, the money can also be used to provide consulting and technical services to providers, outreach, and care coordination.

| Annualized Prior Year Budget Actions | | | | | | |
|---|---|---|---|---|---|---|
| Item | Total Funds | General Fund | Cash Funds | Reappropriated Funds | Federal Funds | FTE |
| FY 21-22 R18 Behavioral health program adjustments | $43,447,378 | $6,149,232 | $3,251,364 | $0 | $34,046,782 | 0.0 |
| FY 21-22 Add 667 IDD enrollments | 19,974,650 | 10,468,169 | 0 | 0 | 9,506,481 | 0.0 |
| SB 21-194 Maternal health providers | 18,504,858 | 7,957,356 | 879,114 | 0 | 9,668,388 | (0.7) |
| SB 21-213 Use of increased Medicaid match | 11,679,436 | 57,330,334 | (57,330,334) | 5,115,593 | 6,563,843 | 0.0 |
| HB 20-1361 Reduce adult dental benefit | 11,130,000 | 0 | 2,941,728 | 0 | 8,188,272 | 0.0 |
| FY 21-22 2.5% Provider rate increase | 7,491,995 | 8,092,328 | (575,863) | 0 | (24,470) | 0.0 |
| FY 21-22 R20 MMIS annualization delay | 7,376,207 | 2,035,713 | 0 | 0 | 5,340,494 | 0.0 |
| FY 20-21 Local minimum wage adjustment | 6,273,126 | 3,136,561 | 0 | 0 | 3,136,565 | 0.0 |
| FY 20-21 BA13 Public school health services | 4,706,022 | 0 | 5,196,936 | 0 | (490,914) | 0.0 |
| FY 21-22 Decrease member copayment | 4,404,931 | 954,930 | 274,532 | 0 | 3,175,469 | 0.0 |
| SB 20-033 Medicaid buy-in age 65 and over | 2,879,621 | (248,611) | 1,816,181 | 0 | 1,312,051 | 0.0 |
| SB 21-025 Family planning services | 2,495,283 | 640,273 | 57,936 | 0 | 1,797,074 | (0.8) |
| HB 21-1275 Medicaid reimbursement for pharmacist | 2,423,343 | 798,411 | 192,919 | 0 | 1,432,013 | 0.4 |
| FY 21-22 R8 Supported living services flexibility | 940,719 | 470,360 | 0 | 0 | 470,359 | 0.0 |
| FY 21-22 NPBA1 CBMS PEAK | 755,237 | 377,416 | 42,560 | 17 | 335,244 | 0.0 |
| SB 21-038 Complementary and alternative medicine | 737,129 | 225,525 | 143,039 | 0 | 368,565 | 0.1 |
| FY 21-22 R11 Medicaid funding for Connect 4 Health | 482,663 | 0 | 189,918 | 0 | 292,745 | 0.0 |
| SB 18-200 PERA unfunded liability | 457,518 | 203,830 | 17,381 | 4,847 | 231,460 | 0.0 |
| FY 21-22 R10 Convert contractor resources to FTE | 306,688 | (738) | 6,070 | 0 | 301,356 | 0.5 |
| HB 21-1198 Health care billing for indigent care | 299,633 | 299,633 | 0 | 0 | 0 | 2.1 |
| FY 06-07 DI8 Fund nursing facility appraisals | 279,746 | 139,873 | 0 | 0 | 139,873 | 0.0 |
| FY 20-21 R19 Leased space | 173,278 | 71,839 | 14,799 | 0 | 86,640 | 0.0 |
| HB 21-1085 Secure transport behavioral health crisis | 139,300 | 104,717 | 5,433 | 0 | 29,150 | 0.1 |
| FY 21-22 Restore funding for SB 19-195 | 94,095 | 47,048 | 0 | 0 | 47,047 | 1.0 |
| HB 21-1232 Standardized health benefit CO Option | 80,289 | 80,289 | 0 | 0 | 0 | 1.2 |
| HB 21-1166 Behavioral health crisis response training | 67,680 | 67,680 | 0 | 0 | 0 | 0.0 |
| FY 19-20 R9 Adult LTHH/PDN clinical assessment | 36,710 | 18,355 | 0 | 0 | 18,355 | 0.0 |
| FY 19-20 Increase funding for IDD enrollment | 13,517 | 6,759 | 0 | 0 | 6,758 | 0.0 |
| FY 19-20 HUM NP12 Salesforce | 1,087 | 544 | 0 | 0 | 543 | 0.0 |
| FY 21-22 CUSOM clinical reviews | 131 | 0 | 65 | 0 | 66 | 0.2 |
| FY 21-22 Public health emergency extension | 0 | 3,308,679 | 9,487,867 | 38,950 | (12,835,496) | 0.0 |
| FY 21-22 BA10 Public health emergency end resources | (7,002,728) | (2,556,275) | 2,241,738 | 0 | (6,688,191) | 0.0 |
| FY 21-22 R24 Addressing health care disparities | (5,900,000) | (1,000,000) | 0 | 0 | (4,900,000) | 0.0 |
| SB 21-211 Adult dental benefit | (5,565,000) | 0 | (1,522,875) | 0 | (4,042,125) | 0.0 |
| FY 21-22 R23 Behavioral health claims and eligibility | (5,420,147) | (5,420,147) | 0 | 0 | 0 | 0.0 |
| FY 20-21 R15 Medicaid recovery third party liability | (2,360,799) | (669,553) | (102,725) | 0 | (1,588,521) | 0.0 |
| FY 21-22 BA15 Implement eConsult program | (2,170,076) | (377,537) | (18,528) | 0 | (1,774,011) | 0.1 |
| FY 19-20 R16 Employment first initiative, IDD | (1,995,497) | 800,000 | (2,795,497) | 0 | 0 | (2.0) |
| FY 21-22 CUSOM clinical reviews | (1,733,731) | 0 | 0 | 0 | (1,733,731) | 0.0 |
| FY 21-22 R6 Remote supports for HCBS programs | (1,433,231) | (696,695) | (19,921) | 0 | (716,615) | 0.0 |
| SB 21-009 Reproductive health care program | (1,045,771) | (270,732) | 0 | 0 | (775,039) | 0.6 |
| SB 21-016 Protecting preventive health coverage | (905,467) | (90,547) | 0 | 0 | (814,920) | 0.0 |
| FY 21-22 R9 Patient access and interoperability rule | (858,490) | 304,585 | 0 | 0 | (1,163,075) | 0.0 |
| SB 21-137 Behavioral health recovery act | (545,743) | (147,872) | (250,000) | 0 | (147,871) | 0.2 |
| FY 21-22 R16 Provider rate adjustments | (545,169) | (241,986) | (31,945) | 0 | (271,238) | 0.0 |
| SB 21-039 Eliminate subminimum wage employment | (403,941) | (1,257,106) | 1,217,607 | 0 | (364,442) | 0.1 |
| HB 17-1343 to repeal IDD Services Cash Fund | (138,707) | 307,488 | (446,195) | 0 | 0 | 2.0 |
| FY 21-22 R17 Medicaid benefit adjustments | (52,173) | (26,086) | 0 | 0 | (26,087) | 0.0 |
| FY 21-22 Funding for home health and PDN | 0 | 462,686 | 0 | 0 | (462,686) | 0.0 |
| **Total** | **$109,575,600** | **$91,856,728** | **($35,116,696)** | **$5,159,407** | **$47,676,161** | **5.1** |

**Federal match for HCBS:** The request includes a net zero adjustment, including an increase of $210.2 million General Fund and $19.0 million cash funds and a corresponding decrease in federal matching funds, for the expiration of the 10.0 percent enhanced federal medical assistance percentage

(FMAP) increase for eligible Home- and Community-based Services (HCBS) pursuant to the American Rescue Plan Act of 2021.

**CENTRALLY APPROPRIATED ITEMS:** The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; short-term disability; paid family and medical leave insurance; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor's Office of Information Technology (OIT); and CORE operations.

**HUMAN SERVICES PROGRAMS:** The Department's request reflects adjustments for several programs that are financed with Medicaid funds, but operated by the Department of Human Services. *See the briefings for the Department of Human Services for more information.*

**NP EQUITY OFFICERS:** The Department requests $0.2 million total funds and 2.0 FTE to ensure compliance with the Executive Order D 2020 175.

**TRANSFERS TO OTHER STATE AGENCIES:** The Department requests an increase of $0.1 million total funds, including $53,758 General Fund, for transfers to programs administered by other departments.

**TOBACCO FORECAST:** The Department requests a reduction of $20,676 cash funds for a new forecast of tobacco tax revenues available to finance the Children's Basic Health Plan.

## SUPPLEMENTALS

**SET ASIDE FOR SUPPLEMENTALS:** The Governor's budget letter includes a set aside in FY 2021-22 including a net decrease of $112.0 million General Fund for potential supplementals for the Department of Health Care Policy and Financing, including $112.1 million for the most recent forecast of enrollment and expenditures and an increase of $70,825 for the FY 2021-22 impact of discretionary requests. Although the Governor's official supplemental request is not due until January 2022, the budget request for the Department includes projected FY 2021-22 impacts associated with the following requests.

FY 2021-22 SET-ASIDE FOR SUPPLEMENTALS

| | TOTAL FUNDS | GENERAL FUNDS | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS |
|---|---|---|---|---|---|
| R1 Medical Services Premiums | ($193,724,244) | ($102,340,617) | $11,030,627 | ($735,599) | ($101,678,655) |
| R2 Behavioral Health | 100,335,065 | 14,033,780 | 8,724,673 | 0 | 77,576,612 |
| R3 Child Health Plan Plus | (8,778,202) | (5,351,109) | 2,254,146 | 0 | (5,681,239) |
| R4 Medicare Modernization Act | 3,803,082 | 3,803,082 | 0 | 0 | 0 |
| R5 Office of Community Living | (11,250,010) | (22,214,472) | 17,839,255 | 0 | (6,874,793) |
| R16 Urban Indian Health Organization | 70,825 | 70,825 | 0 | 0 | 0 |
| **TOTAL** | **($109,543,484)** | **($111,998,511)** | **$39,848,701** | **($735,599)** | **($36,658,075)** |

# ISSUE: FORECAST TRENDS (R1–R5)

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined they drive an $85.3 million increase in total funds, including a $306.6 million increase in General Fund, in FY 2022-23. These requests explain what drives the budget, but they are non-discretionary, as they represent the expected obligations under current law and policy. It would take a change to current law or policy to change the trends.

## SUMMARY

- Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined they drive an $85.3 million increase in total funds, including a $306.6 million increase in General Fund, in FY 2022-23. They are non-discretionary, as they represent the expected obligations under current law and policy. This is the change over two years and the net remaining change after accounting for annualizations.
- Medical Services Premiums
    - The projection for FY 2021-22 is down a net $193.7 million total funds, including a decrease of $102.3 million General Fund, primarily due to lower per capita costs reflective of the less expensive average cost of services for members that are locked into Medicaid pursuant to the federal Families First Coronavirus Relief Act of 2020. The Department projects:
        - Caseload growth of 9.3 percent in FY 2021-22, primarily in expansion populations as a result of changes in timing around disenrollment assumptions;
        - Lower acute care per capita costs due to lower expenditures for clients on continuous coverage;
        - Lower costs for nursing facilities and long-term services and supports (LTSS) waivers;
        - The need for less General Fund for LTSS waivers due to new information on services that are eligible for an enhanced match rate under the American Rescue Plan Act of 2021 (ARPA); and
        - COVID-19 inpatient hospital stays may increase with the Delta variant and has adjusted the associated forecast upwards as a result.
    - As of the November 2021 forecast, the public health emergency was anticipated to end in December of 2021. As a result, the FY 2021-22 caseload adjustment reflects the enhanced FMAP of 6.2 percent through the calendar year, and the disenrollment of continuous coverage members beginning in June of 2022. In mid-November 2021, the public health emergency was extended into January of 2022, resulting in the continuation of the 6.2 percent enhanced FMAP into the third quarter of state FY 2021-22. The resulting refinance of General Fund will be reflected in the February 2022 forecast.
    - The Department projects expenditures will increase a net $203.8 million total funds, including an increase of $508.2 million General Fund from FY 2021-22 to FY 2022-23, primarily due to increasing per capita costs and the end of the enhanced federal match through the federal Families First Coronavirus Response Act. The Department projects:
        - Caseload to decrease by 9.3 percent in FY 2022-23, with 1.9 percent enrollment decline for the elderly and people with disabilities and 11.3 percent enrollment decline for the ACA expansion populations;

        - Higher acute care per capita costs due to the disenrollment of clients on continuous coverage;
        - Higher costs for nursing facilities and long-term services and supports (LTSS) waivers; and
        - An increase in General Fund for LTSS waivers due to the expiration of the enhanced federal match rate under the American Rescue Plan Act of 2021 (ARPA).
- Behavioral Health
    - For FY 21-22 the Department increased the forecast by $100.3 million total funds, including $14.0 million General Fund, primarily due to higher per capita rates as a greater portion of the Medicaid population utilizes behavioral health services and faster implementation of the Substance Use Disorder benefit.
    - For FY 22-23 the Department projects a net decrease of $38.7 million total funds, including an increase of $41.9 million General Fund. The decrease in total funds is attributable to lower enrollment expectations with the end of the federal public health emergency and federal prohibitions on disenrolling people from Medicaid. The increase in General Fund is due to end of the enhanced federal match for home- and community-based services and the end of the enhanced federal match that is tied to the federal public health emergency.
- Child Health Plan Plus
    - For FY 21-22 the Department projects a net decrease of $8.8 million total funds, including a decrease of $5.4 million General Fund as members transitioning from CHP+ to Medicaid outpace new enrollments in CHP+.
    - For FY 22-23 the Department forecasts an increase of $50.3 million total funds, including a $17.4 million increase in General Fund, almost entirely due to an assumption that members who are locked in on Medicaid with a CHP+ income level will enroll in CHP+ after the public health emergency ends, resulting in a more than 30 percent increase in enrollment.
- Medicare Modernization Act – For FY 21-22 and FY 22-23 combined the Department projects a net increase of $27.9 million General Fund. Of the increases $17.2 million is attributable to the end of the enhanced federal match and the remainder is due to increases in enrollment and pharmaceutical costs.
- Office of Community Living
    - For FY 2021-22 the Department's forecast reflected a net decrease of $11.6 million total funds, including a decrease of $22.2 million General Fund, with $18.4 million of the General Fund decrease attributable to an offset by funds from the Intellectual and Developmental Disabilities Services Cash Fund.
    - For FY 2022-23 the Department projects increases in all four intellectual and developmental disability waiver programs resulting in a net increase in expenditures of $71.1 million total funds, including an increase of $131.5 million General Fund, due to increased caseload and per capita costs, the expiration of the enhanced federal FMAP authorized in the Families First Coronavirus Response Act of 2020 and the American Rescue Plan Act of 2021, and the repeal of the Intellectual and Developmental Disabilities Services Cash Fund on July 1, 2022.

## DISCUSSION

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. In FY 2022-23, the combined forecast requests account for 47.3 percent of the General Fund adjustments proposed by the Department, including a net increase of $85.3 million total funds and an increase $306.6 million General Fund. It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy. The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2021. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2021. The mid-February forecasts come after deadlines for the Governor to submit supplemental budget requests and budget amendments. Typically, governors do not submit official revised requests based on the mid-February forecasts, neither do they submit official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the mid-February forecast for the budget, because it is the most recent data available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2021-22 expenditures. The requests for changes in FY 2021-22 will be officially submitted in January and until then the Governor's budget includes a placeholder for the FY 2021-22 fiscal impact of the forecasts. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2021-22 is the change from the appropriation and not the change from FY 2020-21.

| FY 2021-22 | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS |
| **Appropriation** | | | | | |
| Medical Services Premiums | $9,986,500,296 | $2,403,846,455 | $1,196,746,162 | $83,318,813 | $6,302,588,866 |
| Behavioral Health | 998,723,955 | 204,048,968 | 54,738,645 | 0 | 739,936,342 |
| Children's Basic Health Plan | 170,754,875 | 21,059,365 | 35,628,900 | 0 | 114,066,610 |
| Medicare Modernization Act | 193,398,121 | 193,398,121 | 0 | 0 | 0 |
| Office of Community Living | 830,291,447 | 338,390,236 | 8,947,494 | 0 | 482,953,717 |
| **TOTAL** | **$12,179,668,694** | **$3,160,743,145** | **$1,296,061,201** | **$83,318,813** | **$7,639,545,535** |
| | | | | | |
| **FY 2021-22 Projection (Nov)** | | | | | |
| Medical Services Premiums | 9,792,776,052 | 2,301,505,838 | 1,207,776,789 | 82,583,214 | 6,200,910,211 |
| Behavioral Health | 1,099,059,020 | 218,082,748 | 63,463,318 | 0 | 817,512,954 |
| Children's Basic Health Plan | 161,976,673 | 15,708,256 | 37,883,046 | 0 | 108,385,371 |
| Medicare Modernization Act | 197,201,203 | 197,201,203 | 0 | 0 | 0 |
| Office of Community Living | 819,041,437 | 316,175,764 | 26,786,749 | 0 | 476,078,924 |

| FY 2021-22 | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS |
| **TOTAL** | **$12,070,054,385** | **$3,048,673,809** | **$1,335,909,902** | **$82,583,214** | **$7,602,887,460** |
| | | | | | |
| **Difference Proj. to Approp.** | | | | | |
| Medical Services Premiums | (193,724,244) | (102,340,617) | 11,030,627 | (735,599) | (101,678,655) |
| Behavioral Health | 100,335,065 | 14,033,780 | 8,724,673 | 0 | 77,576,612 |
| Children's Basic Health Plan | (8,778,202) | (5,351,109) | 2,254,146 | 0 | (5,681,239) |
| Medicare Modernization Act | 3,803,082 | 3,803,082 | 0 | 0 | 0 |
| Office of Community Living | (11,250,010) | (22,214,472) | 17,839,255 | 0 | (6,874,793) |
| **TOTAL** | **($109,614,309)** | **($112,069,336)** | **$39,848,701** | **($735,599)** | **($36,658,075)** |
| | | | | | |
| **Percent Change** | | | | | |
| Medical Services Premiums | -1.9% | -4.3% | 0.9% | -0.9% | -1.6% |
| Behavioral Health | 10.0% | 6.9% | 15.9% | n/a | 10.5% |
| Children's Basic Health Plan | -5.1% | -25.4% | 6.3% | n/a | -5.0% |
| Medicare Modernization Act | 2.0% | 2.0% | n/a | n/a | n/a |
| Office of Community Living | -1.4% | -6.6% | 199.4% | n/a | -1.4% |
| **TOTAL** | **-0.9%** | **-3.5%** | **3.1%** | **-0.9%** | **-0.5%** |

| FY 2022-23 | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS |
| **FY 2021-22 Projection (Nov)** | | | | | |
| Medical Services Premiums | $9,792,776,052 | $2,301,505,838 | $1,207,776,789 | $82,583,214 | $6,200,910,211 |
| Behavioral Health | 1,099,059,020 | 218,082,748 | 63,463,318 | 0 | 817,512,954 |
| Children's Basic Health Plan | 161,976,673 | 15,708,256 | 37,883,046 | 0 | 108,385,371 |
| Medicare Modernization Act | 197,201,203 | 197,201,203 | 0 | 0 | 0 |
| Office of Community Living | 819,041,437 | 316,175,764 | 26,786,749 | 0 | 476,078,924 |
| **TOTAL** | **$12,070,054,385** | **$3,048,673,809** | **$1,335,909,902** | **$82,583,214** | **$7,602,887,460** |
| | | | | | |
| **FY 2022-23 Projection (Nov)** | | | | | |
| Medical Services Premiums | 9,996,539,270 | 2,809,709,910 | 1,180,728,338 | 87,649,207 | 5,918,451,815 |
| Behavioral Health | 1,060,319,865 | 259,958,197 | 78,634,415 | 0 | 721,727,253 |
| Children's Basic Health Plan | 212,269,983 | 33,074,373 | 42,046,298 | 0 | 137,149,312 |
| Medicare Modernization Act | 221,261,883 | 221,261,883 | 0 | 0 | 0 |
| Office of Community Living | 890,162,080 | 447,644,859 | 8,365,949 | 0 | 434,151,272 |
| **TOTAL** | **$12,380,553,081** | **$3,771,649,222** | **$1,309,775,000** | **$87,649,207** | **$7,211,479,652** |
| | | | | | |
| **Difference FY 2021-22 to FY 2022-23** | | | | | |
| Medical Services Premiums | 203,763,218 | 508,204,072 | (27,048,451) | 5,065,993 | (282,458,396) |
| Behavioral Health | (38,739,155) | 41,875,449 | 15,171,097 | 0 | (95,785,701) |
| Children's Basic Health Plan | 50,293,310 | 17,366,117 | 4,163,252 | 0 | 28,763,941 |
| Medicare Modernization Act | 24,060,680 | 24,060,680 | 0 | 0 | 0 |
| Office of Community Living | 71,120,643 | 131,469,095 | (18,420,800) | 0 | (41,927,652) |
| **TOTAL** | **$310,498,696** | **$722,975,413** | **($26,134,902)** | **$5,065,993** | **($391,407,808)** |
| | | | | | |
| **Percent Change** | | | | | |
| Medical Services Premiums | 2.1% | 22.1% | -2.2% | 6.1% | -4.6% |
| Behavioral Health | -3.5% | 19.2% | 23.9% | n/a | -11.7% |
| Children's Basic Health Plan | 31.0% | 110.6% | 11.0% | n/a | 26.5% |
| Medicare Modernization Act | 12.2% | 12.2% | n/a | n/a | n/a |
| Office of Community Living | 8.7% | 41.6% | -68.8% | n/a | -8.8% |
| **TOTAL** | **2.6%** | **23.7%** | **-2.0%** | **6.1%** | **-5.1%** |

*FEDERAL MATCH RATES*

The standard Medicaid FMAP rate for the state of Colorado is 50.0 percent. During the COVID-19 pandemic, pursuant to the federal Families First Coronavirus Response Act (FFCRA) of 2020, the FMAP was increased by 6.2 percent between January 1, 2020 and the end of the quarter in which the declared public health emergency ends. To be eligible to receive the 6.2 percentage point FMAP increase, states must adhere to a set of requirements which include, but are not limited to, maintaining eligibility standards, methodologies, and procedures; covering medical costs related to the testing, services, and treatment of COVID-19; and not terminating individuals from Medicaid if such individuals were enrolled in the Medicaid program as of the date of the beginning of the emergency period or during the emergency period.

As of the November 1st submission date for the FY 2022-23 budget request, the state was eligible for the enhanced FMAP through December 31, 2021. **The November forecast reflects an assumed 56.2 percent federal match rate for the first two quarters of state FY 2021-22 (an average FMAP of 53.1 for the entire year).** The Department was notified in November that the public health emergency has been extended into January of 2022, resulting in the extension of the enhanced FMAP through March 31, 2022 and an average FY 2021-22 FMAP of 54.65 percent. The updated February 2022 will reflect the FMAP bump for the third quarter of state FY 2021-22. The Department projects that this three-month extension of the FMAP bump into the third quarter of FY 2021-22 to result in a decrease of approximately $120 million General Fund with an offsetting increase in federal funds.

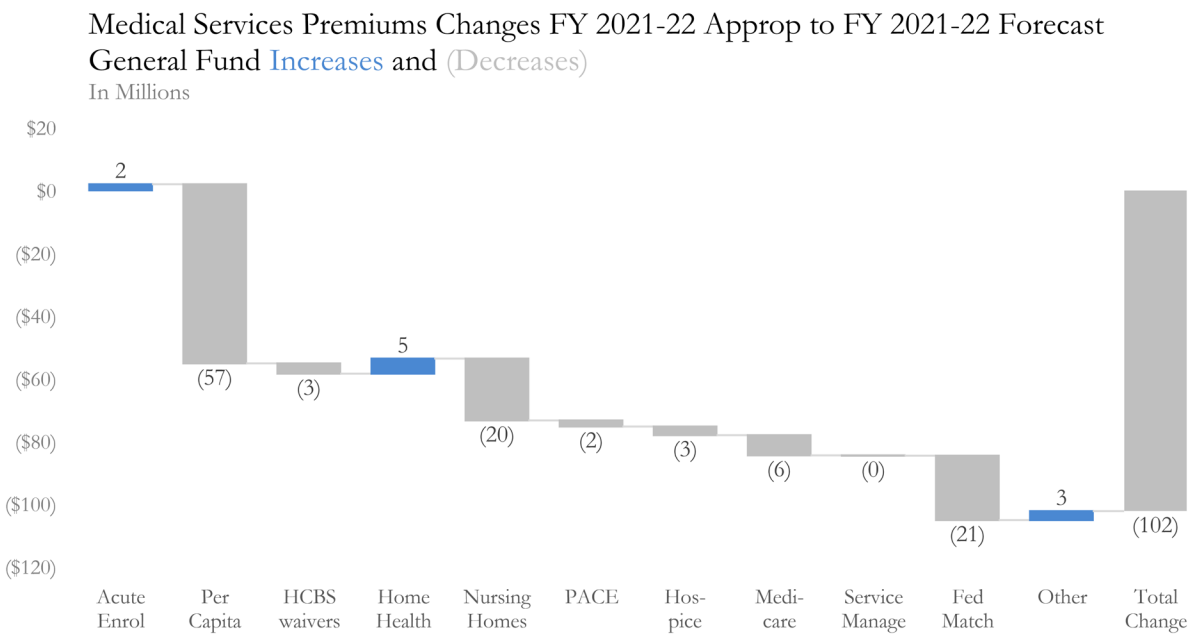
In addition to the FFCRA enhanced match rate, an additional FMAP increase was made available to states through the American Rescue Plan Act of 2021. The Act makes available a 10.0 percent FMAP increase for Medicaid Home- and Community-based Services (HCBS) between April 1, 2021 and March 31, 2022. The Act requires states to use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The FY 2021-22 forecast is based on the assumption that the FMAP will be reduced by 10.0 percent beginning April 1, 2022, therefore a blended FMAP rate of 60.6 percent is used for FY 2021-22 for eligible HCBS programs.

The FY 2022-23 forecast is based on an assumed match rate of 50.0 percent for standard Medicaid and HCBS programs.

## R1 MEDICAL SERVICES PREMIUMS

**FY 2021-22**

The projection for FY 2021-22 is down a net $193.7 million total funds, including a decrease of $102.3 million General Fund. The graph below shows the major contributors to the General Fund change from the FY 2021-22 appropriation to the Department's November 2021 forecast for FY 2021-22. It does not show differences from FY 2020-21 expenditures. As indicated the majority of the decrease is related to decreased per capita costs for acute care.




Specific values by fund source for the preceding chart are provided below.

| FY 2021-22 Medical Services Premiums Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Other State | Federal Funds |
| FY 2021-22 Appropriation | $9,986,500,296 | 2,403,846,455 | 1,280,064,975 | 6,302,588,866 |
| Acute Care | | | | |
| Enrollment | 94,824,582 | 1,926,200 | 15,568,800 | 77,329,582 |
| Per capita | (211,390,847) | (57,187,068) | (2,316,302) | (151,887,477) |
| *Subtotal - Acute Care* | *(116,566,265)* | *(55,260,868)* | *13,252,498* | *(74,557,895)* |
| Long-term Services and Supports | | | | |
| HCBS waivers | (8,240,534) | (3,246,770) | 0 | (4,993,764) |
| Long-Term Home Health/PDN | 12,166,845 | 4,793,737 | 0 | 7,373,108 |
| Nursing homes | (48,812,886) | (19,738,437) | (49,387) | (29,025,062) |
| PACE | (3,996,659) | (1,874,433) | 0 | (2,122,226) |
| Hospice | (8,511,671) | (2,775,546) | 0 | (5,736,125) |
| *Subtotal - LTSS* | *(57,394,905)* | *(22,841,449)* | *(49,387)* | *(34,504,069)* |
| Medicare insurance premiums | (11,661,813) | (6,395,302) | 0 | (5,266,511) |
| Service management | 3,521,372 | (133,216) | 1,526,196 | 2,128,392 |
| Federal match rate | 0 | (20,575,861) | (1,128,971) | 21,704,832 |
| Other | (11,622,603) | 2,866,109 | (3,305,308) | (11,183,404) |
| **TOTAL** | **$9,792,776,082** | **$2,301,505,868** | **$1,290,360,003** | **$6,200,910,211** |
| | | | | |
| Increase/(Decrease) | (193,724,214) | (102,340,587) | 10,295,028 | (101,678,655) |
| Percentage Change | -1.9% | -4.3% | 0.8% | -1.6% |

*Acute Care*

The acute care category includes expenditures for hospitals, primary care, specialty care, and pharmacy, among others.

Enrollment

While the Department overestimated FY 2021-22 enrollment for elderly and disabled population and parents and pregnant women in its February 2021 forecast, the Department underestimated the FY 2021-22 expansion population enrollment due to an earlier than realized end date for the COVID-19 public health emergency. Extension of the public health emergency into the second quarter of the state fiscal year, resulted in an update in the November 2021 forecast reflecting application of the enhanced FMAP of 6.2 percent through December 2021. In mid-November 2021, the public health emergency was extended into January of 2022, resulting in the continuation of the 6.2 percent enhanced FMAP into the third quarter of state FY 2021-22. The resulting refinance of General Fund will be reflected in the February 2022 forecast.

In addition to application of the enhanced FMAP for an additional quarter, the Department lowered its projection of the number of members who will be disenrolled based on year-to-date actuals for the continuous coverage population. The November 2021 forecast reflects 404,959 members will be locked into Medicaid by December 31, 2021, and that just over 220,000 people will be disenrolled from Medicaid when the public health emergency ends. The Department estimates that of the number of locked in members, 55 percent will be disenrolled between June and December of 2022. Caseload adjustments for the continuous coverage members related to the extension of the public health emergency will be reflected in the February 2022 forecast.

Per Capita

FY 2020-21 actual per capita expenditures were lower than expected, due to the number of members locked into continuous coverage. As a result the Department decreased the projected FY 2021-22 per capita expenditures.

COVID-19, RSV, and Flu Treatment costs

The forecast includes a total cost to treat COVID-19, RSV, and the flu of $119.9 million. Of this amount $83.0 million is for hospitalizations related to COVID-19. This is an increase of $67.6 million total funds, including $56.2 million General Fund, above the amount identified in the February 2021 forecast.

*LONG-TERM SERVICES AND SUPPORTS*

The forecast for long-term services and supports is somewhat influenced by the lower Medicaid enrollment forecast noted above, but overall reductions for enrollment are offset by increases in the estimated cost per utilizer.

HCBS waivers

Home- and Community-Based Services (HCBS) assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube. The November 2021 forecast includes a slight adjustment downward to account for decreased cost per utilizer for the Elderly, Blind, and Disabled waiver.

ARPA FMAP Change

The American Rescue Plan Act of 2021 (ARPA) included an additional enhanced federal match of 10.0 percent for eligible Home- and Community-Based Services (HCBS). The November forecast

reflects a refinance of General Fund with federal funds due to the identification of additional services that are eligible for the FMAP increase.

Home Health/PDN
Long-term home health and private duty nursing (PDN) are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS services and long-term home health or private duty nursing. The difference between long-term home health and private duty nursing is a matter of degree, with private duty nursing the more intensive service and generally limited to people who are machine-dependent and/or require round-the-clock care. In addition to traditional nursing services, home health includes physical therapy, occupational therapy, and speech therapy.

The Department increased the projected units per utilizer for private duty nursing and the projected client count and paid rate by for long-term home health, based on trends in actual expenditures per utilizer.

Nursing homes
The Department lowered the estimated bed days based on year-to-date data.

PACE
The Department adjusted the enrollment downward due to slower than projected growth.

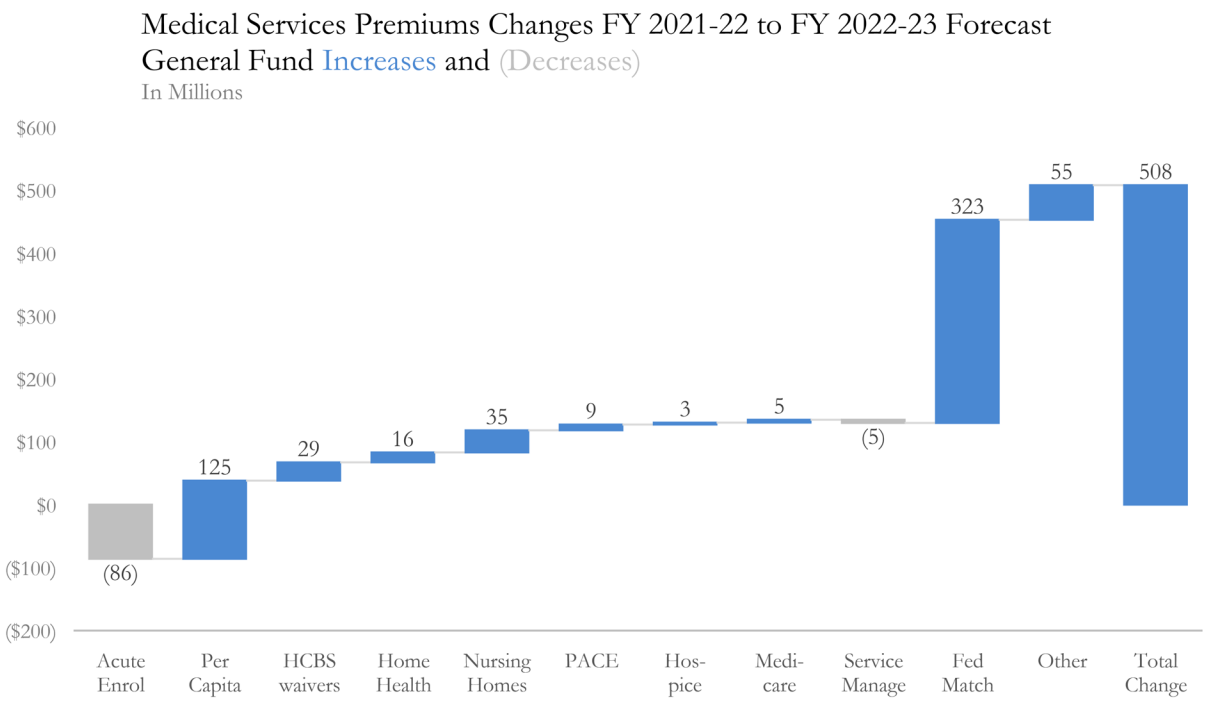
*OTHER*

Medicare insurance premiums
For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. The change is due to the lower forecast of enrollment.

Service management
The change is due to an increase in Accountable Care Collaborative administration payments to expansion populations and children offset by lower payments to elderly/disabled and low-income parents.

Federal match rate
The appropriation assumed that the public health emergency would conclude in the second quarter of state FY 2021-22, therefore the additional 6.2 percent federal match would be available through December of 2021. In November of 2021, the Department was notified that the public health emergency has been further extended into January 2022, thereby extending the duration of the enhanced federal match. The February 2022 forecast will reflect the associated adjustments.

**FY 2022-23**
The Department projects expenditures will increase a net $203.8 million total funds, including an increase of $508.2 million General Fund from FY 2021-22 to FY 2022-23. The graph below shows the major contributors to the General Fund change. As illustrated, the biggest driver of the General Fund increase is a change in the federal match rate.




Specific values by fund source for the preceding chart are provided below.

| FY 2022-23 Medical Services Premiums Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Other State | Federal Funds |
| FY 2022-23 Projection | $9,792,776,082 | $2,301,505,868 | $1,290,360,003 | $6,200,910,211 |
| Acute Care | | | | |
| Enrollment | (427,696,991) | (86,106,151) | (26,799,598) | (314,791,242) |
| Per capita | 366,150,124 | 124,502,037 | 11,161,017 | 230,487,070 |
| *Subtotal - Acute Care* | *(61,546,867)* | *38,395,886* | *(15,638,581)* | *(84,304,172)* |
| Long-term Services and Supports | | | | |
| HCBS waivers | 73,401,033 | 28,920,007 | 0 | 44,481,026 |
| Long-Term Home Health/PDN | 40,279,973 | 15,870,309 | 0 | 24,409,664 |
| Nursing homes | 75,057,251 | 35,201,851 | 0 | 39,855,400 |
| PACE | 23,070,109 | 9,089,623 | 0 | 13,980,486 |
| Hospice | 8,544,130 | 3,366,387 | 0 | 5,177,743 |
| *Subtotal - LTSS* | *220,352,496* | *92,448,177* | *0* | *127,904,319* |
| Medicare Insurance Premiums | 8,394,141 | 4,596,632 | 0 | 3,797,509 |
| Service management | (22,231,896) | (5,076,726) | (2,153,665) | (15,001,505) |
| Federal match rate | 0 | 322,598,223 | (6,333,902) | (316,264,321) |
| Other | 58,795,344 | 55,241,880 | 2,143,690 | 1,409,774 |
| **TOTAL** | **$9,996,539,300** | **$2,809,709,940** | **$1,268,377,545** | **$5,918,451,815** |
| | | | | |
| Increase/(Decrease) | 203,763,218 | 508,204,072 | (21,982,458) | (282,458,396) |
| Percentage Change | 2.1% | 22.1% | -1.7% | -4.6% |

*ACUTE CARE*

The acute care category includes expenditures for hospitals, primary care, specialty care, and pharmacy, among others.

Enrollment

The Department projects overall enrollment decrease of 7.6 percent, with 3.8 percent enrollment decline for the elderly and people with disabilities, 4.4 percent enrollment decline for parents and pregnant women, and 7.4 percent enrollment decline for the ACA expansion populations.

Per capita

The Department projects a 4.6 percent year-over-year growth based on historical trends and due to disenrollment of lower cost continuous coverage members.

*LONG-TERM SERVICES AND SUPPORTS*

The Department projects continuation of the historical trend of increasing costs for long-term services and supports.

HCBS Waivers

Home- and Community-Based Services (HCBS) assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube. The Department projects enrollment growth of 3.0 percent and per capita growth of 6.0 percent.

Home Health/PDN

Long-term home health and private duty nursing (PDN) are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS services and long-term home health or private duty nursing. The difference between long-term home health and private duty nursing is a matter of degree, with private duty nursing the more intensive service and generally limited to people who are machine-dependent and/or require round-the-clock care. In addition to traditional nursing services, home health includes physical therapy, occupational therapy, and speech therapy.

The increase is primarily driven by a forecasted 6.0 percent increase in enrollment in long-term home health, and a projected 2.0 percent increase in per capita costs for people utilizing private duty nursing.

Nursing homes

The increase is due to a projected 7.0 percent increase in patient days as utilization rebounds closer to historical averages and to the 3.0 percent statutory increase in per diem rates.

PACE

The Department projects continued strong growth in both per capita costs (3.5 percent) and enrollment (7.0 percent).

*OTHER*

Medicare insurance premiums
For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. The change is primarily due to increasing enrollment, but includes inflation in Medicare premiums.

Service management
The forecast reflects decreases in Accountable Care Collaborative administration corresponding to decreases in caseload with ramp down of continuous coverage requirement from the public health emergency.

Hospital supplemental payments
The Department projects an increase in supplemental payments to hospitals that are financed with the Healthcare Affordability and Sustainability (HAS) Fee, based on projections of the federal Upper Payment Limit and net patient revenue and the expiration of the enhanced FMAP.

Federal match rate
The Department projects a large increase in General Fund and decrease in federal funds for the end of the temporary extra 6.2 percent federal match provided through the federal Families First Coronavirus Response Act. The higher federal match is available for services from January 1, 2020 through the last quarter when a disaster is declared by the federal Secretary of Health and Human Services. Based on the current disaster declaration, the higher federal match would expire at the end of March 2022, but the disaster declaration could be extended further.

## R2 BEHAVIORAL HEALTH

**FY 2021-22**
The table below shows the major contributors to the change from the FY 2021-22 appropriation to the Department's November 2021 forecast for FY 2021-22. It does not show differences from FY 2020-21 expenditures.

| FY 2021-22 Behavioral Health Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2021-22 Appropriation | $890,228,973 | $204,590,739 | $58,768,332 | $626,869,902 |
| Enrollment | 12,105,543 | (1,686,138) | 1,125,591 | 12,666,090 |
| Per capita | 71,354,935 | 7,448,283 | 8,426,333 | 55,480,319 |
| Substance Use Disorder capacity | 16,874,587 | 8,271,635 | (827,251) | 9,430,203 |
| **TOTAL** | **$990,564,038** | **$218,624,519** | **$67,493,005** | **$704,446,514** |
| | | | | |
| Increase/(Decrease) | 100,335,065 | 14,033,780 | 8,724,673 | 77,576,612 |
| Percentage Change | 11.3% | 6.9% | 14.8% | 12.4% |

*ENROLLMENT*
The state pays predetermined amounts per member per month to the Regional Accountable Entitites (RAEs) for behavioral health services for Medicaid clients. With the higher enrollment forecast, especially for expansion adults, discussed above under Medical Services Premiums, the number of per member payments increases.

*PER CAPITA*

The actual per member per month rates for FY 2021-22 came in much higher than the projection used for the appropriation. This is attributable to a greater portion of the Medicaid population utilizing behavioral health services. The quantity of services per utilizer remained relatively similar.

*SUBSTANCE USE DISORDER CAPACITY*

The Department expected a ramp up of capacity for the substance use disorder benefit as providers signed up for Medicaid and new providers entered the market. The speed of uptake is exceeding expectations, causing the Department to increase the projection for FY 2021-22.

**FY 2022-23**

The table below shows the major contributors to the change from the FY 2021-22 forecast to the FY 2021-22 forecast.

| FY 2022-23 Behavioral Health Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2022-23 Projection | $990,564,038 | $218,624,519 | $67,493,005 | $704,446,514 |
| Enrollment | (77,793,346) | (11,385,487) | (3,457,062) | (62,950,797) |
| Per capita | 39,054,091 | 17,516,136 | 3,044,191 | 18,493,764 |
| Federal match for HCBS | 0 | 20,065,606 | 14,411,006 | (34,476,612) |
| Federal match for public health emergency | 0 | 15,679,194 | 1,172,862 | (16,852,056) |
| **TOTAL** | **$951,824,783** | **$260,499,968** | **$82,664,002** | **$608,660,813** |
| | | | | |
| Increase/(Decrease) | (38,739,255) | 41,875,449 | 15,170,997 | (95,785,701) |
| Percentage Change | -3.9% | 19.2% | 22.5% | -13.6% |

*ENROLLMENT*

As described above under Medical Services Premiums, the Department projects a decrease in enrollment due to the end of the federal public health emergency and federal prohibitions on disenrolling people from Medicaid.

*PER CAPITA*

The Department projects a 3.0 percent increase in capitation rates based on utilization trends, continued ramp up of the new Substance Use Disorder (SUD) benefit, and an assumption that disenrollments due to the public health emergency will mostly be among low utilizers of behavioral health services.

*FEDERAL MATCH FOR HCBS*

The forecast includes an increase in General Fund and cash funds and a corresponding decrease in federal funds due to the end of an extra 10 percent federal match for certain home- and community-based services as part of the federal American Rescue Plan Act (ARPA). The ARPA match applied to behavioral health rehabilitative services.

*FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY*

The forecast includes an increase in General Fund and cash funds and a corresponding decrease in federal funds due to the expected end of an extra 6.2 percent federal match that is tied to the duration of the federal public health emergency.

## R3 CHILD HEALTH PLAN PLUS (CHP+)

**FY 2021-22**

The table below shows the major contributors to the change from the FY 2021-22 appropriation to the Department's November 2021 forecast for FY 2021-22. It does not show differences from the FY 2020-21 expenditures.

| FY 2021-22 Children's Basic Health Plan Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2021-22 Appropriation | $170,754,875 | $21,059,365 | $35,628,900 | $114,066,610 |
| Enrollment | (15,883,351) | (6,441,622) | 1,012,038 | (10,453,767) |
| Per capita | 3,126,012 | 249,841 | 776,429 | 2,099,742 |
| Reconciliations | 3,979,137 | 840,672 | 465,679 | 2,672,786 |
| **TOTAL** | **$161,976,673** | **$15,708,256** | **$37,883,046** | **$108,385,371** |
| | | | | |
| Increase/(Decrease) | (8,778,202) | (5,351,109) | 2,254,146 | (5,681,239) |
| Percentage Change | -5.1% | -25.4% | 6.3% | -5.0% |

*ENROLLMENT*

The Department lowered the enrollment projection as members transitioning from CHP+ to Medicaid outpace new enrollments in CHP+. Due to the federal freeze on disenrollment from Medicaid, children and pregnant adults are not churning from Medicaid to CHP+.

*PER CAPITA*

Actual managed care rates were slightly higher than the forecast used for the appropriation.

*RECONCILIATIONS*

The Department updated the forecast of reconciliations for a system issue that caused overpayment in FY 20-21 that will be recouped in FY 21-22.

**FY 2022-23**

The table below shows the major contributors to the change from the FY 2021-22 forecast to the FY 2022-23 forecast.

| FY 2022-23 Children's Basic Health Plan Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2021-22 Projection | $161,976,673 | $15,708,256 | $37,883,046 | $108,385,371 |
| Enrollment | 47,441,629 | 12,516,013 | 3,496,302 | 31,429,314 |
| Per capita | 2,851,681 | 269,257 | 666,950 | 1,915,474 |
| Federal match rate | 0 | 4,580,847 | 0 | (4,580,847) |
| **TOTAL** | **$212,269,983** | **$33,074,373** | **$42,046,298** | **$137,149,312** |
| | | | | |
| Increase/(Decrease) | 50,293,310 | 17,366,117 | 4,163,252 | 28,763,941 |
| Percentage Change | 31.0% | 110.6% | 11.0% | 26.5% |

*ENROLLMENT*

The Department expects members who are locked in on Medicaid with a CHP+ income level will enroll in CHP+ after the public health emergency ends, resulting in a more than 30 percent increase in enrollment.

*PER CAPITA*

The Department projects a relatively small increase in managed care capitation rates.

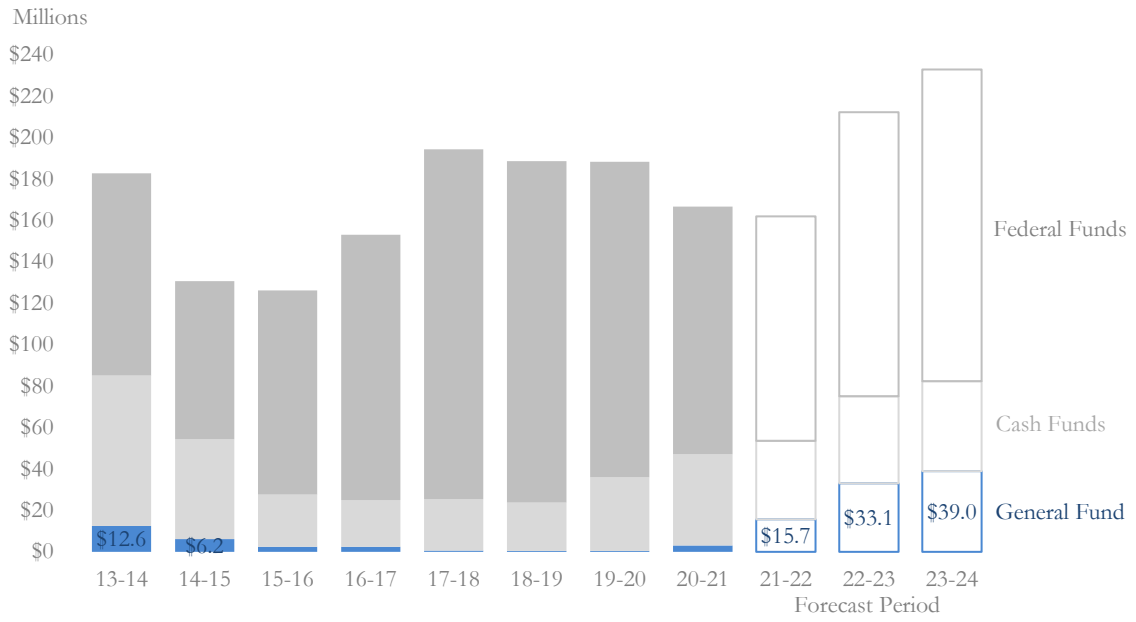
*FEDERAL MATCH RATE*

The forecast includes an increase in General Fund and a corresponding decrease in federal funds due to the expected end of the enhanced federal match through the Families First Coronavirus Relief Act.

Favorable federal match rates from FY 15-16 through FY 19-20 made General Fund costs for the CHP+ minimal and allowed for the accumulation of a fund balance in the CHP+ Trust. When the favorable federal match rates began to phase out the General Assembly spent down the reserves in the CHP+ Trust to soften the blow to the General Fund. In FY 21-22 the Department projects there will be no more reserves in the CHP+ Trust and the General Fund will need to increase to make up the difference. In addition, the projected expiration of the enhanced federal match through the federal Families First Coronavirus Response Act requires more General Fund in FY 2022-23. This is a level reset of the General Fund needed for CHP+ and in future years the Department expects the General Fund to move more in concert with the enrollment and per capita trends.

Favorable federal match rates from FY 15-16 through FY 19-20 made General Fund costs for the Children's Basic Health Plan minimal

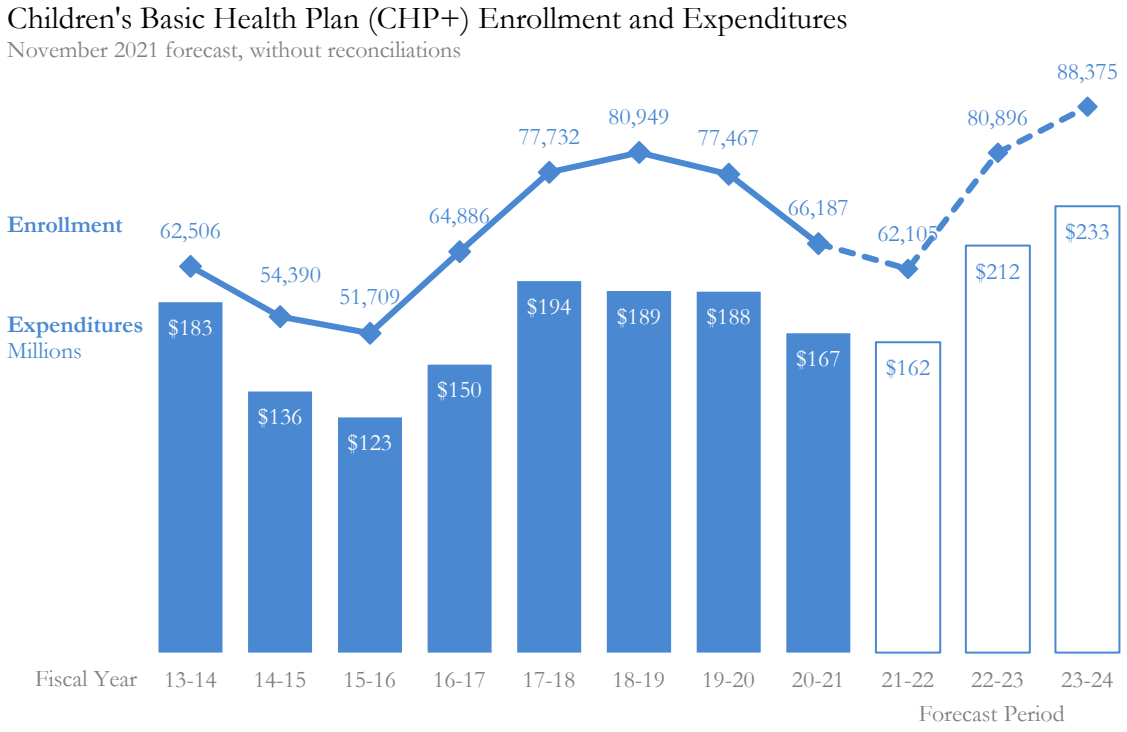
November forecast, including reconciliations




The chart below summarizes the projected cash flow for the Children's Basic Health Plan Trust.

| CHILDREN'S BASIC HEALTH PLAN TRUST | | | | |
|---|---|---|---|---|
| | FY 20-21 | FY 21-22 | FY 22-23 | FY 23-24 |
| Beginning Fund Balance | $11,365,656 | $843,772 | $0 | $0 |
| | | | | |
| Revenue | $14,547,107 | $14,115,179 | $14,336,033 | $15,062,257 |
| Fees | 13,195 | 518,018 | 1,209,463 | 1,251,379 |
| Tobacco Settlement | 14,464,690 | 13,536,000 | 12,906,000 | 13,554,000 |
| Interest | 64,682 | 61,161 | 220,570 | 256,878 |
| Recoveries | 4,540 | 0 | 0 | 0 |
| | | | | |
| Expenses | $25,068,991 | $14,958,951 | $14,336,033 | $15,062,257 |
| | | | | |
| Net Cash Flow | ($10,521,884) | ($843,772) | $0 | $0 |
| | | | | |
| Ending Fund Balance | $843,772 | $0 | $0 | $0 |

The next chart summarizes the Department's forecast of enrollment and expenditures for CHP+.




## R4 Medicare Modernization Act

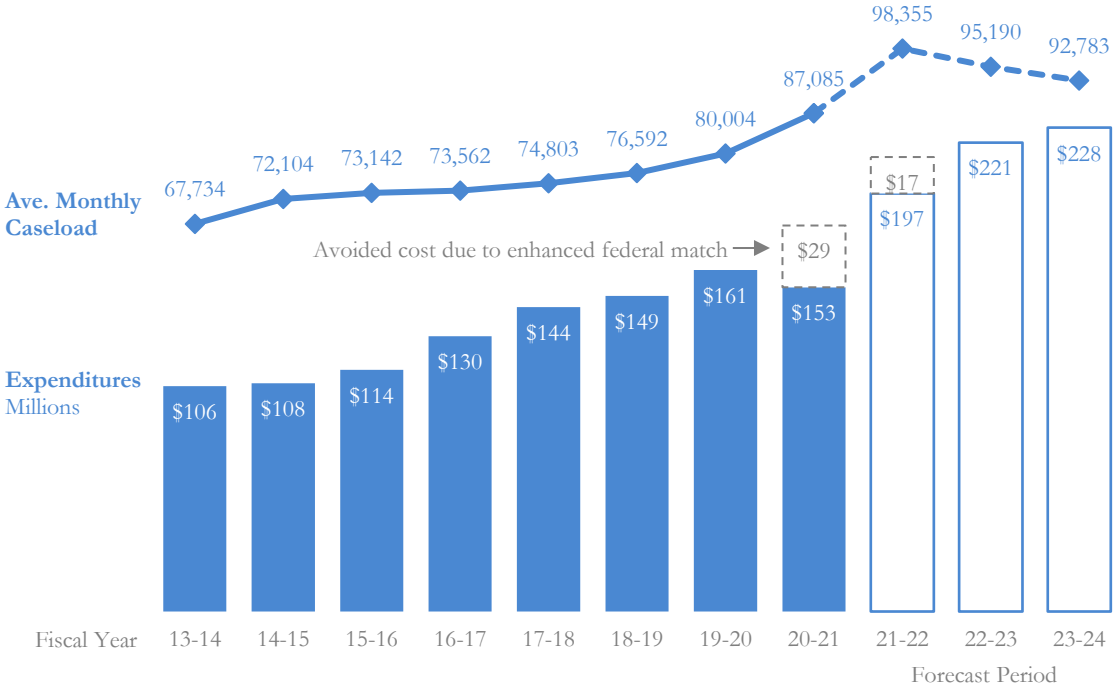
The Department requests an increase of $27.9 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. The total requested change is the sum of the forecasted changes in FY 2021-22 and in FY 2022-23. The Department will officially submit a supplemental request for FY 2021-22 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2022.

In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid in Medicaid, as estimated by a federal formula. Growth in the enrollment of people dually eligible for Medicare and Medicaid and changes in the cost of pharmaceuticals drive expenditures.

The enhanced federal match through the federal Families First Coronavirus Response Act reduced the state obligation under the Medicare Modernization Act. The Department estimates Colorado is saving $29.0 million General Fund in FY 2020-21, including a credit or $6.7 million for payments in FY 2019-20 and an expected $22.5 million for invoices in FY 2020-21. The Department projected additional savings of $17.2 in FY 2021-22, but that will increase with the known extension of the public health emergency.

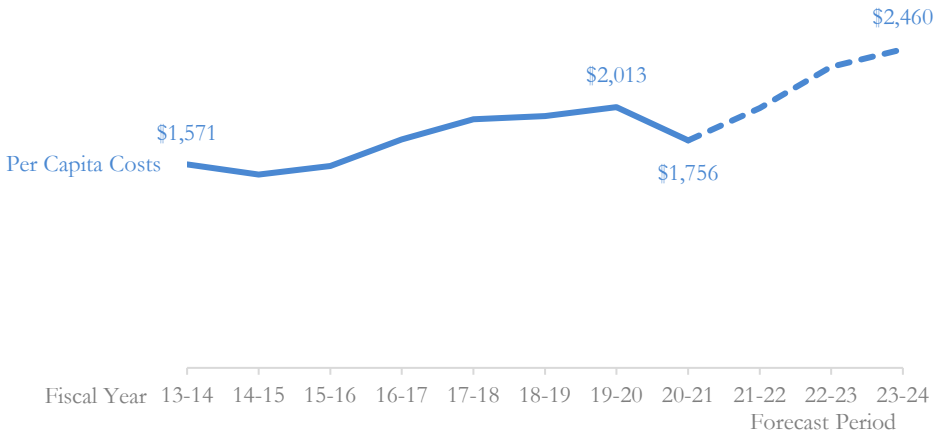
Medicare Modernization Act Caseload and Expenditures

November 2021 forecast




Per capita costs have been increasing due to higher prices for pharmaceuticals. The drop in FY 2020-21 was due to the enhanced match through the federal Families First Coronavirus Response Act and absent that enhanced federal match the per capita costs would have increased.

Medicare Modernization Act per capita costs are rising based on the federal formula calculation of prescription drug costs




The Medicare Modernization Act is normally a 100 percent General Fund obligation, but from FY 2012-13 to FY 2014-15, in order to offset General Fund costs, Colorado applied bonus payments received from the federal government for meeting performance goals for enrolling children in Medicaid and CHP+ toward this obligation.

The federal Centers for Medicare and Medicaid Services (CMS) believes Colorado miscalculated the bonus payments earned and is seeking to recover $38.4 million. The Department is disputing the attempted recovery in court. If Colorado loses it would need to come up with the $38.4 million. There are scenarios where Colorado might be able to allocate some of the costs to sources other than the General Fund and/or spread the repayment out over multiple years.

## R5 Office of Community Living

The Department is responsible for the administration of four Medicaid waivers through which eligible individuals with intellectual and developmental disabilities (IDD) may access services. Individuals who are not eligible for Medicaid may access IDD services through programs funded with state General Fund. The Department uses per capita costs and average full program equivalent (FPE) to calculate the funding needs for each waiver.

**FY 2021-22**

The projection for FY 2021-22 is down a net $11.6 million total funds, including a decrease of $22.2 million General Fund. The majority of the decrease is related to decreased enrollment trends. To determine the necessary funding to provide services, the Department factors in enrollment, utilization, and per capita costs for each program area.

*Medicaid Programs*

Comprehensive/Developmental Disabilities Waiver

The Comprehensive waiver provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports. The service provider is responsible for supporting individuals in securing living arrangements that can range from host home settings with 1-2 persons, individualized settings of 1-3 persons, and group settings of 4-8 persons. Support is also available for participants who live in their own home or who live with and/or are provided services by members of their family.

Annually, the Department requests funding for reserved capacity and emergency enrollments. The FY 2021-22 appropriation includes funding for 411 enrollments, including 41 transitions from institutions, 47 ageing caregiver enrollments, 189 emergency enrollments, 43 foster care transitions, and 91 youth transitions. In addition, the JBC approved funding to increase the enrollment onto the Comprehensive waiver by 667 enrollments, increasing appropriations by $18.1 million total funds, including $8.5 million General Fund. As of June, 2021, the waiting list for those requesting enrollment as soon as available is 2,819.

The FY 2021-22 maximum enrollment in the Comprehensive waiver is 8,158 members. The Accounting for churn and enrollment lag, the estimated fiscal year-end enrollment is 7,831 members. The forecast is based on the number of FPE who are anticipated to be served, in this case 7,382. It reflects a net decrease of $3.9 million total funds, including a decrease of $24.3 million General Fund and an increase of $18.3 million cash funds from the Intellectual and Development Disabilities (IDD) Services Cash Fund. The net decrease is primarily due to decreased enrollment trends. The significant reduction in General Fund is due to its refinancing with available funds in the IDD Services Cash Fund. The cash fund is repealed as July 1, 2022. The Department will make adjustments to the forecast based on the utilization and per capita costs for the 7,382 FPE.

Supported Living Services Waiver

The Supported Living Services (SLS) waiver provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. It promotes individual choice and decision-making through the individualized planning process and the tailoring of services and supports to address prioritized, unmet needs. In addition, this waiver is designed to supplement existing natural supports and traditional community resources with targeted and cost-effective services and supports. The person receiving services is responsible for his or her living arrangements that can include living with family or in their own home. Up to three persons receiving services can live together. Participants on this waiver do not require twenty-four (24) hour supervision on a continuous basis for services and supports offered on this waiver. The rate of some services and the Service Plan Authorization Limit (SPAL) is determined through member intake and assessments. The number of FPE anticipated to be served in FY 2021-22 is 4,535. There is no waiting list for SLS waiver enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

The forecast reflects a downward adjustment related to enrollment trends. Increased enrollment on the Comprehensive waiver results in a reduction in the number of members enrolled on the SLS waiver. The Department projects the reduction will result in a decrease of $0.5 million General Fund in FY 2021-22.

Children's Extensive Support Waiver

The Children's Extensive Support (CES) waiver provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood. The number of FPE anticipated to be served in FY 2021-22 is 2,069. There is no waiting list for CES enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

The forecast reflects a downward adjustment related to enrollment trends, resulting in a decrease of $0.5 million total funds, including $0.3 million General Fund.

Children's Habilitation Residential Program Waiver

The Children's Habilitation Residential Program (CHRP) waiver provides residential services for children and youth in foster care or at risk of child welfare involvement who have a developmental disability and very high needs that put them at risk for institutional care. Services are intended to help children and youth learn and maintain skills that are necessary for successful community living. The number of FPE anticipated to be serviced in FY 2021-22 is 165. There is no waiting list for CHRP enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

In FY 2020-21, the JBC approved the requested targeted rate increase for the CHRP daily rate, increasing the rate from $198 to $720 for the highest acuity individuals. This has resulted in an increase in the number of children enrolled and receiving services through the waiver.

The November 2021 forecast reflects an upward trend resulting in an increase of $2.4 million total funds, including $0.7 million General Fund.

Case Management

Individuals with IDD who are enrolled in HCBS waivers receive case management, monitoring, and assessment services.

- Targeted Case Management (TCM) provides assessment of each client's long-term care needs, the development and implementation of personalized care plans, coordination and monitoring of the delivery of services, and evaluation of the effectiveness of services. As of July 1, 2020, Community Centered Boards receive a per member per month TCM payment for each client.
- Four monitoring visits per year are provided to each client. These quarterly visits with a case manager include an evaluation of service delivery and quality, evaluation of choice in providers, and the promotion of self-determination, self-representation, and self-advocacy.
- Intake, an annual Continued Stay Review assessment, and a Supports Intensity Scale (SIS) assessment are required and are necessary to determine the member's functional level for activities of daily living. The SIS specifically measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. For children enrolled in the CHRP waiver, the Inventory for Client and Agency Planning assessment is used to measure support needs by determining adaptive behavior skills. Support needs identified by the assessments help determine the level of support each client needs, which subsequently informs the Service Plan Authorization Limit (SPAL).

The forecast reflects a downward adjustment due to decreased enrollment trends and a delay in the implementation of S.B. 16-192 (Single Assessment Tool) resulting in a net decrease of $8.6 million total funds, including an increase of $2.4 million General Fund.

*STATE-ONLY PROGRAMS*

State-only programs are made available to individuals with intellectual and developmental disabilities who do not meet the Medicaid eligibility requirements. The November 2021 forecast reflects minimal adjustments to programs funded with state-only funds.

**FY 2022-23**

The projection for FY 2022-23 includes a net increase of $71.1 million total funds, including an increase of $131.5 million General Fund, relative to the current FY 2021-22 appropriation. The total funds increase, including an increase of $26.9 million General Fund, is primarily driven by Comprehensive waiver enrollment, including an increase of 411 reserved capacity and emergency enrollment and the annualization of 667 waitlist enrollments approved by the JBC during the 2021 Legislative Session. In addition, the Department projects increases in per capita costs, specifically those related to the utilization of day habilitation and non-medical transportation as members become more comfortable using those services.

In addition to the increases related to enrollment and services, the Department projects a significant increase in General Fund ($104.6 million), offsetting like-decreases in cash and federal funds, including:

- An increase of $21.0 million General Fund and a corresponding decrease in cash funds appropriations from the IDD Services Cash Fund upon its repeal on July 1, 2022;
- An increase of $59.2 million General Fund for the annualization of the 10.0 percent enhanced FMAP for eligible Home- and Community-based Services under the American Rescue Plan Act of 2021 (ARPA); and

- An increase of $24.5 million General Fund for the annualization of the 6.2 percent enhanced FMAP under the Families First Coronavirus Response Act of 2020.

*MEDICAID PROGRAMS*

Comprehensive/Developmental Disabilities Waiver

The Comprehensive waiver provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports. The service provider is responsible for supporting individuals in securing living arrangements that can range from host home settings with 1-2 persons, individualized settings of 1-3 persons, and group settings of 4-8 persons. Support is also available for participants who live in their own home or who live with and/or are provided services by members of their family.

Annually, the Department requests funding for reserved capacity and emergency enrollments. The FY 2022-23 appropriation includes funding for 411 enrollments, including 41 transitions from institutions, 47 ageing caregiver enrollments, 189 emergency enrollments, 43 foster care transitions, and 91 youth transitions.

The FY 2022-23 maximum enrollment in the Comprehensive waiver is 8,791 members. The Accounting for churn and enrollment lag, the estimated fiscal year-end enrollment is 8,464 members. The forecast is based on the number of FPE who are anticipated to be served, in this case 8,114. It reflects a net increase of $34.2 million total funds, including an increase of $34.4 million General Fund. The net increase is primarily due to the annualization of the 667 enrollments approved by the JBC during the 2021 Legislative Session and increases in per capita costs. The significant increase in General Fund is due to the annualization of the enhanced FMAP of 10.0 percent authorized under the American Rescue Plan Act of 2021. The Department will reflect adjustments in its February 2022 forecast based on the utilization and per capita costs for the 8,114 FPE.

Supported Living Services Waiver

The Supported Living Services (SLS) waiver provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. It promotes individual choice and decision-making through the individualized planning process and the tailoring of services and supports to address prioritized, unmet needs. In addition, this waiver is designed to supplement existing natural supports and traditional community resources with targeted and cost-effective services and supports. The person receiving services is responsible for his or her living arrangements that can include living with family or in their own home. Up to three persons receiving services can live together. Participants on this waiver do not require twenty-four (24) hour supervision on a continuous basis for services and supports offered on this waiver. The rate of some services and the Service Plan Authorization Limit (SPAL) is determined through member intake and assessments. The number of FPE anticipated to be served in FY 2022-23 is 4,525. There is no waiting list for SLS waiver enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

The forecast reflects a downward adjustment related to enrollment trends. Increased enrollment on the Comprehensive waiver results in a reduction in the number of members enrolled on the SLS

waiver. The Department projects the reduction will result in a net decrease of $2.0 million total funds, including $0.5 million General Fund in FY 2022-23.

Children's Extensive Support Waiver

The Children's Extensive Support (CES) waiver provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood. The number of FPE anticipated to be served in FY 2022-23 is 2,197. There is no waiting list for CES enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

The forecast reflects an upward adjustment related to enrollment trends, resulting in a net increase of $1.7 million total funds, including an increase of $2.0 million General Fund.

Children's Habilitation Residential Program Waiver

The Children's Habilitation Residential Program (CHRP) waiver provides residential services for children and youth in foster care or at risk of child welfare involvement who have a developmental disability and very high needs that put them at risk for institutional care. Services are intended to help children and youth learn and maintain skills that are necessary for successful community living. The number of FPE anticipated to be serviced in FY 2022-23 is 171. There is no waiting list for CHRP enrollment, therefore the Department will adjust the costs based on actual enrollment, utilization, and per capita trends.

The November 2021 forecast reflects an upward trend resulting in an increase of $2.8 million total funds, including $1.7 million General Fund.

Case Management

Individuals with IDD who are enrolled in HCBS waivers receive case management, monitoring, and assessment services.

- Targeted Case Management (TCM) provides assessment of each client's long-term care needs, the development and implementation of personalized care plans, coordination and monitoring of the delivery of services, and evaluation of the effectiveness of services. As of July 1, 2020, Community Centered Boards receive a per member per month TCM payment for each client.
- Four monitoring visits per year are provided to each client. These quarterly visits with a case manager include an evaluation of service delivery and quality, evaluation of choice in providers, and the promotion of self-determination, self-representation, and self-advocacy.
- Intake, an annual Continued Stay Review assessment, and a Supports Intensity Scale (SIS) assessment are required and are necessary to determine the member's functional level for activities of daily living. The SIS specifically measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. For children enrolled in the CHRP waiver, the Inventory for Client and Agency Planning assessment is used to measure support needs by determining adaptive behavior skills. Support needs identified by the assessments help determine the level of support each client needs, which subsequently informs the Service Plan Authorization Limit (SPAL).

The forecast reflects a net decrease of $0.3 million, including an increase of $2.6 million General Fund primarily related to the annualization of the ARPA enhanced FMAP.

*STATE-ONLY PROGRAMS*

State-only programs are made available to individuals with intellectual and developmental disabilities who do not meet the Medicaid eligibility requirements. The November 2021 forecast reflects no adjustments to these programs relative to the FY 2021-22 forecast.

# ISSUE: VALUE-BASED PAYMENTS (R6)

Alternative payment models are designed to provide incentive payments for the delivery of high-quality and cost-effective care. The Department of Health Care Policy and Financing is requesting funding to implement three alternative payments models. Provider participation would be mandatory.

## SUMMARY

- The Department requests $22.9 million total funds, including $7.4 million General Fund, and 9.6 FTE for the planning and implementation or expansion of three alternative payment models in which participation by providers will be mandatory. In addition, the Department requests $11.4 million in roll-forward authority in the event that the development phase is delayed.
- The alternative payment models are intended to improve the quality and cost-effectiveness of care in the areas of prescription drugs, maternity care, and primary care for both adults and children.
- The Department plans to develop the alternative payment models in partnership with the Division of Insurance and the Department of Personnel in order to establish an aligned approach to value-based payment across public and private payers in Colorado.
- The Department plans to distribute incentive payments to providers out of savings if they meet specific requirements.
- Significant cost drivers in the Department's request are related to the design, development, and implementation of solutions intended to be integrated with existing IT platforms.

## RECOMMENDATION

JBC staff recommends that the Committee consider asking the Department to respond to the following questions:

- Does the Department plan to participate in a Centers for Medicare and Medicaid demonstration project during which the effectiveness of the alternative payment models in the three practice areas for which funding is requested will be evaluated? If so, please provide information concerning the evaluation of the project(s).
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established models focused on shifting health care from fee-for-service to value-based care. Please discuss any models established at the federal level specific to Medicaid or the three practice areas for which funding is requested.
- The request indicates that the alternative payment models will be developed in partnership with the Division of Insurance and the Department of Personnel to establish an aligned approach to value-based payments in the State. Please discuss the roles of each of the Departments.
- The Department intends to make provider participation in the alternative payment models mandatory. Since participation in Medicaid itself is not mandatory, how will the Department ensure that the number of Medicaid providers will not decrease when the models are implemented?
- Pharmacy Prescriber Tool:
    - What formal evaluation of the Pharmacy Prescriber Tool has been or is being performed and what metrics are evaluated in the process? Specifically, what metrics are evaluated in measuring utilization management?

    - How is the preferred drug list developed? What factors are considered when adding a drug to the list? How frequently is it updated? What involvement do pharmaceutical companies have in the development of the preferred drug list?
    - If evaluations of the Pharmacy Prescriber Tool indicate that the desired outcomes are achieved, are the incentive payments to prescribers intended to continue in perpetuity?
    - In which line item do under-expenditures exist that are allowing the Department to develop and prepare to implement the model within existing resources in FY 2021-22.
- Maternity Care Bundled Payments:
    - How will the Department account for diminished patient outcomes that result from things that are beyond the physicians control when developing the algorithm for payment distribution?
    - The target budget for the "entire maternity episode" will include all services related to "that condition." Is there only one set budget for all risk level of this type of episode, or are there variable budgets that account for members who are experiencing high-risk pregnancies? How do payments to providers who see a larger percentage of patients with high-risk pregnancies compare with payments to those who see fewer at-risk patients?
    - What quality goals are measured in this program? Is there a formal evaluation of the effectiveness of the program in both reducing costs and improving patient outcomes?
    - If the Department only pays 50 percent of the savings to the providers who meet all quality goals, and it pays nothing to those that do not, what will the Department do with the remaining funds?
- Primary Care Partial Capitation
    - The partial capitation payments will provide physicians the opportunity to spend additional time with Medicaid members, reducing the number of patients a physician may need to see in a given day to cover the overhead costs of the practice and presumable improving patient outcomes. Has the Department analyzed the impact of reduced practice capacity in rural areas in which there may only be one provider? Does the Department anticipate reduced access to care resulting in increased health care costs for a period of time as the market readjusts and additional providers can be incentivized to move into those areas?
    - What strategies has the Department considered to encourage more primary care physicians to serve the rural counties/regions of the state?
    - Is the monthly revenue upon which the capitated payment is calculated based on historical/current actual revenue, or is it based on what it actually costs the provider to do business?
    - How will Department account for diminished patient outcomes in chronic conditions that result from things that are beyond the physicians control (such as patient behavior) when developing the algorithm for incentive payments?
- Please discuss the implementation process and purpose of the Providers of Distinction programs proposed by the Department.

Significant cost drivers in the Department's request are related to the design, development, and implementation of solutions intended to be integrated with existing platforms. In consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

## DISCUSSION

In its FY 2022-23 R6 Value Based Payments budget request, the Department requests $22.9 million total funds, including $7.4 million General Fund for the planning and implementation of three alternative payment models in which participation by providers will be mandatory. In addition, the Department requests $11.4 million in roll-forward authority in the event that the development phase is delayed.

Alternative payment models are designed to provide incentive payments for the delivery of high-quality and cost-effective care. Many of these programs were initiated upon the creation of the Center for Medicare and Medicaid Innovation, established under the Affordable Care Act of 2010. The Innovation Center and the Centers for Medicare and Medicaid Services (CMS) "support the development and testing of innovative health care payment and service delivery models" and "is driving a national public-private effort to adopt alternative payment models that reward the quality of health care over quantity."[7] The Department proposes to pay incentive payments to providers for improved patient outcomes and lower costs.

Pursuant to Section 25.5-4-401.2, C.R.S., prior to implementing performance-based payments, the department must submit to the Joint Budget Committee either evidence that the performance-based payments are designed to achieve budget savings or a budget request for costs associated with the performance-based payments. The Department's request is intended to meet the statutory requirement. The Department plans to develop the alternative payment models in partnership with the Division of Insurance and the Department of Personnel in order to establish an aligned approach to value-based payment across public and private payers in Colorado. The intent is to drive improved health outcomes and care quality while reducing health care costs and health disparities.

### PHARMACY PRESCRIBER TOOL

The Prescriber Tool is intended to help employers and Coloradans save money on healthcare by ensuring that providers have information on prescription drug costs and affordable alternatives. The goal of the Prescriber Tool is to help improve patient health outcomes and service, reduce administrative burden for prescribers, and improve prescription drug affordability. Senate Bill 18-266 (Controlling Medicaid Costs) appropriated funding to the Department for the implementation of the Prescriber Tool. The tool makes available to providers information concerning the Department's drug cost information, preferred drug listing, Prior Authorization Requirements, and member-based risk factors based on the diagnosis.

[7] Pham, Katherine. "Alternative payment approaches for advancing comprehensive medication management in primary care." US National Library of Medicine, National Institutes of Health. Retrieved on December 1, 2021 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7739512/

In FY 2022-23, the Department requests $1.1 million total funds, including $364,529 General Fund, in order to implement an alternative payment model requiring prescribers to have the Pharmacy Prescriber Tool enabled. The Department intends to require mandatory participation by providers effective FY 2022-23. The Department will enroll all prescribers into a shared savings model to incentivize usage of the prescriber tool and lower spending on prescription drugs.

The Department reports that the Prescriber Tool leads to better utilization management of drugs by connecting physicians to the department's preferred drug list. Prescribers earn shared savings as they increase their percentage of prescriptions drugs chosen from the list or choose a lower cost option from multiple drug choices on the list. The Department will distribute savings realized from use of the tool on a quarterly basis. To ensure that high-quality care is provided, prescribers are required to meet quality goals to earn shared savings. The Department is developing and preparing to implement the model within existing resources in FY 2021-22. The model will include a quality and financial model to incentivize prescribers to use the tool.

Fiscal year 2022-23 funding will be used for stakeholder engagement, actuarial payment development and shared savings calculations, and updates to the payment and quality model based on stakeholder feedback and learned experience while operating the model. Ongoing funding will be used for the continuation of annual stakeholder engagement processes, development of payment targets with the Department's actuary, and professional evaluation of the program.

| PHARMACY PRESCRIBER ALTERNATIVE PAYMENT MODEL | | | | | |
|---|---|---|---|---|---|
| ITEM | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| Stakeholder engagement | $98,500 | $49,250 | $0 | $49,250 | 0.0 |
| Actuarial contractor for savings reimbursement | 95,400.0 | 47,700 | 0 | 47,700 | 0.0 |
| Program development consulting | 151,500.0 | 75,750 | 0 | 75,750 | 0.0 |
| Analytical tools & systems costs | 901,839.0 | 225,460 | 0 | 676,379 | 0.0 |
| Costs avoided | (125,856.0) | (33,631) | (7,197) | (85,028) | 0.0 |
| **Total Pharmacy Prescriber APM** | **$1,121,383** | **$364,529** | **($7,197)** | **$764,051** | **0.0** |

## MATERNITY CARE BUNDLED PAYMENTS

Maternity Care Bundled Payments were implemented by the Department in November 2020 with the intent of improving maternal health. At this time, the provider participation in the program is optional, with three providers participating, and funding for its implementation is limited. Bundled payment methodology is based on the total episode cost reconciled retrospectively with the provider. Shared savings are distributed on a quarterly basis. Payments of shared savings are not distributed to obstetrical providers who have a statistically significant difference in the total cost of care, or the number of services rendered, between the sub-group of pregnant people of color and white pregnant people. Participating obstetrical providers are required to complete a cultural competency training to ensure person-centered care is being provided.

The bundled payment methodology is based on a target budget for the entire maternity episode, including all services related to that condition. According to the Department, the budget will be based on historical average expenditures for the episode, with a targeted reduction to the costs associated with avoidable clinical events (such as a Cesarean delivery for a low risk delivery) for that episode. The department will continue to pay providers based on submitted claims, but after the episode is completed the department will reconcile actual expenditures for each service to the budget. If expenditures are higher than the budget, the main care provider will owe the Department 50 percent

of the difference. If expenditures are lower than the budget, the Department will share 50 percent of the savings with obstetrical care providers if all quality goals were met.

The Department requests $5.8 million total funds, including $1.0 General Fund to expand the maternity bundled payments model to all 242 obstetrical providers in Colorado. Funding will be used to engage stakeholders, develop the budgets for obstetrical providers with the Department's actuary, and hire a vendor to assist with project management and strategy development. In addition, the Department will hire a vendor to engage obstetrical providers, stakeholders, and Medicaid members to determine updates to the program before it becomes mandatory in FY 2023-24.

| MATERNITY BUNDLE ALTERNATIVE PAYMENT MODEL | | | | | |
|---|---|---|---|---|---|
| ITEM | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| Stakeholder engagement | $246,250 | $123,125 | $0 | $123,125 | 0.0 |
| Actuarial Rate Development | $148,400 | 74,200 | 0 | 74,200 | 0.0 |
| Project management | $249,750 | 124,875 | 0 | 124,875 | 0.0 |
| Program development consulting | $494,900 | 247,450 | 0 | 247,450 | 0.0 |
| Analytical tools & systems costs | $4,614,060 | 461,406 | 0 | 4,152,654 | 0.0 |
| **Total Maternity Bundle APM** | **$5,753,360** | **$1,031,056** | **$0** | **$4,722,304** | **0.0** |

A large portion of the funding is requested to cover the design, development, and implementation cost for a data sharing solution integrated with the Colorado Business Intelligence and Data Management system. This will be designed to integrate into provider electronic health records to supply obstetrical providers with up to date performance data compared with budgets and performance compared with program quality metrics. In consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

### PRIMARY CARE PHYSICIAN PARTIAL CAPITATION

The Department has developed two alternative payment models for primary care. The first uses a modified fee-for-service payment methodology and an incentive payment methodology when quality metrics are met. The second voluntary model provides a partial capitation advanced payment to providers for services that are expected to be delivered in a given month. The Department requests funding to implement the prospective partial capitation alternative payment model for both adult and pediatric primary care beginning in January 2022 on a voluntary basis with provider participation becoming mandatory in FY 2024-25.

The Department anticipates that the payment arrangement will result in increased cash flow for primary care providers even while demand may fluctuate. Under this model, physicians will select the share of monthly revenue attributed to the prospective payments and the rest will come from fee for service payments. In addition, meeting quality metrics will be incentivized when chronic conditions

are appropriately managed. Providers will earn shared savings from reductions in the total cost of care on their patient panel

The Department requests $2.6 million total funds, including $0.7 million General Fund, for the primary care alternative payment model for providers serving adults; and $2.4 million total funds, including $0.7 million General Fund, for pediatric providers. Funding will be used to engage stakeholders, develop the budgets for primary care providers with the Department's actuary, and hire a vendor to assist with project management and strategy development. In addition, the Department will hire a vendor to engage both adult and pediatric primary care doctors, stakeholders, and Medicaid members to determine updates to the program before it is made mandatory for 850 primary care providers in FY 2024-25.

| ADULT PRIMARY CARE ALTERNATIVE PAYMENT MODEL | | | | | |
|---|---|---|---|---|---|
| ITEM | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| Stakeholder engagement | $98,500 | $49,250 | $0 | $49,250 | 0.0 |
| Actuarial Rate Development | $381,600 | 190,800 | 0 | 190,800 | 0.0 |
| Project management | $249,750 | 124,875 | 0 | 124,875 | 0.0 |
| Program development consulting | $494,900 | 247,450 | 0 | 247,450 | 0.0 |
| Analytical tools & systems costs | $1,349,263 | 134,926 | 0 | 1,214,337 | 0.0 |
| **Total Adult Primary Care APM** | **$2,574,013** | **$747,301** | **$0** | **$1,826,712** | **0.0** |

| PEDIATRIC PRIMARY CARE ALTERNATIVE PAYMENT MODEL | | | | | |
|---|---|---|---|---|---|
| ITEM | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| Stakeholder engagement | $98,500 | $49,250 | $0 | $49,250 | 0.0 |
| Actuarial Rate Development | $190,800 | 95,400 | 0 | 95,400 | 0.0 |
| Project management | $249,750 | 124,875 | 0 | 124,875 | 0.0 |
| Program development consulting | $494,900 | 247,450 | 0 | 247,450 | 0.0 |
| Analytical tools & systems costs | $1,349,263 | 134,926 | 0 | 1,214,337 | 0.0 |
| **Total Pediatric Primary Care APM** | **$2,383,213** | **$651,901** | **$0** | **$1,731,312** | **0.0** |

A large portion of the funding is requested to cover the design, development, and implementation cost for a data sharing solution integrated with the Colorado Business Intelligence and Data Management system. This will be designed to integrate into provider electronic health records to supply providers with up to date performance data compared with budgets and performance compared with program quality metrics. In consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

## COLORADO PROVIDERS OF DISTINCTION

The department requests to plan and implement separate Colorado Providers of Distinction programs in primary care, specialty care, and hospital-based procedures, starting in FY 2023-24. The Colorado Providers of Distinction programs identify health care providers that deliver high-value care and demonstrate better outcomes for Colorado patients and families. The programs will evaluate and report on health care outcomes and episode price for specific conditions in primary care, specialty care, and hospital-based procedures to offer insights to providers and patients and promote referrals to the respective provider of distinction in their region.

In order to implement Providers of Distinction in primary care, specialty care, and for hospital based procedures, the Department needs to develop episode based analytics to identify the separate groups of Providers of Distinction, stakeholders need to be engaged from each group and analytics to alter member choice of provider, and the Department needs support with strategy and clinical design of each of the three programs in FY 2022-23. The Department's request includes fund for the design and implement of a solution that will integrate the Colorado Providers of Distinction analytics with the Department's eConsult system to influence referrals between primary care and specialty care.

The Department requests $9.9 million total funds, including $4.1 million General Fund for the development and implementation of the Colorado Providers of Distinction programs. JBC staff will discuss this portion of the Department's request in greater detail at figure setting. Staff recommends that the Committee ask the Department to discuss the proposal during the Department's hearing.

| COLORADO PROVIDERS OF DISTINCTION | | | | | |
|---|---|---|---|---|---|
| ITEM | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| Analytics | $3,912,750 | $1,956,375 | $0 | $1,956,375 | 0.0 |
| Stakeholder engagement | $295,500 | 147,750 | 0 | 147,750 | 0.0 |
| Strategy/design consulting | $3,484,500 | 1,742,250 | 0 | 1,742,250 | 0.0 |
| Systems costs | $2,251,102 | 225,110 | 0 | 2,025,992 | 0.0 |
| **Total Colorado Providers of Distinction** | **$9,943,852** | **$4,071,485** | **$0** | **$5,872,367** | **0.0** |

In addition, because this portion of the request includes funding for the design and implementation of a solution that integrates analytics with the eConsult system, in consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

## DEPARTMENT FTE

Finally, the Department requests $1.1 million total funds, including $0.5 million General Fund, and 9.6 FTE in FY 2022-23 for staff to support the implementation of the alternative payment models

and the Colorado Providers of Distinction programs. JBC staff will provide analysis on this portion of the Department's request at figure setting.

| Alternative Payment Model and Colorado Providers of Distinction Support | | | | | |
|---|---|---|---|---|---|
| Item | Total Funds | General Fund | Cash Funds | Federal Funds | FTE |
| APM and CPD financial rate analysts | $299,132 | $149,566 | $0 | $149,566 | 3.8 |
| Analytic tools statistical analyst | $77,038 | 38,519 | 0 | 38,519 | 1.0 |
| APM and CPD program administrators | $211,086 | 105,543 | 0 | 105,543 | 2.9 |
| RAE alignment program administrators | $140,724 | 70,362 | 0 | 70,362 | 1.9 |
| **Total APM and PoD Support** | **$727,980** | **$363,990** | **$0** | **$363,990** | **9.6** |

| FTE Costs | | | | | |
|---|---|---|---|---|---|
| Item | Total Funds | General Fund | Cash Funds | Federal Funds | FTE |
| FTE centrally appropriated costs | $201,273 | $100,636 | $0 | $100,637 | 0.0 |
| FTE operating costs | $79,500 | 39,750 | 0 | 39,750 | 0.0 |
| FTE leased space | $66,000 | 33,000 | 0 | 33,000 | 0.0 |
| **Total APM and PoD FTE Costs** | **$346,773** | **$173,386** | **$0** | **$173,387** | **0.0** |

# ISSUE: PROVIDER RATES (R10, R9)

Through R10 Provider Rate Adjustments the Department requests adjustments to member contributions for copayments and personal needs allowances, several targeted rate increases, and an across-the-board rate adjustment for providers not receiving the targeted rate adjustments. The FY 2022-23 request is for an increase of $104.4 million total funds, including $41.3 million General Fund. Targeted rate increases are also identified in the Department's R9 Office of Community Living Program Enhancements budget request.

## SUMMARY

- Through the process authorized by S.B. 15-228 (Medicaid Provider Rate Review) provider rates are reviewed at least once every five years.
- Multiple rate categories reviewed in 2021 are included in the targeted rate adjustment portion of the Department's FY 2022-23 R10 Provider Rate Adjustments budget request.
- The Department recommends moving rates that fall below 80.0 percent of the appropriate benchmark up to 80.0 percent of the benchmark; however funding for targeted rate increases is requested to move the rates closer to 80.0 percent for most of the reviewed services and not all the way up to 80.0 percent of the benchmark.
- The Department proposes reducing rates for speech therapy and durable medical equipment that exceed 100.0 percent of the appropriate benchmark down to 100.0 percent.
- The $15 per hour wage increase for Home- and Community-based Services direct service providers approved by the JBC as part of the American Rescue Plan Act Home- and Community-based Services Spending Plan will be implemented January 1, 2022 through April 15, 2023. The Department requests funding to continue the wage increase through FY 2022-23 and ongoing.
- In its R9 Office of Community Living Program Enhancements budget request, the Department requests funding for specific targeted rate increases in the Office of Community Living waiver services.

## DISCUSSION

### PROVIDER RATE REVIEW PROCESS UNDER S.B. 15-228

In developing it R10 Provider Rate Adjustments budget request, the Department leaned on recommendations from the provider rate review process created by S.B. 15-228 (Medicaid Provider Rate Review). The JBC sponsored S.B. 15-228 to assist the legislature in evaluating rate change proposals. As Medicaid became an increasingly important payer for medical services, complaints concerning the insufficiency of reimbursement rates were often shared with JBC members. The process established by S.B. 15-228 was intended to address these issues by providing data to support rate setting decisions, and by establishing formal procedures for the Department to engage with providers regarding rate setting priorities. While the process has resulted in some improvements concerning rate setting, balancing the budget on an annual basis continues to be a limiting factor in the development of provider rate requests.

Concurrent with the passage of S.B. 15-228, the federal government issued new rules requiring states to conduct periodic rate reviews. The federal rules require states to review certain rates at least once every three years. There is some overlap between the rate reviews required by federal regulation and

those required by S.B. 15-228. The federal rules emphasize analysis of regional variations in access, so the Department has incorporated a discussion of regional access in the S.B. 15-228 process. Significantly, the federal rules require an analysis of the expected effect on member access to services prior to any reduction in Medicaid rates.

## EVALUATING RATE SUFFICIENCY

Statute directs the Department and the MPRRAC to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. To do this the Department makes comparisons to benchmark rates, analyzes claims data for access issues, and solicits stakeholder feedback.

The Department's reports emphasize that there are a number of limitations to claims-based analysis of access to consider before drawing conclusions. First, factors other than rates may influence observed access issues, such as the administrative burden of participation in Medicaid, client characteristics and behaviors, provider outreach efforts, and provider scheduling practices. Second, rates may not be optimal when there are no observed access issues. For example, rates can drive over utilization or underutilization of services in a manner inconsistent with best practices. Third, claims data alone does not reveal potentially important information such as the number of providers accepting new clients, the supply of providers not participating in Medicaid, appointment wait times, the level of care provided compared to the level of need, or the portion of payments passed on to employee wages. For these reasons, the Department encourages looking at the claims-based analysis of access in context of the other information available, including the benchmark comparisons and stakeholder input.

The Department just completed Year 1 of the Second Five Year Review Cycle, including:

- Emergency Medical Transportation (EMT)
- Non-Emergent Medical Transportation (NEMT)
- Home and Community-Based Services (HCBS) Waivers
- Targeted Case Management (TCM)

The Department submitted the Medicaid Provider Rate Review Recommendation Report to the JBC on June 15, 2021. The report contains analyses, rate comparisons, and sufficiency assessments for the sets of services identified above. Recommendations are summarized in the report submitted November 9, 2021. The Recommendation Report can be found here: Rate Review Reports | Colorado Department of Health Care Policy & Financing

## R10 PROVIDER RATE ADJUSTMENTS

The Department requests several adjustments to provider rates, including an across-the-board increase of 0.5 percent for most providers and targeted rate adjustments for others. For most services, the request is based on the assumption that the requested rate adjustments will be effective July 1, 2022. The table below summarizes the dollar changes requested in the Department's FY 2022-23 R10 Provider Rate Adjustments budget request.

| R10 Provider Rate Adjustments | | | | | |
|---|---|---|---|---|---|
| Rate | Change | Total Funds | General Fund | Cash Funds | Federal Funds |
| Across the board rate adjustment | 0.5 percent increase | $32,230,602 | $11,432,806 | $1,499,074 | $19,298,722 |
| Targeted rate increases | | | | | |
| Durable medical equipment | Rebalancing (between 80 and 100 percent) | $1,596,720 | $798,360 | $0 | $798,360 |
| Massage therapy | 34.5 percent increase | 27,293 | 13,647 | 0 | 13,646 |
| Non-emergent medical transport | Increase rates below 60.8 percent up to 60.8 percent | 22,816,821 | 7,393,642 | 4,014,769 | 11,408,410 |
| Emergency medical transport | Increase rates below 50 percent up to 50 percent | 8,298,520 | 1,948,546 | 453,943 | 5,896,031 |
| Non-medical transport | Increase rates below 70 percent up to 70 percent | 3,046,513 | 1,523,256 | 0 | 1,523,257 |
| Speech therapy | Rebalancing (between 70 percent and 100 percent) | 1,134,728 | 567,364 | 0 | 567,364 |
| Home- and community-based services | Maintain $15/hr wage through remainder of FY 2022-23 | 33,373,436 | 16,686,725 | 0 | 16,686,711 |
| Subtotal targeted rate increases | | $70,294,031 | $28,931,540 | $4,468,712 | $36,893,779 |
| Changes to member contributions | | | | | |
| Changes to copayments | Increase fr $6 to $8 | ($26,920) | ($5,275) | ($1,637) | ($20,008) |
| Personal needs allowance | Increase fr $152.00 to $383.33 | 1,937,115 | 968,558 | 0 | 968,557 |
| Subtotal changes to member contributions | | $1,910,195 | $963,283 | ($1,637) | $948,549 |
| **Total Provider Rate Adjustments** | | **$104,434,828** | **$41,327,629** | **$5,966,149** | **$57,141,050** |

**ACROSS THE BOARD RATE ADJUSTMENT**

The Department requests a 0.5 percent increase in provider rates for those providers for which targeted rate increases are not requested, with the exception of the home- and community-based services (HCBS) providers receiving increases to raise direct support professional wages to $15 per hour. Because the wage increases are implemented as part of the American Rescue Plan Act (ARPA) HCBS Spending Plan and will go into effect on January 1, 2022, both the targeted rate increase and the common policy provider rate increase is requested for the eligible HCBS providers.

The Governor's FY 2022-23 budget request includes a 1.0 percent provider rate increase for most community providers, however, the Department of Health Care Policy and Financing adjusts the common policy provider rate downward to make funding available to cover targeted rate increases. Independent of its decision concerning requests for targeted rate adjustments, the JBC typically applies the common policy provider rate adjustment across all departments.

The Department requests $32.2 million total funds, including $11.4 million General Fund, to increase rates for most providers by 0.5 percent. The amount is calculated based on 11 months in order to account for the cash basis accounting of claims processing.

**TARGETED RATE ADJUSTMENTS**

*DURABLE MEDICAL EQUIPMENT*

Analysis of Durable Medical Equipment (DME) services identified rates that fell below 80 percent of the Medicare benchmark for some services and above 100 percent of the benchmark for others. The

Department's request includes an increase of rates up to 80 percent for those falling below the 80 percent benchmark, and to reduce rates down to 100 percent for those that are above the 100 percent benchmark. The Department requests $1.6 million total funds, including $0.8 million General Fund, to rebalance DME rates.

*MASSAGE THERAPY*

The Department requests funding to increase massage therapy rates for the Spinal Cord Injury (SCI) waiver and the Children with Life Limiting Illness (CLLI) waiver to align them with Supported Living Services (SLS) waiver rates. The Department requests $27,293 total funds, including $13,646 General Fund, to increase massage therapy rates for the SCI waiver by 34.5 percent (from $14.20 to $19.10).

*NON-EMERGENT MEDICAL TRANSPORT*

According to the 2020 MPRRAC analysis, average rates for Non-emergent Medical Transportation (NEMT) services are estimated at 37.51 percent of the benchmark, with individual rates falling within the range of 27.06 and 134.51 percent. The Department recommends increasing rates up to 80.0 percent of the benchmark and monitoring the rates in the future. The Department requests $22.8 million total funds, including $7.4 million General Fund, to increase NEMT rates that are currently below 60.8 percent of the benchmark up to 60.8 percent of the benchmark in order to move the rates closer to the target of 80.0 percent.

*EMERGENCY MEDICAL TRANSPORT*

Based on the 2020 MPRRAC analysis, average rates for Emergency Medical Transportation (EMT) services are estimated to be 40.92 percent of the benchmark with individual rates for services falling within the range of 29.44 and 99.51 percent of the benchmark. The report indicates that the current rates may not be sufficient to provide high value services. The Department recommends increasing rates up to 80.0 percent of the benchmark. The Department requests $8.3 million total funds, including $1.9 million General Fund, to increase rates that are currently below 50.0 percent of the benchmark up to 50.0 percent of the benchmark in order to move the rates closer to the target of 80.0 percent.

*NON-MEDICAL TRANSPORTATION*

Non-medical Transportation (NMT) average rates are estimated to be 86.98 percent of the benchmark with individual rates for services falling within the range of 56.21 and 265.80 percent of the benchmark. The Department recommends an investigation of rate disparities for services across waivers in order to improve rate equity. The Department requests $3.0 million total funds, including $1.5 million General Fund, to increase NMT rates that are below 70.0 percent of the benchmark up to 70.0 percent of the benchmark in order to create equity for non-medical transportation services across waivers.

*SPEECH THERAPY*

According to the MPRRAC analysis, Speech Therapy rates are estimated to be 73.51 percent of the benchmark with individual rates for services falling within the range of 16.82 and 107.2 percent of the benchmarks. Providers indicate that rates are insufficient to offer competitive wages, retain specialized providers, and cover overhead costs. The Department recommends rebalancing rates that were identified below 80.0 percent and above 100.0 percent of the benchmark. The Department requests $1.1 million total funds, including $0.6 million General Fund, to increase the rates for speech therapy services that are below 70.0 percent of the benchmark up to 70.0 percent of the benchmark in order

to move rates closer to the 80.0 percent target; and to decrease rates over 100.0 percent down to 100.0 percent of the benchmark.

*HOME- AND COMMUNITY-BASED SERVICES*

Home- and community-based services allow individuals to receive essential care and remain in a community setting. As a part of the ARPA Spending Plan approved by the JBC and the Centers for Medicare and Medicaid Services (CMS) in September 2021, the Department increased rates for certain HCBS services with a required wage pass through for providers to pay at least $15 per hour base wage for frontline staff providing direct hands-on care. Increases under the spending plan are effective from January 1, 2022 through April 15, 2023 for targeted services, including:

- Adult day;
- Alternative care facility;
- Consumer-direct attendant support services (CDASS);
- Community connector;
- Day habilitation;
- Homemaker;
- In-home support services (IHSS);
- Mentorship;
- Personal care;
- Prevocational services;
- Residential habilitation;
- Respite care;
- Supported community connections; and
- Supportive living program.

The Department's budget request includes $33.4 million, including $16.7 million General Fund, to continue the $15 wage pass through from April 16 through June 30, 2023. This request annualizes to $159.8 million total funds, including $79,920,597 General Fund in FY 2023-24.

**CHANGES TO MEMBER CONTRIBUTIONS**

*CHANGES TO COPAYMENTS*

Member copayments are required on several services, including non-emergent outpatient hospital services, physician services, telemedicine services, rural health clinic services, pharmacy, optometry services, podiatry services, durable medical equipment, laboratory services, and radiology services. The cost of copayments is based on the services rendered and the income of the member. Pursuant to federal law, copayments may not exceed 5.0 percent of the total income of a Medicaid member. The Department's request includes a decrease of $26,920 total funds, including $5,275 General Fund, as a result of increases in member copayments to the maximum allowable amount of $8 (from $6) for hospital outpatient emergency room visits for non-emergent care in order to discourage improper use of emergency services.

*PERSONAL NEEDS ALLOWANCE*

Personal needs allowances (PNA) are used by Medicaid members to purchase items such as non-covered medical items, clothing, toiletries, eyeglasses, entertainment, technology, and snacks. Members may not have more than $152 in PNA, regardless of income, an amount that is insufficient

for monthly expenses incurred by members. The Department contends that raising the monthly maximum PNA will result in improved financial stability for members residing in residential settings.

The Department requests $1.9 million total funds, including $1.0 million General Fund, to increase the PNA maximum from $152 per month to $383.33 per month and to reimburse providers the difference between the member contribution and costs associated with alternative care. This request annualizes to $4.6 million total funds, including $2.3 million General Fund, in FY 2023-24.

**PROVIDERS EXEMPT FROM ACROSS-THE-BOARD RATE INCREASES**

Across-the-board rate adjustments are given to most Medicaid providers, with the exception of:

- A portion of the expenditure related to non-medical emergency transportation services as services are rendered under a fixed price contract;
- Dental administrative payments, as payment rates were agreed upon during a competitively procured contract process;
- Pharmaceutical reimbursements, as they are based on a methodology that reflects the actual costs of purchasing and dispensing medications;
- Rural health clinics, as rates are based on actual costs or the Medicare upper payment limit;
- Physical health managed care programs, as rates are negotiated within the parameters of their respective rate setting methodology;
- Medicaid and CHP risk-based physical health managed care programs and regional accountable entities, as rates are set in accordance with federal regulation and actuarial standards which do not generally permit general provider rate increases; and
- Services receiving targeted rate adjustments.

## R9 OFFICE OF COMMUNITY LIVING ENHANCEMENTS

In addition to the Department's request to apply targeted provider rate or a common policy provider rate increases, rate increases are requested in the Department's FY 2022-23 R9 Office of Community Living Enhancements budget request. These rate increases are identified in the following table:

| R9 OFFICE OF COMMUNITY LIVING PROGRAM ENHANCEMENTS | | | | | |
|---|---|---|---|---|---|
| RATE | CHANGE | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| Brain Injury Waiver (high acuity members) | | | | | |
| Transitional Living Program (change in rate methodology) | 41.6 percent increase | $208,321 | $104,161 | $0 | $104,160 |
| Supported Living Program (newly negotiated rate) | new tier, 20 percent above tier 6 - $538.38 | (264,159) | (132,080) | 0 | (132,079) |
| Subtotal Brain Injury Waiver | | ($55,838) | ($27,919) | $0 | ($27,919) |
| Case Management | | | | | |
| Rate alignment | various increases | $839,791 | $419,896 | $0 | $419,895 |
| Children with Complex Needs | | | | | |
| Respite and residential rates (alignment) | various increases | $222,811 | $111,405 | $0 | $111,406 |
| **Total Provider Rate Adjustments** | | **$1,006,764** | **$503,382** | **$0** | **$503,382** |

*BRAIN INJURY WAIVER*

The highest rates available to providers for two programs that serve individuals with high acuity brain injuries are insufficient to ensure the necessary capacity to serve members who need these services.

Transitional Living Program

The Transitional Living Program (TLP) is available through the Brain Injury waiver and offers intensive services in an assisted living setting for recently injured people with high acuity brain injuries. It is designed to help members transition back into the community post-injury. It is available within 18 months after the first brain injury or three months after the second brain injury with a hospital stay. The Department reports that the program is successful in reducing hospital readmissions, however the number of utilizers is significantly limited due to provider capacity issues. The TLP has five tiers of rates, however the rate for high acuity brain injuries is not sufficient to encourage increased community capacity. The Department is requesting funding to increase the average daily rate for TLP from $463.58 to $656.47.

Supported Living Program

The Supported Living Program (SLP) is available through the Brain Injury waiver and is a specialized assisted living service for people with high acuity brain injuries. It includes 24-hour oversight, assessment, training and supervision of self-care, medication management, behavioral management, and cognitive supports. The SLP has six tiers of rates, however the rates for high acuity brain injuries is not sufficient to increase access to care for members. The Department is requesting funding to create a negotiated daily rate of $538.38 for high acuity utilizers in this program in order to increase the number of members who are able to receive care in the community as opposed to in a hospital.

*CHILDREN'S HABILITATION RESIDENTIAL PROGRAM*

The Children's Habilitation Residential Program (CHRP) provides services and supports for children and youth who have an intellectual or developmental disability and very high needs. Pursuant to H.B. 18-1328 (Redesign Residential Child Health Care Waiver), administration of the CHRP waiver was transferred to the Department in FY 2018-19 and expanded in order to allow children or youth who are not in the custody of child welfare agencies to enroll in the waiver. Members of the waiver can access residential supports if they require out-of-home placement. Options for placement include foster homes, group homes, and Residential Child Care Facilities, but do not include host home residential care. While many residential service providers offer both foster home and host home care to members, the reimbursement rates for the services are aligned. Foster home rates across all support levels are lower than those for host homes.

The Department is requesting funding to align respite reimbursement rates for CHRP placements with similar services provided through the Children's Extensive Services (CES) waiver; and to increase CHRP reimbursement rates for foster home and group home care to align with the rates paid for host home and group residential care on the Comprehensive waiver. Rate adjustments include:

- Increases of approximately 17 percent for each of the six levels of CHRP foster home rates to align with Individual Residential Services and Supports/Host Home rates; and
- Increase for each of the six levels of CHRP group home rates to align with Group Residential Services and Supports:
    - Level 1 – 42.0 percent (from $84.32 to $119.74);
    - Level 2 – 29.9 percent (from $111.00 to $144.23);
    - Level 3 – 24.8 percent (from $160.76 to $163.20);
    - Level 4 – 17.0 percent (from $154.46 to $186.20);
    - Level 5 – 19.5 percent (from $170.64 to $203.95); and
    - Level 6 – 17.7 percent (from $201.22 to $236.90).

*CASE MANAGEMENT*

Case management is provided to members enrolled in an HCBS waiver and includes facilitation of the member's enrollment in a program that meets their level of care requirements; locating, coordinating, and monitoring needed HCBS waiver services; and coordinating with non-waiver resources, including medical, social, and educational resources. Of the 49 case management agencies (CMAs), 24 are Single Entry Points (SEPs), 20 are Community Centered Boards (CCBs), and 5 are private agencies. Case management rates vary between SEPs and CCBs across activities. The Department is requesting funding to align rates for case management training, appeals, and ongoing monitoring. The rate adjustments include:

- An increase of 0.4 percent in the CCB Training rate (from $602.79 to $605.39);
- An increase of 44.6 percent in the CCB Appeals rate (from 343.02 to $496.08);
- An increase of 62.7 percent in the SEP Appeals Hearing rate (from $281.65 to $458.15); and
- An increase of 17.1 percent in the SEP Monitoring rate (from $83.45 to $97.74).

# ISSUE: MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE

The Medicaid Provider Rate Review Advisory Committee (MPRRAC) was established in 2015 to assist the Department of Health Care Policy and Financing with reviewing Medicaid provider rates. The committee is required to meet at least once per quarter through September 1, 2025. Pursuant to Section 25.5-4-401.5, the Department must review Medicaid provider rates based on a schedule that allows for the review of each provider rate at least every five years. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) or the Joint Budget Committee (JBC), by majority vote, may direct the Department to conduct a review of a provider rate not scheduled for review during a given year, or to include an exempted rate in the review. If the JBC requests a rate review, it must notify the Department of the out-of-cycle rate review by December 1st.

## SUMMARY

- The Medicaid Provider Rate Review Advisory Committee (MPRRAC) was created in 2015 to assist the Department of Health Care Policy and Financing with reviewing Medicaid provider rates.
- Each year, the Department submits a report containing an analysis of the reviewed rates, including information on the level of access, service, quality, and utilization provided, as well as comparisons of the rates with available benchmarks, including Medicare and usual and customary rates paid by private payers.
- While not a perfect process, JBC staff believes that it has improved the information made available to the JBC when making decisions concerning provider rate adjustments.
- As the process enters its seventh year, it may be beneficial to consider modifications to the process.

## RECOMMENDATION

JBC staff recommends that the JBC consider asking the Department to discuss existing challenges with and potential improvements, including statutory changes, that can be made to the MPRRAC committee and rate review process.

## DISCUSSION

During the 2015 Legislative Session, the Joint Budget Committee (JBC) sponsored S.B. 15-228 (Medicaid Provider Rate Review) to assist the legislature in evaluating Medicaid rate change proposals. The bill established the Medicaid Provider Rate Review Advisory Committee (MPRRAC) assist the Department of Health Care Policy and Financing with reviewing Medicaid provider rates, and requires annual reporting to the JBC concerning the analysis of the reviewed rates to available benchmarks and the Department recommendation concerning the analyzed rates. The Department considers the recommendations of the MPRRAC and stakeholders when developing its annual budget request.

Statute requires the following:

- A five-year review cycle of provider rates – 2021 begins the second five-year cycle of rate review and during which rates for emergency and non-emergent medical transportation, home and community-based services waivers, and targeted case management were reviewed a second time.
- An analysis report – An analysis report of the rates is required to be submitted to the JBC by May 1 each year, providing information for the rates under review on the level of access, service, quality,

and utilization provided, as well as comparisons of the rates with available benchmarks, including Medicare and usual and customary rates paid by private payers. The report must assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. If a rate is identified as needing adjustment, but the budget does not support a change, the annual reports ensure the data and analysis remain available to inform decision making in future years.

- A recommendation report - A second report, due by November 1 each year, explains the Department's recommendations on the rates. It is important to note that while the Department may recommend a rate increase to within a specified percentage of the benchmarks, the subsequent budget request may not include funding to actually increase that rate to that level. (See the issue briefing concerning "*Provider Rates"* for examples.)
- Creation of the MPRRAC – This 24 member advisory committee, appointed by the House and Senate leadership and composed of providers and stakeholders, reviews the Department's May 1 report and helps the Department devise strategies for responding to the findings, including non-fiscal approaches or rebalancing of rates. The Advisory Committee also holds meetings with the Department to solicit public comment on the rates under review. The MPRRAC may direct the Department to change the rate review schedule and may make recommendations to the General Assembly for how to improve the rate review process.

When asked about the effectiveness of the MPRRAC and process, stakeholder responses vary. Some stakeholders report that the process has been beneficial, others report that they would prefer it if the MPRRAC went away. While JBC staff has not officially polled all stakeholders about process effectiveness, she has asked those stakeholders who have met with her how they would improve the process. Unfortunately, stakeholders with negative opinions about the process have provided no direct feedback specifically related to improving it. The Department, on the other hand, has indicated that much thought, however, has only provided feedback on JBC staff's Medicaid rate review memo presented to the JBC on December 18, 2021. **JBC staff recommends that the JBC consider asking the Department to discuss improvements that can be made to the MPRRAC committee and rate review process, including any recommended statutory changes.**

### CHALLENGES WITH THE CURRENT PROCESS

While likely not an exhaustive list, JBC staff recognizes the following challenges with the current process:

- The size of the MPRRAC may be too large – 24 seats on a committee is a large number of seats to fill and potentially resulting in the lack of representation the providers whose rates are being reviewed during a given year.
- Representatives appointed to the MPRRAC are not required by statute to reside in the State of Colorado during the term of their appointment.
- The authority and responsibility rest with the Department, potentially resulting in biased analysis of the benchmarks, however the same can be said if a rate adjustment is recommended by a provider or its representative(s).
- There exists an inherent lack of trust between providers and state departments resulting from the internally competitive model of resource allocation that exists across government. Stakeholder meetings may not necessarily yield the best possible answer when the entity responsible for facilitating them has its own "skin in the game."

- Executive Branch priorities may change with the change in administration, possibly resulting in inconsistent commitment to rate adjustments over time.
- While the JBC has the authority to direct the Department to perform an out of cycle review of a rate, as was done on November 18, 2021, the Department may choose to provide detailed reasons why it cannot or will not comply with that direction.

### POINTS TO CONSIDER

JBC staff does not believe repealing the MPRRAC and rate review process is the answer, however, does believe that modifications to it may prove beneficial.

- While not the only option, the JBC may wish to consider reducing the size of the MPRRAC to 10 representatives and aligning appointments with the rate review schedule established by the department to ensure that those who are seated are representative of the rates being reviewed. In this option, appointments would also be cyclical over the five-year rate review schedule. In addition, the MPRRAC can utilize subject matter experts to inform the review of particular rates.
- Given that the process is specific to the State of Colorado, the JBC may wish to consider amending statute to require that seated members reside in the state, or that someone is appointed in place of an individual who moves out of state.
- Initially, two options present themselves to address potential bias and changing Executive Branch priorities:
    - Amend statute to require an outside contractor to facilitate the stakeholder discussions, select the benchmarks, perform the analysis, and make recommendations concerning rate adjustments. Require the required reports to be submitted to the Department, the Office of State Planning and Budgeting, and Joint Budget Committee for consideration during the budget process.
    - Amend statute to move the rate review process out of the Executive Branch and into the Legislative Branch and require that the process and its associated requirements be facilitated and performed by non-partisan staff or through vendors contracted by the General Assembly.

### FISCAL IMPACT

Senate Bill 15-228 included an appropriation of $592,770 total funds, including $269,912 General Fund, and 4.0 FTE in FY 2015-16. A fiscal analysis will be necessary to determine the impact of any changes made to the process, including whether or not the federal match would be available if the review process is performed by an entity other than the Department. In addition, it is likely that the Department will still require staffing resources to assist in the process. It is very unlikely that moving the process into the Legislative Branch would be fiscally neutral, however the General Assembly may benefit from analyses that are not limited by the priorities of the Executive Branch.

# ISSUE: MEDICAID MANAGEMENT INFORMATION SYSTEM (R14)

The Medicaid Enterprise consists of four components, including the Medicaid Management Information System, the Business Intelligence and Data Management system, the Pharmacy Benefit Management System, and the Colorado Benefits Management System (CBMS). Funding for all but CBMS is appropriated in the MMIS line item in the Long Bill. The Department currently utilizes contractors to manage each of the four components.

## SUMMARY

- The Medicaid Enterprise includes four components, each providing separate services, including claims processing functions, data analytics, eligibility determination, and pharmacy and benefits management services. Each component is managed by a different contractor.
- New guidance from the Centers of Medicare and Medicaid Services (CMS) concerning the re-procurement or transition of vendors for information systems services moves towards interoperable module implementations, resulting in the increased importance of the integration of the four systems.
- The Department intends to shift towards utilizing state FTE as opposed to contractors to perform much of the ongoing integration and requires additional FTE to handle the increased workload associated with the re-procurement expectations for each module.

## RECOMMENDATION

In consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

In addition, JBC staff recommends that the JBC consider asking the Department to discuss its plan to transition away from contracted resources toward the utilization of state FTE, the timeline for completing the transition, and the contingency plan if the state FTE cannot be hired and trained by the targeted date(s).

## DISCUSSION

In its FY 2022-23 R14 MMIS Funding Adjustment and Contractor Conversion budget request, the Department requests:

- A one-time reduction to its FY 2022-23 appropriation to accurately reflect current costs associated with operating the overall system and current federal match rates; and

- Reallocation of one-time reduction to increase Department staff by 8.0 FTE to address gaps in operation and management for current and upcoming Medicaid Enterprise modular re-procurements and for the maintenance and improvements of the electronic visit verification system; and
- Reallocation of Services Integrator contract funding to 5.0 permanent state FTE.

The reduction in necessary funding results from leveraging higher federal financial participation (FFP) match rates, combining several projects, negotiations with vendors for rate reductions, and collaborating with other states to obtain project scope and pricing insight. This portion of the Department's request will be discussed in greater detail during figure setting.

While mentioned briefly below, the request for 8.0 FTE to address issues related to modular re-procurements for the Medicaid Enterprise and for maintenance and improvements of the electronic visit verification will be further discussed during figure setting.

### MEDICAID ENTERPRISE SERVICES INTEGRATION

The Medicaid Enterprise consists of the following:

- The Medicaid Management Information System (MMIS) which supports the core MMIS functions such as clams processing and Fiscal Agent services;
- The Business Intelligence and Data Management (BIDM) system which provides data analytics services;
- The Pharmacy Benefit Management System (PBMS) which provides pharmacy management services; and
- The Colorado Benefits Management System (CBMS) which provide eligibility determination services.

Funding for all but CBMS is appropriated in the MMIS appropriation in the Long Bill. Each of the four services is provided through separate contractors. As Centers for Medicare and Medicaid Services (CMS) guidance concerning the re-procurement or transition of vendors for information systems services moves towards interoperable module implementations, integration of the four systems increases in importance. Services Integration ensures that the numerous modules provided by different vendors in the Medicaid Enterprise are fully integrated and interoperable, with accurate and consistent communication and flow of data between modules, well-designed modular system architecture, and alignment with CMS requirements. The Department received funding to begin integration work in FY 2019-20.

Under the current contract structure, the Department is required to re-procure or re-evaluate each component on a modular timeline, resulting in the management of multiple procurements on different timelines and an increased workload. The Department indicates that it does not have sufficient staff to manage the contracts under the CMS modular re-procurement rules. In addition, while the Department states that several IT projects have come in under budget year after year, it argues that outside vendors are a less cost-effective way to meet the Department's goals for the administrative duties because they cost more than state FTE. The Department contends that:

- State FTE are better suited to manage the Medicaid Enterprise systematic benefit and policy rules from a federal and state regulatory compliance level;

- Transition from one vendor to another results in delays in completion of deliverables, but that this would not occur with state FTE;
- The continued use of contractor resources will require oversight and management by state FTE in order to ensure continuity of Medicaid and CHP+ rules on the forefront of every project;
- State FTE is necessary to ensure contractors understand workflow requirements; and
- State FTE typically cost less than paying an hourly rate for contracted work.

The 5.0 Service Integrator state FTE will be responsible for:

- Defining technical requirements on Medicaid Enterprise enhancement projects and interfacing with contractors to ensure the Department's business requirements are fulfilled;
- Leading the Department's services operations and other staff and coordinating the overseeing process adherence related to modular implementation activities;
- Coordinating all system testing efforts, providing process direction and assistance to Department staff and monitoring contractor testing performance;
- Overall testing of integrated services, testing of multiple modules across multiple services to ensure proper integration, and supporting all testing to ensure the service functions as designed before going into production; and
- Oversight of staff and comprehensive program and project oversight of the planning and execution of modular service projects across the Medicaid Enterprise, including communication, organizational change management, and risk management.

## POINTS TO CONSIDER AND STAFF RECOMMENDATIONS

The Department's budget request includes several decision points, however, JBC staff focused on two aspects of the request in this briefing: 1) integration of the four components of the Medicaid Enterprise, and 2) the request for state FTE for this purpose.

### SERVICE INTEGRATION

Integration of the four components into one "enterprise" system is complex. While JBC staff understands that the initial budget request to begin this process was approved in FY 2019-20, converting the project from contractor resources to state FTE with the added challenge of meeting new CMS guidelines requires a review by those with more technical expertise. In consultation with JBC staff for Information Technology Projects and Joint Technology Committee (JTC) staff, staff recommends that the Committee refer this request to the Joint Technology Committee (JTC), pursuant to Joint Rule 45(b).

Staff recommends that this request remain for consideration in the operating budget as submitted; however, staff requests a JTC review and recommendation as an IT-related operating request item. Staff additionally recommends potential JTC progress tracking or oversight as determined by the JTC.

JBC staff for Information Technology Projects will present this recommendation in a single document for Committee action at a later date.

### STATE FTE

JBC staff does not necessarily disagree with the position of the Department concerning the cost of state FTE versus contracted resources, she is concerned about whether or not the Department will be able to successfully fill newly created positions in the current workforce environment and when

applicants can go to work for a contractor that offers a better total compensation package. In addition, she does not agree that the Department will not experience transition-related delays in deliverables with state FTE like they have when using contracted vendors. JBC staff is concerned for three reasons:

1) The Department reports an overall turnover rate of 9 percent and an overall vacancy rate of 12 percent, therefore turnover, hiring practices, and training needs will impact capacity to achieve deliverables;[8]
2) Applications per job decreased by 32 percent in state and local governments between 2019 and 2021; and
3) The quality of the received applications has also declined.[9]

JBC staff recommends that the JBC consider asking the Department to discuss its plan to transition away from contracted resources toward the utilization of state FTE, the timeline for completing the transition, and the contingency plan if the state FTE cannot be hired and trained by the targeted date(s).

[8] Department of Health Care Policy and Financing response to Joint Budget Committee's Request for Information (multiple departments) #1. Retrieved on November 30, 2021 from https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Common%20LRFI%20%231%20FTE%20vacancy%20and%20turnover%20rate.pdf

[9] Barrett, Katherine and Richard Greene. Route Fifty. "The Government Job Application Drop-off is 'Snow-balling.;" Retrieved on November 30, 2021 from https://www.route-fifty.com/health-human-services/2021/11/state-and-local-government-employment-application-drop-snowballing/186824/

# ISSUE: BEHAVIORAL HEALTH

The JBC received concerns last session and over the interim about conflicts between behavioral health providers and the Regional Accountable Entities (RAEs) with many of the issues revolving around payments. This issue brief discusses how behavioral health rates are set, the relationships between the Department, the RAEs, and providers, and the role of the Medicaid Provider Rate Review Advisory Committee (MPRRAC).

## SUMMARY

- Behavioral health for Medicaid clients is delivered through managed care contracts with the Regional Accountable Entities (RAEs).
- There are tradeoffs with managed care, including less direct state control over payments to providers.
- Managed care has perceived benefits related to mitigating risk, improved economic incentives, greater flexibility and innovation, and better care coordination, although the actual advantages might be less robust than perceptions. Nevertheless, managed care is popular with providers and advocates.
- The roles of the RAEs in providing care coordination and utilization management can lead to conflict with providers.
- The Department annually analyzes and adjusts the rates for the RAEs to meet the federal goal of reasonably likely to cover provider costs for the acuity of clients.
- The managed care rates that the state pays to RAEs are heavily influenced by actual costs reported by the Community Mental Health Centers, which are the dominant providers statewide.
- The RAEs contract with providers and set the rates for the providers.
- The Medicaid Provider Rate Review Advisory Committee (MPRRAC) does not review the majority of behavioral health rates, because the behavioral health rates are already adjusted annually according to federal guidelines. The MPRRAC plays a role in setting the small percentage of rates paid on a fee-for-service basis.
- Providers and advocates continue to express concerns about lack of parity in access to behavioral health and physical health.

## DISCUSSION

### OVERVIEW

To provide behavioral health services the Department enters into managed care contracts with the Regional Accountable Entities (RAEs). The Department pays per-member-per-month fees to the RAEs. The per-member-per-month fees differ based on the eligibility categories of the clients (e.g. foster child vs expansion adult vs person with disability, etc.) and based on regional differences in costs and the scope of services available.

The RAEs are then responsible for developing the Medicaid behavioral health provider network and contracting with providers to deliver services. The RAEs also manage the care of Medicaid clients to achieve the best health outcomes with cost effective services. Examples of the managed care functions of the RAEs include tracking client appointments to ensure they receive appropriate preventive

services, communicating with providers to reduce duplication of services, communicating with clients to promote adherence to treatment plans, and following up with clients and providers after acute episodes.

Contracts between the RAEs and the providers set the reimbursement levels for providers. The RAEs are also responsible for processing claims, making payments in a timely manner, and investigating and resolving disputes. The Department provides oversight to ensure the RAEs are adhering to Department policies and contract obligations.

Up to a point, if the RAEs successfully manage the care of clients for less than the per-member-per-month payments from the Department, then the RAEs can keep the difference, and if the costs exceed the per-member-per-month payments then the RAEs absorb the cost. The limit on how much the RAEs can keep is called the medical loss ratio and, pursuant to federal regulation, it caps the proportion of payments used for administration and profit at 15 percent.

The Department does not tell the RAEs what to pay providers. That would be counter to managed care philosophy that is supposed to give managed care organizations the freedom and flexibility to get the job done in the most effective way. This delegation of responsibility and consequent loss of control is one of the many tradeoffs associated with a managed care arrangement.

## WHY MANAGED CARE?

Managed care presents different issues, challenges, and leverage points than fee-for-service reimbursement. Less direct state control over payments to providers is part of the price of a managed care system. Some of the purported benefits of managed care are described below, along with some caveats to consider regarding whether managed care really delivers on each promise and the value of that benefit.

- **Transfers some of the risk for higher or lower costs to another party.** This is true, but the state pays a premium for those other parties to accept the risk. Arguably, the state has the resources to manage the risk, so the value of transferring the financial risk to other parties is questionable.

- **Changes the economic incentives for providers.** In a fee-for-service system providers that offer more services make more money. In a capitated managed care system providers can make money by achieving better outcomes or similar outcomes more efficiently through methods such as more or better preventive care or alternate services. However, managed care can create adverse incentives to ration care. To counteract potential adverse incentives there are lots of federal and state regulations and performance metrics to ensure quality of care. There are lots of regulations and performance metrics around fee-for-service, too, but in fee-for-service the objective is often to prevent over-utilization of services, rather than under-utilization. The risks in a fee-for-service environment are more to the payer than the client.

- **Allows payment for services that are not currently reimbursable in fee-for-service.** Colorado operates managed care for behavioral health under a federal waiver that allows payment for cost-effective services that would not be covered under standard Medicaid fee-for-service, such as peer recovery services, respite care, clubhouse and drop-in centers, intensive case management, and short-term inpatient stays. While Colorado's authorization for these services is under a managed care waiver, it is possible Colorado could get approval for these same types of services through a

different waiver that would allow fee-for-service payment. It is not known if the federal Centers for Medicare and Medicaid Services would approve these same services under a different type of waiver, because Colorado has not asked, but it seems likely that CMS would see the benefit for the same reasons it allows payment in the managed care waiver.

- **Provides flexibility for providers to innovate.** Capitated payments are perceived to be more stable for the provider, allowing them to experiment with new ways of delivering services without risk of losing funding. Maybe this is true in the short term, but in the long term the rates for managed care are based on the traditional allowed services. If a RAE or a provider starts using Medicaid money for non-covered services, such as embedding therapists with law enforcement, then their managed care rates will eventually decline. Arguably, the interest and ability of organizations in implementing an innovation like law enforcement partnerships is more dependent on the mission of the organization and its ability to cobble together outside resources than on the flexibility of a managed care contract with Medicaid.

- **Incentivizes care coordination.** In managed care there are people responsible for ensuring clients receive care in the most cost effective manner and that care across providers is coordinated to minimize duplication. The managed care organization has a financial incentive to perform this function well. However, the same care coordination can and does exist in the fee-for-service realm. In fee-for-service the state makes performance-based payments to the Regional Accountable Entities to coordinate physical health care.

In initial plans for merging the care coordination of behavioral health and physical health, the Department considered converting behavioral health reimbursement to fee-for-service. However, the idea met with resistance from providers, advocates, and the Joint Budget Committee and the Department quickly abandoned that approach.

### PROVIDERS AND RAES

The merger of behavioral health and physical health care coordination resulted in changes to who the Department contracts with for behavioral health managed care. The old Behavioral Health Organizations had financial, leadership, and legal ties to the Community Mental Health Centers that the Department viewed as problematic and full of potential for conflicts of interest. The new Regional Accountable Entities include many contractors with stronger experiences and backgrounds coordinating physical health care, who have been criticized at times for a lack of leadership and understanding of behavioral health issues.

When clients receive well-coordinated care it can be as much or more a result of work by the primary physical and behavioral health providers for the client as the managed care organization, but the financial benefits accrue to the managed care organization, unless the RAE chooses to share the financial benefits with providers through the way contracts are structured. This could be an argument for greater financial integration between the RAEs and providers, rather than less. The Department is exploring ways to better align the financial incentives for RAEs and providers, which could include more sub capitation payments, particularly for the Community Mental Health Centers.

There is natural tension between managed care organizations and the providers they contract with to deliver services. The managed care organizations rely on high level data, generalized policies about best and evidence-based practices, and staff with a variety of credentials to coordinate the care of

clients. Most of the care coordinators have mid-level health credentials, such as nurses, or bachelor degrees and are not behavioral health specialists. This can create friction with providers that typically have more direct contact with clients and more experience addressing behavioral health issues. However, this same dynamic occurs between fee-for-service providers and utilization management agencies and is not unique to managed care.

### RATE SETTING

Each year the Department analyzes and adjusts the rates it pays the RAEs in accordance with strict federal guidelines. One of the federal requirements is that the rates must be actuarially sound, meaning that a third party actuary agrees the rates are reasonably likely to cover provider costs based on the projected acuity of clients. The actuary brings to the rate setting process some specialized skills in projecting patient acuity and standardized methods for estimating costs, but there is nothing magical about the actuary. It is still a person making judgements. Many of the actuary's assumptions are based on past practices and may not represent what a provider thinks is fair, optimal, or appropriate.

The rate setting process is heavily influenced by the Community Mental Health Centers (CMHCs) that represent anywhere from 30 to 60 percent of behavioral health expenditures by region and 40-50 percent of expenditures statewide. The CMHCs submit detailed cost reports to the Department and their actual expenditures for covered services heavily influence the managed care rates. There is about a two-year lag between when an actual expenditure is incurred and when it affects the managed care rates, due to the time required for data collection and analysis. The actuary inflates data from the cost reports to account for this lag, but inflationary adjustments may not accurately account for level shifts in expenditures. Also, there is danger that they can be circular, feeding an increase in rates that leads to an increase in expenditures that leads to an increase in rates.

One of the more sophisticated CMHCs described to the JBC staff a potential strategy for using one-time federal stimulus money to increase employee compensation. The CMHC speculated that if it could sustain the increase for two years, then the higher employee compensation would be picked up in the rate setting process, resulting in a higher managed care capitation rate that would allow the CMHC to sustain the higher employee compensation into the future. Obviously, the General Fund, Healthcare Affordability and Sustainability (HAS) fee, and matching federal funds would be paying for that higher managed care capitation rates after the one-time federal stimulus money was gone.

When asked about this concept, a few rate setting staff for the Department eventually agreed that if everything else was constant a two-year increase in employee compensation would lead to an increase in rates. However, they emphasized that all things are never constant. Utilization is always changing. Also, staff turnover impacts capacity and the amount of services provided. If an increase in compensation stabilizes staff turnover, it might not lead to an increase in rates so much as avoid a decrease in rates due to fewer services provided, which is probably consistent with some of the intent of the federal COVID-related funds. The technical rate setting staff downplayed the likelihood that providers could manipulate future managed care rates using one-time federal stimulus money, arguing there are too many other variables involved in the rate setting process. This was the view of some technical rate setting staff and not a position of the Department.

It should be noted that the behavioral health components of the Department's spending plan for the additional federal funds available through the American Rescue Plan Act do not explicitly include any increases in provider employee compensation. Instead, the Department focuses on short-duration

strategies to improve services, like temporary enhanced supports to help people transition from institutional to community settings or additional training for direct service providers. The discussion of employee compensation increases is intended to explore the dynamics of how the rate setting process works, rather than to reflect a real proposal in front of the JBC.

The rates the RAEs pay providers are dependent on the contracts between each RAE and provider. The Department pays the RAEs a per-member-per-month rate, but the RAEs might pay providers a capitated rate or fee-for-service rate. The RAEs might include performance-based incentives. There might be clawbacks if utilization is lower than expected. All these parameters are dependent on the negotiations between the RAEs and the providers.

## ROLE OF THE MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE (MPRRAC)

Most behavioral health rates are exempt from review by the MPRRAC because they are part of a managed care contract and the Department is already analyzing and adjusting the rates annually in accordance with stringent federal guidelines. The exception is a relatively small volume of behavioral health payments that are made on a fee-for-service basis. The MPRRAC reviews the fee-for-service rates at least once every five years.

Almost all of the fee-for-service behavioral health payments are for retroactive eligibility. If someone receives behavioral health services and is later determined eligible for Medicaid, then in certain circumstances Medicaid will retroactively cover services already provided for the episode that triggered the eligibility determination. However, it would not make sense in this situation to pay the managed care organizations for these costs, because the managed care organizations were not actively managing care for the client before the client was determined eligible for Medicaid. Instead, the Department pays the providers directly on a fee-for-service basis.

For FY 2021-22 the Department projects it will make managed care payments of $1,082,206,910 total funds, including $214,979,129 General Fund, compared to fee-for-service payments of $16,852,110 total funds, including $3,103,619 General Fund.

The MPRRAC last reviewed behavioral health fee-for-service rates in 2019. The MPRRAC found that overall behavioral health fee-for-service payments were 94.67 percent of the benchmark. The selected benchmark for the majority of rates was Medicare, but for a few services not covered by Medicare the Department used a benchmark based on the average rates paid by Medicaid programs in 11 other states. While the aggregate compensation was fairly close to the benchmark, the MPRRAC noted that rates for individual services varied widely from 22.71 percent of the benchmark to 231.23 percent of the benchmark. As a result, the Department's recommendation report proposed rebalancing rates to within 80-100 percent of the benchmark. The recommendation required an increase of $1,586,971 total funds, including $875,964 General Fund, but most of that was driven by high cost Residential Child Care Facilities where the rates were 68.6 percent of the benchmark. The other proposed positive and negative rate changes largely balanced out to be budget neutral. The General Assembly approved the Department's request to rebalance the rates.

The JBC received specific complaints about family therapy versus individual therapy rates, with requests that the JBC ask the MPRRAC to reexamine family therapy and individual therapy rates. According to the Department, the current fee-for-service hourly rate for family therapy is $84.07

versus $125.52 for individual therapy. The JBC staff does not know why the rates are different (on the surface it would seem family and individual therapy require similar credentials and time) and the JBC could ask the Department to explain the rationale. The next scheduled MPRRAC review is in 2024. The JBC could ask the MPRRAC to review family therapy and individual therapy rates out of cycle. However, an MPRRAC review of fee-for-service rates would impact a relatively small portion of reimbursements for family and individual therapy.

The vast majority of reimbursements for family and individual therapy are through the managed care contracts and are governed by the individual negotiations between providers and RAEs, rather than any recommendations from the MPRRAC. It is possible that some RAEs and some providers use the Department's fee-for-service rates as a reference point in negotiating managed care payments, so the fee-for-service rates may have some influence on managed care payments in some circumstances.

### PARITY

Both federal and state laws require parity for behavioral health and medical or surgical services. Providers and advocates typically take a more expansive view of what parity requires than the Department's more narrow and legalistic interpretation. In the Legislative Request for Information the Department described the issue as follows:

> *There is a common impression that Parity requires that access to services and reimbursement be equal, and that any use of utilization management is a violation of parity. However, parity regulations are focused on whether processes are comparable to and applied no more stringently within broad classifications of inpatient, outpatient, prescription drugs, and emergency care. The Department conducts a comprehensive assessment of compliance with Parity at least one time annually; these assessments have been approved by the Centers for Medicare and Medicaid Services (CMS). This year, in order to address these areas of confusion and evaluate the Department's processes for monitoring Parity, the Department has contracted with an external vendor to:*
>
> - *Provide a written assessment of the Department's annual Parity report and whether the Department followed standard practices.*
> - *Host an educational webinar describing parity and provide other documented materials.*

As an example of parity concerns, many providers and advocates argue that currently required assessments, including the Colorado Client Assessment Record (CCAR), Drug and Alcohol Coordinating Data System (DACODS), and Interstate Compact on Mental Health, represent a barrier to access and go well beyond any intake requirements for physical health. These assessments must be completed in narrow time windows at the beginning of treatment. They are intended to identify current clinical issues and measure progress during treatment, but advocates and providers describe them as invasive, discriminatory, administratively burdensome, and duplicative of information already obtainable from the electronic health records.

The CCAR involves a battery of questions regarding daily functioning in 25 different clinical domains and includes questions about prior institutional involvement, alcohol and drug use, and sexual activity, which may cause clients to balk. In contrast, a patient pursuing medical or surgical care would typically be asked to complete a short medical history with check boxes about allergies and potentially inherited diseases and more detailed questions would be reserved for the provider's professional judgement and assessment during the examination of what is relevant to the client's needs. Providers describe completing the CCAR assessment as taking most of the initial session with clients before even getting to the reasons a client sought care.

The Department's annual report on parity[10] discusses non-quantitative treatment limitations, such as preauthorization requirements, but does not mention or address these required assessments as a potential barrier to parity in access to care.

These particular assessments are attributable to Department policies, rather than the RAEs, but providers and advocates are not necessarily concerned with the distinction and blame all parties.

The expansive view of providers and advocates about what parity requires also results in concerns about policies of the RAEs. For example, if a RAE does not increase provider rates when medical and surgical rates increase, this is described as a lack of parity.

[10] https://hcpf.colorado.gov/sites/hcpf/files/2021%20MHPAEA%20Parity%20Report.pdf

# APPENDIX A
# NUMBERS PAGES
# (DIGITAL ONLY)

Appendix A details actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. This information is listed by line item and fund source. ***Appendix A is only available in the online version of this document.***

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**<br>**Kim Bimestefer, Executive Director** | | | | | |
| **(1) EXECUTIVE DIRECTOR'S OFFICE** | | | | | |
| Primary functions: Provides all of the administrative, audit and oversight functions for the Department. | | | | | |
| **(A) General Administration** | | | | | |
| Personal Services | 37,379,178 | 47,513,817 | 46,430,090 | 53,095,462 | * |
| FTE | 0.0 | 573.0 | 560.9 | 630.4 | |
| General Fund | 12,514,723 | 15,160,759 | 17,965,940 | 20,463,904 | |
| Cash Funds | 3,568,550 | 3,931,315 | 4,404,610 | 4,721,207 | |
| Reappropriated Funds | 1,802,959 | 1,543,625 | 1,892,340 | 2,284,747 | |
| Federal Funds | 19,492,946 | 26,878,118 | 22,167,200 | 25,625,604 | |
| Health, Life, and Dental | 4,790,328 | 5,264,801 | 6,863,806 | 9,043,302 | * |
| General Fund | 1,700,447 | 1,342,322 | 2,642,297 | 3,629,801 | |
| Cash Funds | 421,237 | 548,313 | 556,742 | 627,929 | |
| Reappropriated Funds | 126,088 | 138,532 | 166,554 | 245,723 | |
| Federal Funds | 2,542,556 | 3,235,634 | 3,498,213 | 4,539,849 | |
| Short-term Disability | 66,598 | 72,366 | 102,458 | 91,617 | * |
| General Fund | 24,002 | 26,778 | 50,803 | 36,311 | |
| Cash Funds | 5,301 | 5,695 | 9,763 | 6,112 | |
| Reappropriated Funds | 2,206 | 1,607 | 3,300 | 2,232 | |
| Federal Funds | 35,089 | 38,286 | 38,592 | 46,962 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| S.B. 04-257 Amortization Equalization Disbursement | 1,984,802 | 2,188,905 | 2,360,586 | 2,864,152 | * |
| General Fund | 722,807 | 810,157 | 924,349 | 1,134,884 | |
| Cash Funds | 159,398 | 172,037 | 177,353 | 192,056 | |
| Reappropriated Funds | 46,310 | 48,635 | 52,920 | 69,769 | |
| Federal Funds | 1,056,287 | 1,158,076 | 1,205,964 | 1,467,443 | |
| S.B. 06-235 Supplemental Amortization Equalization Disbursement | 1,984,802 | 2,188,905 | 2,360,586 | 2,864,151 | * |
| General Fund | 722,807 | 810,157 | 924,349 | 1,134,884 | |
| Cash Funds | 159,398 | 172,037 | 177,353 | 192,055 | |
| Reappropriated Funds | 46,310 | 48,635 | 52,920 | 69,769 | |
| Federal Funds | 1,056,287 | 1,158,076 | 1,205,964 | 1,467,443 | |
| PERA Direct Distribution | 1,010,190 | 0 | 1,077,009 | 1,117,582 | |
| General Fund | 402,910 | 0 | 401,537 | 451,764 | |
| Cash Funds | 81,734 | 0 | 83,411 | 72,811 | |
| Reappropriated Funds | 20,451 | 0 | 24,889 | 21,079 | |
| Federal Funds | 505,095 | 0 | 567,172 | 571,928 | |
| Salary Survey | 1,305,312 | 0 | 1,273,930 | 1,739,584 | |
| General Fund | 478,526 | 0 | 474,954 | 701,453 | |
| Cash Funds | 104,700 | 0 | 98,663 | 117,370 | |
| Reappropriated Funds | 26,282 | 0 | 29,439 | 32,730 | |
| Federal Funds | 695,804 | 0 | 670,874 | 888,031 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Paid Family Medical Leave Initiative | 0 | 0 | 0 | 119,081 | |
| General Fund | 0 | 0 | 0 | 48,017 | |
| Cash Funds | 0 | 0 | 0 | 8,034 | |
| Reappropriated Funds | 0 | 0 | 0 | 2,240 | |
| Federal Funds | 0 | 0 | 0 | 60,790 | |
| Paid Family Medical Leave Funding | 0 | 0 | 0 | 5,978 | * |
| General Fund | 0 | 0 | 0 | 2,411 | |
| Cash Funds | 0 | 0 | 0 | 403 | |
| Reappropriated Funds | 0 | 0 | 0 | 112 | |
| Federal Funds | 0 | 0 | 0 | 3,052 | |
| Worker's Compensation | 110,040 | 128,527 | 160,589 | 138,687 | |
| General Fund | 45,610 | 53,287 | 64,559 | 53,874 | |
| Cash Funds | 9,410 | 10,976 | 14,502 | 12,823 | |
| Reappropriated Funds | 0 | 0 | 976 | 5,644 | |
| Federal Funds | 55,020 | 64,264 | 80,552 | 66,346 | |
| Operating Expenses | 2,199,237 | 1,788,412 | 2,775,315 | 2,996,747 | * |
| General Fund | 855,772 | 862,725 | 1,209,995 | 1,212,043 | |
| Cash Funds | 243,961 | 221,951 | 251,588 | 251,833 | |
| Reappropriated Funds | 13,297 | 13,297 | 13,297 | 59,604 | |
| Federal Funds | 1,086,207 | 690,439 | 1,300,435 | 1,473,267 | |
| Legal Services | 1,620,684 | 1,251,687 | 1,172,759 | 961,138 | |
| General Fund | 547,919 | 398,303 | 384,389 | 373,797 | |
| Cash Funds | 262,423 | 222,539 | 206,798 | 95,239 | |
| Reappropriated Funds | 0 | 0 | 0 | 21,337 | |
| Federal Funds | 810,342 | 630,845 | 581,572 | 470,765 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Administrative Law Judge Services | 663,321 | 735,806 | 807,180 | 856,571 | |
| General Fund | 274,932 | 305,065 | 330,159 | 333,532 | |
| Cash Funds | 56,728 | 62,838 | 70,687 | 79,076 | |
| Reappropriated Funds | 0 | 0 | 2,172 | 34,800 | |
| Federal Funds | 331,661 | 367,903 | 404,162 | 409,163 | |
| Payment to Risk Management and Property Funds | 121,414 | 110,332 | 173,686 | 387,377 | * |
| General Fund | 50,326 | 45,744 | 68,018 | 151,486 | |
| Cash Funds | 10,381 | 9,422 | 16,390 | 35,654 | |
| Reappropriated Funds | 0 | 0 | 1,928 | 15,603 | |
| Federal Funds | 60,707 | 55,166 | 87,350 | 184,634 | |
| Leased Space | 2,570,069 | 2,559,590 | 2,790,748 | 3,382,731 | * |
| General Fund | 1,062,201 | 1,051,765 | 1,157,045 | 1,368,318 | |
| Cash Funds | 222,833 | 228,030 | 238,330 | 266,792 | |
| Reappropriated Funds | 0 | 0 | 0 | 31,842 | |
| Federal Funds | 1,285,035 | 1,279,795 | 1,395,373 | 1,715,779 | |
| Capitol Complex Leased Space | 547,755 | 591,064 | 651,086 | 624,977 | |
| General Fund | 227,031 | 245,055 | 266,157 | 243,123 | |
| Cash Funds | 46,846 | 50,477 | 57,078 | 57,730 | |
| Reappropriated Funds | 0 | 0 | 1,828 | 25,407 | |
| Federal Funds | 273,878 | 295,532 | 326,023 | 298,717 | |
| Payments to OIT | 8,368,127 | 8,298,082 | 8,470,924 | 8,839,968 | * |
| General Fund | 3,263,023 | 3,218,758 | 3,454,378 | 3,625,882 | |
| Cash Funds | 893,637 | 930,283 | 910,893 | 883,310 | |
| Reappropriated Funds | 0 | 0 | 0 | 8,002 | |
| Federal Funds | 4,211,467 | 4,149,041 | 4,105,653 | 4,322,774 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| CORE Operations | 139,608 | 184,939 | 112,780 | 166,418 | |
| General Fund | 61,598 | 81,743 | 56,303 | 65,127 | |
| Cash Funds | 11,940 | 15,794 | 5,835 | 15,313 | |
| Reappropriated Funds | 0 | 0 | 0 | 6,740 | |
| Federal Funds | 66,070 | 87,402 | 50,642 | 79,238 | |
| General Professional Services and Special Projects | 13,757,424 | 8,992,784 | 20,770,683 | 31,608,665 | * |
| General Fund | 3,843,924 | 2,368,910 | 6,740,590 | 12,172,253 | |
| Cash Funds | 2,113,981 | 1,227,887 | 3,257,637 | 3,218,224 | |
| Reappropriated Funds | 150,000 | 150,000 | 150,000 | 81,000 | |
| Federal Funds | 7,649,519 | 5,245,987 | 10,622,456 | 16,137,188 | |
| Statewide training | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Merit Pay | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **SUBTOTAL - (A) General Administration** | 78,618,889 | 81,870,017 | 98,354,215 | 120,904,188 | 22.9% |
| *FTE* | 0.0 | 573.0 | 560.9 | 630.4 | 12.4% |
| General Fund | 26,798,558 | 26,781,528 | 37,115,822 | 47,202,864 | 27.2% |
| Cash Funds | 8,372,458 | 7,809,594 | 10,537,633 | 10,853,971 | 3.0% |
| Reappropriated Funds | 2,233,903 | 1,944,331 | 2,392,563 | 3,018,380 | 26.2% |
| Federal Funds | 41,213,970 | 45,334,564 | 48,308,197 | 59,828,973 | 23.8% |
| **(B) Transfers to Other Departments** | | | | | |
| Public School Health Services Administration, Education | 140,162 | 120,652 | 193,926 | 191,731 * | |
| General Fund | 70,081 | 60,326 | 96,962 | 95,865 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 70,081 | 60,326 | 96,964 | 95,866 | |
| Nurse Home Visitor Program, Human Services | 102,831 | 173,642 | 3,010,000 | 3,010,000 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 49,186 | 67,019 | 1,505,000 | 1,505,000 | |
| Federal Funds | 53,645 | 106,623 | 1,505,000 | 1,505,000 | |
| Host Home Regulation, Local Affairs | 49,400 | 118,747 | 133,445 | 133,445 | |
| General Fund | 24,700 | 59,373 | 66,722 | 66,722 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 24,700 | 59,374 | 66,723 | 66,723 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs | 280,396 | 265,698 | 296,989 | 296,989 | |
| General Fund | 140,198 | 132,849 | 148,495 | 148,495 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 140,198 | 132,849 | 148,494 | 148,494 | |
| Facility Survey and Certification, Public Health and Environment | 7,237,925 | 6,930,318 | 8,507,461 | 8,651,460 | * |
| General Fund | 2,442,578 | 2,346,574 | 3,163,819 | 3,218,674 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 4,795,347 | 4,583,744 | 5,343,642 | 5,432,786 | |
| Prenatal Statistical Information, Public Health and Environment | 5,888 | 5,888 | 5,887 | 5,887 | |
| General Fund | 2,944 | 2,944 | 2,944 | 2,944 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 2,944 | 2,944 | 2,943 | 2,943 | |
| Nurse Aide Certification, Regulatory Agencies | 324,041 | 324,040 | 324,041 | 324,041 | |
| General Fund | 147,369 | 147,369 | 147,369 | 147,369 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 14,652 | 14,651 | 14,652 | 14,652 | |
| Federal Funds | 162,020 | 162,020 | 162,020 | 162,020 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Reviews, Regulatory Agencies | 0 | 0 | 3,750 | 3,750 | |
| General Fund | 0 | 0 | 1,875 | 1,875 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 1,875 | 1,875 | |
| Local Public Health Agencies, Public Health and Environment | 367,730 | 364,052 | 0 | 0 | |
| General Fund | 367,730 | 364,052 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Regulation of Medicaid Transportation Providers, Regulatory Agencies | 66,890 | 41,540 | 0 | 0 | |
| General Fund | 33,445 | 20,770 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 33,445 | 20,770 | 0 | 0 | |
| **SUBTOTAL - (B) Transfers to Other Departments** | 8,575,263 | 8,344,577 | 12,475,499 | 12,617,303 | 1.1% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 3,229,045 | 3,134,257 | 3,628,186 | 3,681,944 | 1.5% |
| Cash Funds | 0 | 0 | 0 | 0 | 0.0% |
| Reappropriated Funds | 63,838 | 81,670 | 1,519,652 | 1,519,652 | 0.0% |
| Federal Funds | 5,282,380 | 5,128,650 | 7,327,661 | 7,415,707 | 1.2% |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(C) Information Technology Contracts and Projects** | | | | | |
| Medicaid Management Information System Maintenance and Projects | 32,757,020 | 15,864,583 | 93,728,681 | 38,425,695 | * |
| General Fund | 1,801,183 | 0 | 16,660,075 | 3,518,793 | |
| Cash Funds | 3,658,287 | 2,098,574 | 6,698,062 | 3,854,774 | |
| Reappropriated Funds | 0 | 12,204 | 12,204 | 12,204 | |
| Federal Funds | 27,297,550 | 13,753,805 | 70,358,340 | 31,039,924 | |
| Colorado Benefits Management Systems, Operating and Contract Expenses | 43,623,654 | 41,210,186 | 49,129,319 | 46,105,443 | * |
| General Fund | 6,258,519 | 4,984,722 | 11,230,398 | 8,941,968 | |
| Cash Funds | 4,514,038 | 4,562,697 | 5,561,441 | 5,544,368 | |
| Reappropriated Funds | 1,717 | 473 | 1,637 | 1,654 | |
| Federal Funds | 32,849,380 | 31,662,294 | 32,335,843 | 31,617,453 | |
| Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center | 1,885,054 | 1,633,016 | 2,005,074 | 2,005,074 | |
| General Fund | 631,097 | 536,552 | 634,715 | 634,715 | |
| Cash Funds | 297,506 | 279,590 | 354,194 | 354,194 | |
| Reappropriated Funds | 53 | 20 | 73 | 73 | |
| Federal Funds | 956,398 | 816,854 | 1,016,092 | 1,016,092 | |
| Office of eHealth Innovations Operations | 1,937,375 | 6,556,066 | 6,465,845 | 6,465,845 | |
| FTE | 0.1 | 0.1 | 3.0 | 3.0 | |
| General Fund | 530,213 | 660,675 | 3,372,367 | 3,372,367 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,407,162 | 5,895,391 | 3,093,478 | 3,093,478 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| All-Payer Claims Database | 5,272,339 | 3,938,816 | 3,795,498 | 3,995,498 | * |
| General Fund | 4,036,463 | 2,962,231 | 2,962,231 | 3,162,231 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,235,876 | 976,585 | 833,267 | 833,267 | |
| Health Information Exchange Maintenance and Projects | 6,937,231 | 8,901,743 | 0 | 0 | |
| General Fund | 799,003 | 981,083 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 6,138,228 | 7,920,660 | 0 | 0 | |
| Connect for Health Colorado Systems | 490,760 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 122,690 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 368,070 | 0 | 0 | 0 | |
| State Innovation Model Operations | 134,436 | 0 | 0 | 0 | |
| FTE | 0.6 | 0.0 | 0.0 | 0.0 | |
| General Fund | 134,436 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **SUBTOTAL - (C) Information Technology Contracts and Projects** | 93,037,869 | 78,104,410 | 155,124,417 | 96,997,555 | (37.5%) |
| *FTE* | 0.7 | 0.1 | 3.0 | 3.0 | (0.0%) |
| General Fund | 14,190,914 | 10,125,263 | 34,859,786 | 19,630,074 | (43.7%) |
| Cash Funds | 8,592,521 | 6,940,861 | 12,613,697 | 9,753,336 | (22.7%) |
| Reappropriated Funds | 1,770 | 12,697 | 13,914 | 13,931 | 0.1% |
| Federal Funds | 70,252,664 | 61,025,589 | 107,637,020 | 67,600,214 | (37.2%) |
| **(D) Eligibility Determinations and Client Services** | | | | | |
| Medical Identification Cards | 179,560 | 218,898 | 0 | 35,115 | |
| General Fund | 56,252 | 74,470 | 0 | 24,812 | |
| Cash Funds | 32,351 | 34,561 | 0 | 171 | |
| Reappropriated Funds | 17 | 0 | 0 | 0 | |
| Federal Funds | 90,940 | 109,867 | 0 | 10,132 | |
| Contracts for Special Eligibility Determinations | 2,904,179 | 2,932,388 | 5,890,755 | 12,039,555 | |
| General Fund | 900,608 | 856,390 | 1,129,071 | 1,129,071 | |
| Cash Funds | 429,464 | 232,019 | 1,269,068 | 4,343,468 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,574,107 | 1,843,979 | 3,492,616 | 6,567,016 | |
| County Administration | 78,231,835 | 76,847,916 | 104,194,924 | 107,093,585 | * |
| General Fund | 12,590,592 | 12,476,154 | 16,014,288 | 17,661,875 | |
| Cash Funds | 15,314,460 | 14,975,853 | 22,550,330 | 24,598,316 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 50,326,783 | 49,395,909 | 65,630,306 | 64,833,394 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Medical Assistance Sites | 795,537 | 843,705 | 1,531,968 | 1,531,968 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 362,558 | 402,384 | 402,984 | 402,984 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 432,979 | 441,321 | 1,128,984 | 1,128,984 | |
| Administrative Case Management | 688,588 | 729,944 | 869,744 | 869,744 | |
| General Fund | 344,294 | 364,972 | 434,872 | 434,872 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 344,294 | 364,972 | 434,872 | 434,872 | |
| Customer Outreach | 5,401,245 | 2,520,295 | 3,461,071 | 3,486,071 | |
| General Fund | 2,363,978 | 936,784 | 1,393,915 | 1,406,415 | |
| Cash Funds | 336,621 | 323,363 | 336,621 | 336,621 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 2,700,646 | 1,260,148 | 1,730,535 | 1,743,035 | |
| Centralized Eligibility Vendor Contract Project | 5,161,409 | 4,845,249 | 5,053,644 | 5,093,723 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 1,668,272 | 1,541,955 | 1,745,342 | 1,765,381 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 3,493,137 | 3,303,294 | 3,308,302 | 3,328,342 | |
| Connect for Health Colorado Eligibility Determination | 4,327,277 | 15,945,067 | 9,653,251 | 10,135,914 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 1,667,767 | 6,762,934 | 3,798,350 | 3,988,268 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 2,659,510 | 9,182,133 | 5,854,901 | 6,147,646 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Eligibility Overflow Processing Center | 0 | 0 | 1,853,731 | 1,904,677 | |
| General Fund | 0 | 0 | 277,689 | 285,320 | |
| Cash Funds | 0 | 0 | 185,744 | 190,849 | |
| Federal Funds | 0 | 0 | 1,390,298 | 1,428,508 | |
| Returned Mail Processing | 0 | 818,170 | 3,298,808 | 3,298,808 | |
| General Fund | 0 | 240,653 | 985,808 | 985,808 | |
| Cash Funds | 0 | 50,124 | 244,919 | 244,919 | |
| Reappropriated Funds | 0 | 23,329 | 111,942 | 111,942 | |
| Federal Funds | 0 | 504,064 | 1,956,139 | 1,956,139 | |
| Work Number Verification | 0 | 21,516 | 3,305,114 | 3,305,114 | |
| General Fund | 0 | 7,085 | 1,089,815 | 1,089,815 | |
| Cash Funds | 0 | 3,548 | 545,013 | 545,013 | |
| Federal Funds | 0 | 10,883 | 1,670,286 | 1,670,286 | |
| **SUBTOTAL - (D) Eligibility Determinations and Client Services** | 97,689,630 | 105,723,148 | 139,113,010 | 148,794,274 | 7.0% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 16,255,724 | 14,956,508 | 21,325,458 | 23,017,988 | 7.9% |
| Cash Funds | 19,811,493 | 24,326,741 | 31,078,371 | 36,415,990 | 17.2% |
| Reappropriated Funds | 17 | 23,329 | 111,942 | 111,942 | 0.0% |
| Federal Funds | 61,622,396 | 66,416,570 | 86,597,239 | 89,248,354 | 3.1% |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | | Request vs. Appropriation |
|---|---|---|---|---|---|---|
| **(E) Utilization and Quality Review Contracts** | | | | | | |
| Professional Service Contracts | 15,186,368 | 14,826,120 | 23,504,074 | 26,961,574 | * | |
| General Fund | 4,671,282 | 7,299,182 | 6,803,020 | 7,236,040 | | |
| Cash Funds | 1,018,383 | 857,869 | 1,503,937 | 2,032,069 | | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | |
| Federal Funds | 9,496,703 | 6,669,069 | 15,197,117 | 17,693,465 | | |
| **SUBTOTAL - (E) Utilization and Quality Review Contracts** | 15,186,368 | 14,826,120 | 23,504,074 | 26,961,574 | | 14.7% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0% |
| General Fund | 4,671,282 | 7,299,182 | 6,803,020 | 7,236,040 | | 6.4% |
| Cash Funds | 1,018,383 | 857,869 | 1,503,937 | 2,032,069 | | 35.1% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | 0.0% |
| Federal Funds | 9,496,703 | 6,669,069 | 15,197,117 | 17,693,465 | | 16.4% |
| **(F) Provider Audits and Services** | | | | | | |
| Professional Audit Contracts | 3,335,540 | 3,148,703 | 5,122,382 | 4,655,865 | * | |
| General Fund | 1,264,086 | 1,361,059 | 1,858,780 | 1,816,102 | | |
| Cash Funds | 526,429 | 281,124 | 622,963 | 582,801 | | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | |
| Federal Funds | 1,545,025 | 1,506,520 | 2,640,639 | 2,256,962 | | |
| **SUBTOTAL - (F) Provider Audits and Services** | 3,335,540 | 3,148,703 | 5,122,382 | 4,655,865 | | (9.1%) |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0% |
| General Fund | 1,264,086 | 1,361,059 | 1,858,780 | 1,816,102 | | (2.3%) |
| Cash Funds | 526,429 | 281,124 | 622,963 | 582,801 | | (6.4%) |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | 0.0% |
| Federal Funds | 1,545,025 | 1,506,520 | 2,640,639 | 2,256,962 | | (14.5%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(G) Recoveries and Recoupment Contract Costs** | | | | | |
| Estate Recovery | 921,410 | 843,618 | 700,000 | 700,000 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 460,705 | 421,809 | 350,000 | 350,000 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 460,705 | 421,809 | 350,000 | 350,000 | |
| Third-Party Liability Cost Avoidance Contract | 0 | 7,134,460 | 16,787,286 | 17,248,905 | |
| General Fund | 0 | 2,523,513 | 5,539,804 | 5,692,139 | |
| Cash Funds | 0 | 1,043,717 | 2,853,839 | 2,932,314 | |
| Federal Funds | 0 | 3,567,230 | 8,393,643 | 8,624,452 | |
| **SUBTOTAL - (G) Recoveries and Recoupment Contract Costs** | 921,410 | 7,978,078 | 17,487,286 | 17,948,905 | 2.6% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 0 | 2,523,513 | 5,539,804 | 5,692,139 | 2.7% |
| Cash Funds | 460,705 | 1,465,526 | 3,203,839 | 3,282,314 | 2.4% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 460,705 | 3,989,039 | 8,743,643 | 8,974,452 | 2.6% |
| **(H) Indirect Cost Assessment** | | | | | |
| Indirect Cost Assessment | 907,971 | 855,070 | 890,057 | 790,162 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 304,937 | 364,495 | 270,035 | 274,461 | |
| Reappropriated Funds | 112,343 | 0 | 106,490 | 121,263 | |
| Federal Funds | 490,691 | 490,575 | 513,532 | 394,438 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **SUBTOTAL - (H) Indirect Cost Assessment** | 907,971 | 855,070 | 890,057 | 790,162 | (11.2%) |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 0 | 0 | 0 | 0 | 0.0% |
| Cash Funds | 304,937 | 364,495 | 270,035 | 274,461 | 1.6% |
| Reappropriated Funds | 112,343 | 0 | 106,490 | 121,263 | 13.9% |
| Federal Funds | 490,691 | 490,575 | 513,532 | 394,438 | (23.2%) |
| **TOTAL - (1) Executive Director's Office** | 298,272,940 | 300,850,123 | 452,070,940 | 429,669,826 | (5.0%) |
| *FTE* | 0.7 | 573.1 | 563.9 | 633.4 | 12.3% |
| General Fund | 66,409,609 | 66,181,310 | 111,130,856 | 108,277,151 | (2.6%) |
| Cash Funds | 39,086,926 | 42,046,210 | 59,830,475 | 63,194,942 | 5.6% |
| Reappropriated Funds | 2,411,871 | 2,062,027 | 4,144,561 | 4,785,168 | 15.5% |
| Federal Funds | 190,364,534 | 190,560,576 | 276,965,048 | 253,412,565 | (8.5%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(2) MEDICAL SERVICES PREMIUMS** | | | | | |
| Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid. | | | | | |
| Medical and Long-Term Care Services for Medicaid Eligible Individuals | 8,099,261,570 | 8,876,769,374 | 9,986,500,266 | 10,051,013,187 * | |
| General Fund | 1,645,024,128 | 1,944,486,087 | 1,538,562,226 | 1,965,990,235 | |
| General Fund Exempt | 523,323,333 | 0 | 865,284,199 | 865,284,199 | |
| Cash Funds | 933,323,923 | 1,282,521,053 | 1,196,746,162 | 1,185,431,039 | |
| Reappropriated Funds | 88,963,623 | 40,766,832 | 83,318,813 | 87,549,267 | |
| Federal Funds | 4,908,626,563 | 5,608,995,402 | 6,302,588,866 | 5,946,758,447 | |
| **TOTAL - (2) Medical Services Premiums** | 8,099,261,570 | 8,876,769,374 | 9,986,500,266 | 10,051,013,187 | 0.6% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 1,645,024,128 | 1,944,486,087 | 1,538,562,226 | 1,965,990,235 | 27.8% |
| General Fund Exempt | 523,323,333 | 0 | 865,284,199 | 865,284,199 | 0.0% |
| Cash Funds | 933,323,923 | 1,282,521,053 | 1,196,746,162 | 1,185,431,039 | (0.9%) |
| Reappropriated Funds | 88,963,623 | 40,766,832 | 83,318,813 | 87,549,267 | 5.1% |
| Federal Funds | 4,908,626,563 | 5,608,995,402 | 6,302,588,866 | 5,946,758,447 | (5.6%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | | Request vs. Appropriation |
|---|---|---|---|---|---|---|
| **(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS** | | | | | | |
| Healthcare Affordability and Sustainability Cash Fund. | | | | | | |
| Behavioral Health Capitation Payments | 662,584,643 | 811,992,425 | 983,572,421 | 1,042,724,096 | * | |
| General Fund | 174,001,702 | 173,123,597 | 201,125,147 | 256,073,133 | | |
| Cash Funds | 37,151,063 | 52,718,658 | 53,700,870 | 77,506,128 | | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | |
| Federal Funds | 451,431,878 | 586,150,170 | 728,746,404 | 709,144,835 | | |
| Behavioral Health Fee-for-service Payments | 13,176,139 | 14,851,894 | 15,151,534 | 15,409,065 | * | |
| General Fund | 2,445,911 | 2,692,858 | 2,923,821 | 3,423,197 | | |
| Cash Funds | 798,999 | 989,215 | 1,037,775 | 1,005,331 | | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | |
| Federal Funds | 9,931,229 | 11,169,821 | 11,189,938 | 10,980,537 | | |
| **TOTAL - (3) Behavioral Health Community Programs** | 675,760,782 | 826,844,319 | 998,723,955 | 1,058,133,161 | | 5.9% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0% |
| General Fund | 176,447,613 | 175,816,455 | 204,048,968 | 259,496,330 | | 27.2% |
| Cash Funds | 37,950,062 | 53,707,873 | 54,738,645 | 78,511,459 | | 43.4% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | 0.0% |
| Federal Funds | 461,363,107 | 597,319,991 | 739,936,342 | 720,125,372 | | (2.7%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(4) OFFICE OF COMMUNITY LIVING** | | | | | |
| **(A) Division for Individuals with Intellectual and Developmental Disabilities** | | | | | |
| **(i) Administrative Costs** | | | | | |
| Personal Services | 3,598,584 | 3,407,396 | 3,469,613 | 3,469,613 | |
| FTE | 39.7 | 34.7 | 37.5 | 39.5 | |
| General Fund | 1,678,414 | 1,539,405 | 1,603,367 | 1,858,480 | |
| Cash Funds | 247,286 | 255,113 | 255,113 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,672,884 | 1,612,878 | 1,611,133 | 1,611,133 | |
| Operating Expenses | 206,231 | 160,560 | 281,510 | 281,510 | |
| General Fund | 120,089 | 112,261 | 112,261 | 164,636 | |
| Cash Funds | 31,766 | 0 | 52,375 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 54,376 | 48,299 | 116,874 | 116,874 | |
| Community and Contract Management System | 61,583 | 61,582 | 137,480 | 137,480 | |
| General Fund | 30,792 | 30,791 | 89,362 | 89,362 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 30,791 | 30,791 | 48,118 | 48,118 | |
| Support Level Administration | 39,520 | 49,266 | 59,984 | 59,317 | |
| General Fund | 19,504 | 24,633 | 29,658 | 29,403 | |
| Cash Funds | 255 | 0 | 255 | 255 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 19,761 | 24,633 | 30,071 | 29,659 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Cross-System Response Pilot Program Services | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| **SUBTOTAL -** | 3,905,918 | 3,678,804 | 3,948,587 | 3,947,920 | (0.0%) |
| *FTE* | 39.7 | 34.7 | 37.5 | 39.5 | 5.3% |
| General Fund | 1,848,799 | 1,707,090 | 1,834,648 | 2,141,881 | 16.7% |
| Cash Funds | 279,307 | 255,113 | 307,743 | 255 | (99.9%) |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 1,777,812 | 1,716,601 | 1,806,196 | 1,805,784 | (0.0%) |
| **Medicaid Programs** | | | | | |
| Adult Comprehensive Waiver Services | 0 | 503,845,540 | 587,780,599 | 662,015,782 | * |
| General Fund | 0 | 208,587,557 | 235,212,336 | 329,890,806 | |
| Cash Funds | 0 | 800,001 | 800,001 | 1,117,085 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 294,457,982 | 351,768,262 | 331,007,891 | |
| Adult Supported Living Waiver Services | 0 | 65,883,070 | 76,430,552 | 80,440,052 | * |
| General Fund | 0 | 24,941,566 | 25,813,807 | 34,360,140 | |
| Cash Funds | 0 | 4,090,144 | 4,967,873 | 5,859,888 | |
| Federal Funds | 0 | 36,851,360 | 45,648,872 | 40,220,024 | |
| Children's Extensive Support Services | 0 | 32,668,165 | 36,844,096 | 39,427,375 | * |
| General Fund | 0 | 14,105,642 | 14,596,925 | 19,713,688 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 18,562,523 | 22,247,171 | 19,713,687 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | | Request vs. Appropriation |
|---|---|---|---|---|---|---|
| Children's Habilitation Residential Program | 0 | 4,229,118 | 9,328,155 | 12,477,833 | * | |
| General Fund | 0 | 1,708,771 | 3,964,700 | 6,238,917 | | |
| Federal Funds | 0 | 2,520,347 | 5,363,455 | 6,238,916 | | |
| Case Management for People with IDD | 0 | 0 | 98,633,608 | 99,993,666 | * | |
| General Fund | 0 | 0 | 39,394,621 | 49,814,366 | | |
| Cash Funds | 0 | 0 | 1,313,030 | 1,427,588 | | |
| Federal Funds | 0 | 0 | 57,925,957 | 48,751,712 | | |
| Eligibility Determination and Waiting List Management | 0 | 1,597,270 | 0 | 0 | | |
| General Fund | 0 | 1,301,521 | 0 | 0 | | |
| Federal Funds | 0 | 295,749 | 0 | 0 | | |
| Case Management Services | 0 | 32,871,410 | 0 | 0 | | |
| General Fund | 0 | 14,019,555 | 0 | 0 | | |
| Cash Funds | 0 | 187,939 | 0 | 0 | | |
| Federal Funds | 0 | 18,663,916 | 0 | 0 | | |
| Home and Community Based Services for People with Intellectual and Developmental Disabilities | 0 | 0 | 0 | 0 | | |
| General Fund | 0 | 0 | 0 | 0 | | |
| **SUBTOTAL -** | 0 | 641,094,573 | 809,017,010 | 894,354,708 | | 10.5% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0% |
| General Fund | 0 | 264,664,612 | 318,982,389 | 440,017,917 | | 37.9% |
| Cash Funds | 0 | 5,078,084 | 7,080,904 | 8,404,561 | | 18.7% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | | 0.0% |
| Federal Funds | 0 | 371,351,877 | 482,953,717 | 445,932,230 | | (7.7%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **State-only Programs** | | | | | |
| Family Support Services Program | 0 | 8,636,298 | 7,679,672 | 7,716,215 | * |
| General Fund | 0 | 8,636,298 | 7,308,510 | 7,716,215 | |
| Cash Funds | 0 | 0 | 371,162 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| State Supported Living Services | 0 | 5,539,938 | 10,174,870 | 10,195,314 | * |
| General Fund | 0 | 5,422,133 | 9,538,139 | 10,195,314 | |
| Cash Funds | 0 | 117,805 | 636,731 | 0 | |
| State Supported Living Services Case Management | 0 | 3,703,361 | 2,475,277 | 2,486,235 | * |
| General Fund | 0 | 3,430,432 | 2,191,580 | 2,486,235 | |
| Cash Funds | 0 | 272,929 | 283,697 | 0 | |
| Preventive Dental Hygiene | 0 | 64,894 | 66,460 | 66,792 | * |
| General Fund | 0 | 64,894 | 66,460 | 66,792 | |
| Supported Employment Provider and Certification Reimbursement | 0 | 157,100 | 303,158 | 303,158 | |
| General Fund | 0 | 157,100 | 303,158 | 303,158 | |
| Supported Employment Pilot Program | 0 | 153,814 | 575,000 | 0 | |
| Cash Funds | 0 | 153,814 | 575,000 | 0 | |
| Eligibility Determination and Waiting List Management | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| State-only Programs for People with Intellectual and Developmental Disabilities | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| **SUBTOTAL -** | 0 | 18,255,405 | 21,274,437 | 20,767,714 | (2.4%) |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 0 | 17,710,857 | 19,407,847 | 20,767,714 | 7.0% |
| Cash Funds | 0 | 544,548 | 1,866,590 | 0 | (100.0%) |
| Federal Funds | 0 | 0 | 0 | 0 | 0.0% |
| **(ii) Program Costs** | | | | | |
| Adult Comprehensive Services | 496,790,698 | 0 | 0 | 0 | |
| General Fund | 230,677,046 | 0 | 0 | 0 | |
| Cash Funds | 3,210,918 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 262,902,734 | 0 | 0 | 0 | |
| Adult Supported Living Services | 76,670,765 | 0 | 0 | 0 | |
| General Fund | 39,632,931 | 0 | 0 | 0 | |
| Cash Funds | 1,401,213 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 35,636,621 | 0 | 0 | 0 | |
| Children's Extensive Support Services | 28,592,203 | 0 | 0 | 0 | |
| General Fund | 13,479,265 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 15,112,938 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Children's Habilitation Residential Program | 1,691,596 | 0 | 0 | 0 | |
| General Fund | 780,189 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 911,407 | 0 | 0 | 0 | |
| Case Management | 38,403,508 | 0 | 0 | 0 | |
| General Fund | 19,112,233 | 0 | 0 | 0 | |
| Cash Funds | 452,347 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 18,838,928 | 0 | 0 | 0 | |
| Family Support Services | 9,189,615 | 0 | 0 | 0 | |
| General Fund | 7,499,881 | 0 | 0 | 0 | |
| Cash Funds | 1,689,734 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Preventive Dental Hygiene | 53,445 | 0 | 0 | 0 | |
| General Fund | 53,445 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Eligibility Determination and Waiting List Management | 2,956,670 | 0 | 0 | 0 | |
| General Fund | 2,956,670 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Supported Employment Provider and Certification Reimbursement | 179,700 | 0 | 0 | 0 | |
| General Fund | 179,700 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Supported Employment Pilot Program | 0 | 0 | 0 | 0 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| **SUBTOTAL -** | 654,528,200 | 0 | 0 | 0 | 0.0% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 314,371,360 | 0 | 0 | 0 | 0.0% |
| Cash Funds | 6,754,212 | 0 | 0 | 0 | 0.0% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 333,402,628 | 0 | 0 | 0 | 0.0% |
| **TOTAL - (4) Office of Community Living** | 658,434,118 | 663,028,782 | 834,240,034 | 919,070,342 | 10.2% |
| *FTE* | 39.7 | 34.7 | 37.5 | 39.5 | 5.3% |
| General Fund | 316,220,159 | 284,082,559 | 340,224,884 | 462,927,512 | 36.1% |
| Cash Funds | 7,033,519 | 5,877,745 | 9,255,237 | 8,404,816 | (9.2%) |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 335,180,440 | 373,068,478 | 484,759,913 | 447,738,014 | (7.6%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(4) INDIGENT CARE PROGRAM** | | | | | |
| Safety Net Provider Payments | 301,481,948 | 135,548,026 | 257,909,481 | 261,184,109 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 141,663,260 | 67,774,013 | 119,466,874 | 133,577,400 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 159,818,688 | 67,774,013 | 138,442,607 | 127,606,709 | |
| Pediatric Specialty Hospital | 13,455,012 | 10,764,010 | 10,764,010 | 10,764,010 | |
| General Fund | 6,310,401 | 4,714,636 | 5,048,321 | 5,382,005 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 7,144,611 | 6,049,374 | 5,715,689 | 5,382,005 | |
| Appropriation from Tobacco Tax Fund to the General Fund | 394,977 | 390,989 | 420,001 | 399,325 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 394,977 | 390,989 | 420,001 | 399,325 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Primary Care Fund | 24,846,825 | 24,666,536 | 50,703,870 | 50,703,870 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 24,846,825 | 24,666,536 | 25,373,115 | 25,373,115 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 25,330,755 | 25,330,755 | |

## Appendix A: Numbers Pages

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Children's Basic Health Plan Administration | 1,948,101 | 1,204,364 | 5,033,274 | 3,774,955 * | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 386,067 | 370,894 | 1,652,424 | 1,321,234 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,562,034 | 833,470 | 3,380,850 | 2,453,721 | |
| Children's Basic Health Plan Medical and Dental Costs | 188,339,131 | 166,658,064 | 170,754,875 | 211,583,011 * | |
| General Fund | 0 | 2,761,239 | 20,639,364 | 32,128,099 | |
| General Fund Exempt | 391,683 | 390,989 | 420,001 | 399,325 | |
| Cash Funds | 35,542,120 | 44,010,133 | 35,628,900 | 42,352,808 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 152,405,328 | 119,495,703 | 114,066,610 | 136,702,779 | |
| Clinic Based Indigent Care | 6,039,386 | 6,039,386 | 0 | 0 | |
| General Fund | 2,832,472 | 2,645,251 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 3,206,914 | 3,394,135 | 0 | 0 | |
| **TOTAL - (4) Indigent Care Program** | 536,505,380 | 345,271,375 | 495,585,511 | 538,409,280 | 8.6% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 9,142,873 | 10,121,126 | 25,687,685 | 37,510,104 | 46.0% |
| General Fund Exempt | 391,683 | 390,989 | 420,001 | 399,325 | (4.9%) |
| Cash Funds | 202,833,249 | 137,212,565 | 182,541,314 | 203,023,882 | 11.2% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 324,137,575 | 197,546,695 | 286,936,511 | 297,475,969 | 3.7% |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(5) OTHER MEDICAL SERVICES** | | | | | |
| Old Age Pension State Medical | 141,443 | 23,557 | 10,000,000 | 10,000,000 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 141,443 | 23,557 | 10,000,000 | 10,000,000 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Senior Dental Program | 3,572,551 | 2,987,821 | 3,990,358 | 3,990,358 | |
| General Fund | 3,572,551 | 2,962,510 | 3,962,510 | 3,962,510 | |
| Cash Funds | 0 | 25,311 | 27,848 | 27,848 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Commission on Family Medicine Residency Training Programs | 8,196,518 | 7,130,420 | 9,400,725 | 9,400,725 | |
| General Fund | 3,844,167 | 3,123,124 | 4,197,890 | 4,450,363 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 211,050 | 250,000 | |
| Federal Funds | 4,352,351 | 4,007,296 | 4,991,785 | 4,700,362 | |
| Medicare Modernization Act State Contribution Payment | 161,064,826 | 151,204,900 | 193,398,121 | 221,261,883 | * |
| General Fund | 161,064,826 | 151,204,900 | 193,398,121 | 221,261,883 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| Public School Health Services Contract Administration | 1,114,507 | 1,035,786 | 2,000,000 | 2,000,000 | |
| General Fund | 557,245 | 517,893 | 1,000,000 | 1,000,000 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 557,262 | 517,893 | 1,000,000 | 1,000,000 | |
| Public School Health Services | 124,811,816 | 127,813,978 | 167,386,604 | 172,092,626 | |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 59,889,935 | 57,869,729 | 79,454,838 | 84,651,774 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 64,921,881 | 69,944,249 | 87,931,766 | 87,440,852 | |
| Screening, Brief Intervention, and Referral to Treatment Training Grant Program | 1,499,997 | 500,000 | 1,000,000 | 500,000 | * |
| General Fund | 0 | 0 | 0 | 0 | |
| Cash Funds | 1,499,997 | 500,000 | 1,000,000 | 500,000 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | |
| Reproductive Health Care for Individuals Not Eligible for Medicaid | 0 | 0 | 1,822,095 | 3,614,490 | |
| General Fund | 0 | 0 | 1,822,095 | 3,614,490 | |
| Urban Indian Health Organizations State Only Payments | 0 | 0 | 0 | 48,025 | * |
| General Fund | 0 | 0 | 0 | 48,025 | |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| State University Teaching Hospitals University of Colorado Hospital | 1,631,984 | 1,204,207 | 0 | 0 | |
| General Fund | 538,075 | 330,343 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 225,000 | 197,100 | 0 | 0 | |
| Federal Funds | 868,909 | 676,764 | 0 | 0 | |
| State University Teaching Hospitals Denver Health and Hospital Authority | 2,804,714 | 0 | 0 | 0 | |
| General Fund | 1,315,411 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,489,303 | 0 | 0 | 0 | |
| **TOTAL - (5) Other Medical Services** | 304,838,356 | 291,900,669 | 388,997,903 | 422,908,107 | 8.7% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 170,892,275 | 158,138,770 | 204,380,616 | 234,337,271 | 14.7% |
| Cash Funds | 61,531,375 | 58,418,597 | 90,482,686 | 95,179,622 | 5.2% |
| Reappropriated Funds | 225,000 | 197,100 | 211,050 | 250,000 | 18.5% |
| Federal Funds | 72,189,706 | 75,146,202 | 93,923,551 | 93,141,214 | (0.8%) |

| | FY 2019-20 Actual | FY 2020-21 Actual | FY 2021-22 Appropriation | FY 2022-23 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS** | | | | | |
| **TOTAL - (7) Department of Human Services Medicaid-Funded Programs** | 101,777,195 | 111,442,385 | 123,675,431 | 126,895,336 | 2.6% |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 45,248,877 | 47,208,775 | 56,976,291 | 61,308,764 | 7.6% |
| Cash Funds | 1,888,903 | 1,888,903 | 1,888,903 | 1,888,903 | 0.0% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 54,639,415 | 62,344,707 | 64,810,237 | 63,697,669 | (1.7%) |
| **TOTAL - Department of Health Care Policy and Financing** | 10,674,850,341 | 11,416,107,027 | 13,279,794,040 | 13,546,099,239 | 2.0% |
| *FTE* | 40.4 | 607.8 | 601.4 | 672.9 | 11.9% |
| General Fund | 2,429,385,534 | 2,686,035,082 | 2,481,011,526 | 3,129,847,367 | 26.2% |
| General Fund Exempt | 523,715,016 | 390,989 | 865,704,200 | 865,683,524 | 0.0% |
| Cash Funds | 1,283,647,957 | 1,581,672,946 | 1,595,483,422 | 1,635,634,663 | 2.5% |
| Reappropriated Funds | 91,600,494 | 43,025,959 | 87,674,424 | 92,584,435 | 5.6% |
| Federal Funds | 6,346,501,340 | 7,104,982,051 | 8,249,920,468 | 7,822,349,250 | (5.2%) |

NOTE: An asterisk (*) indicates that the FY 2022-23 request for a line item is affected by one or more decision items.

# APPENDIX B
# FOOTNOTES AND INFORMATION REQUESTS

## UPDATE ON LONG BILL FOOTNOTES

The General Assembly includes footnotes in the annual Long Bill to: (a) set forth purposes, conditions, or limitations on an item of appropriation; (b) explain assumptions used in determining a specific amount of an appropriation; or (c) express legislative intent relating to any appropriation. Footnotes to the 2021 Long Bill (S.B. 21-205) can be found at the end of each departmental section of the bill at https://leg.colorado.gov/bills/SB21-205. The Long Bill footnotes relevant to this document are listed below.

13 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects -- This line item includes $62,000 total funds, including $31,000 General Fund, the purpose of which is the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. It is the General Assembly's intent that the Department also use the $62,000 total funds to evaluate the new behavioral therapy benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Comment: This footnote explains the purpose of the appropriation to provide for the autism waiver program evaluation and the intent of the general Assembly that the Department also evaluate the behavioral therapy benefit. The Department is complying with the footnote.

14 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is complying with the footnote.

15 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2022-23 state fiscal year.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is complying with the footnote.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs - It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Medicaid Programs.

Comment: This footnote provides flexibility for the Department to move money between line items within the Office of Community Living. The Department is complying with the footnote.

17 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, State-only Programs - It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for State-only Programs.

Comment: This footnote provides flexibility for the Department to move money between line items within the Office of Community Living. The Department is complying with the footnote.

18 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., in accordance with the requirements set forth in that section.

Comment: This footnote explains the purpose of the appropriation to provide special dental services for persons with intellectual and developmental disabilities. The Department is complying with the footnote.

19 Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line

item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote authorizes transfers between line items in the Department of Human Services Medicaid-funded Programs section of the Long Bill for centralized appropriations, such as Health, Life, and Dental expenses. The Department is complying with the footnote.

20 Department of Health Care Policy and Financing, Grand Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; and Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $800,000 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $81,709,561, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $81,709,561 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado. In addition, it is assumed that the University of Colorado School of Medicine will use clinical revenues to make an intergovernmental transfer in the amount approved, up to $11,668,599 to the Department of Health Care Policy and Financing, including up to $180,000 for actual administrative costs.

Comment: This footnote explains the General Assembly's assumptions about supplemental payments to the University of Colorado School of Medicine. The Department is complying with the footnote.

# UPDATE ON LONG BILL REQUESTS FOR INFORMATION

The Joint Budget Committee annually submits requests for information to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2021-22 Report):

https://leg.colorado.gov/sites/default/files/fy21-22apprept_0.pdf

The requests for information relevant to this document are listed below.

## REQUESTS AFFECTING MULTIPLE DEPARTMENTS

4 Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1, 2020.

Comment: The departments submitted the report as requested and it is available from the Department's Legislator Resource Center:

https://hcpf.colorado.gov/legislator-resource-center

The JBC staff will be coordinating with the analyst for the Department of Higher Education to provide a full analysis for figure setting.

5 Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of Human Services, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Department of Military and Veterans Affairs, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of Personnel, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division, Administration, General Disease Control,

and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by October 1, 2020 for each program funded with Tobacco Master Settlement Agreement money: the name of the program; the amount of Tobacco Master Settlement Agreement money received and expended by the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals.

Comment: *See the briefing for tobacco-related programs for a discussion of this request for information.*

## DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

1 Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, behavioral health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

Comment: The Department continues to submit the monthly expenditure and caseload reports as requested. *See the issue brief "Forecast Trends" for more information.*

2 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted the report as requested and it is available from the Department's Legislator Resource Center:

https://hcpf.colorado.gov/legislator-resource-center

When schools provide health services to public school children with disabilities, as required by federal and state law[11], and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, and specialized non-emergency transportation services. In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

3 Department of Health Care Policy and Financing, Executive Director's office – The Department is requested to submit a report by April 1, 2021, discussing the appropriate role for the Department in resolving issues between behavioral health providers and payers, including the Regional Accountable Entities (RAEs), around billing, parity of coverage, and prior authorizations. The report should include a description of the tools available to resolve conflicts. The report should assess and discuss the administrative burden on providers, such as cumbersome prior authorization procedures or lack of timely adjudication of claims, and any other challenges with implementing the regional accountability entity structure. As part of the report, please provide a detailed description of who operates the RAEs in each region, how the operators are selected, and how the Department evaluates and prevents potential conflicts of interest. Also, please discuss differences in the performance of the RAEs in implementing the Substance Use Disorder benefit and how the policies of the RAEs are affecting implementation.

Comment: The Department submitted the report as requested and it is available from the Department's Legislator Resource Center:

https://hcpf.colorado.gov/legislator-resource-center

See the issue brief *Behavioral Health* above for more information on the relationships between the Department, the RAEs, and providers.

[11] Individuals with Disabilities Education Act, Section 504 of the Rehabilitation act of 1973, and Title 22, C.R.S.

# APPENDIX C
# DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(b), C.R.S., the Department of Health Care Policy and Financing is required to publish an **Annual Performance Report** for the *previous state fiscal year* by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2022-23 budget request, the FY 2020-21 Annual Performance Report and the FY 2021-22 Performance Plan can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans