JOINT
BUDGET
COMMITTEE

STAFF FIGURE SETTING
FY 2022-23

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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HOW TO USE THIS DOCUMENT

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

DEPARTMENT OVERVIEW

The Department helps pay medical 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** – serves people with low income and people needing long-term care
- **Children's Basic Health Plan** – provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** – 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
- **Old Age Pension Health and Medical Program** – 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, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

SUMMARY OF STAFF RECOMMENDATIONS

Department Of Health Care Policy And Financing						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2021-22 Appropriation						
Other Legislation	$27,402,850	($24,886,030)	($15,086,964)	$0	$67,375,844	0.0
S.B. 21-205 (Long Bill)	1,856,791,916	459,629,366	343,530,940	211,050	1,053,420,560	0.0
H.B. 22-1173 (Supplemental Bill)	77,009,300	11,668,531	(21,796,667)	(13,950)	87,151,386	4.0
Long Bill Supplemental	(8,482,711)	(9,260,128)	5,119,564	0	(4,342,147)	0.0
TOTAL	**$1,952,721,355**	**$437,151,739**	**$311,766,873**	**$197,100**	**$1,203,605,643**	**4.0**
FY 2022-23 Recommended Appropriation						
FY 2021-22 Appropriation	$1,952,721,355	$437,151,739	$311,766,873	$197,100	$1,203,605,643	4.0
Enrollment/utilization trends						
R2 Behavioral health	12,832,408	13,857,322	701,478	0	(1,726,392)	0.0
R3 Child Health Plan Plus	18,265,219	7,894,419	(10,438,034)	0	20,808,834	0.0
R4 Medicare Modernization Act	(3,087,541)	(3,087,541)	0	0	0	0.0
Subtotal - Enrollment/utilization trends	*28,010,086*	*18,664,200*	*(9,736,556)*	*0*	*19,082,442*	*0.0*
Benefits/eligibility adjustments						
DOC transitions to nursing homes	2,791	1,395	0	0	1,396	0.0
Provider rates						
R10 Provide rates	273,270	60,708	17,829	0	194,733	0.0
R16 Urban Indian Health	0	0	0	0	0	0.0
Subtotal - Provider rates	*273,270*	*60,708*	*17,829*	*0*	*194,733*	*0.0*
R8 County administration	(2,941,994)	(620,457)	(224,439)	0	(2,097,098)	0.0
R11 ACC and CHP accountability	(1,258,319)	(410,692)	(29,720)	0	(817,907)	0.0
R17 SBIRT training	0	0	0	0	0	0.0
BA10 HCBS ARPA spending authority	42,406,863	0	42,406,863	0	0	0.0
BA12 Safety net provider payment	(3,735,404)	0	15,311,278	0	(19,046,682)	0.0

Department Of Health Care Policy And Financing						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
BA14 Centralized eligibility vendor	(24,723)	0	(3,698)	0	(21,025)	0.0
Tobacco forecast	(35,188)	0	(35,188)	0	0	0.0
Family medicine residencies	89,445	44,722	0	0	44,723	0.0
Annualize prior year budget actions	57,341,351	8,591,532	13,825,962	0	34,923,857	0.0
Federal match public health emergency	23,537,158	56,448,865	27,825,919	52,900	(60,790,526)	0.0
Federal match for HCBS	0	30,627,165	14,494,458	0	(45,121,623)	0.0
TOTAL	**$2,096,386,691**	**$550,559,177**	**$415,619,581**	**$250,000**	**$1,129,957,933**	**4.0**
Increase/(Decrease)	**$143,665,336**	**$113,407,438**	**$103,852,708**	**$52,900**	**($73,647,710)**	**0.0**
Percentage Change	7.4%	25.9%	33.3%	26.8%	(6.1%)	0.0%
FY 2022-23 Executive Request	**$2,040,395,205**	**$531,743,030**	**$411,844,889**	**$250,000**	**$1,096,557,286**	**4.0**
Request Above/(Below) Recommendation	($55,991,486)	($18,816,147)	($3,774,692)	$0	($33,400,647)	0.0

DESCRIPTION OF INCREMENTAL CHANGES

FY 21-22

Long Bill supplemental: Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast and technical corrections. See the descriptions of R2 through R4 for more information.

FY 22-23

Enrollment/utilization trends

R2 Behavioral Health Programs: Staff recommends a net increase of $12.8 million total funds, including $13.9 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services.

R3 Child Health Plan Plus: Staff recommends a net increase of $18.3 million total funds, including an increase of $7.9 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Child Health Plan Plus.

R4 Medicare Modernization Act: Staff recommends a net decrease of $3.1 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.

Benefits/eligibility adjustments

DOC transitions to nursing homes: Staff recommends an increase of $2,791 total funds, including $1,395 General Fund, for nursing home services for Medicaid eligible parolees.

Provider rates

R10 PROVIDER RATES: Staff recommends an increase of $273,270 total funds, including $60,708 General Fund, for a common policy 2.0 percent community provider rate increase for behavioral health fee-for-service payments.

R16 URBAN INDIAN HEALTH: Staff does not recommend the requested $48,025 General Fund, since the money is already included in H.B. 22-1190.

ADMINISTRATION AND OTHER

R8 COUNTY ADMINISTRATION: Consistent with the recommendations during figure setting for the Executive Director's Office, the staff recommendation includes a decrease of $2.9 million total funds, including a decrease of $620,457 General Fund.

R11 ACC AND CHP ACCOUNTABILITY: Staff recommends a decrease of $1.1 million total funds, including a decrease of $368,236 General Fund, and 2.0 FTE to increase oversight of the Accountable Care Collaborative (ACC) and the Child Health Plan Plus (CHP+) and to true up appropriations for the contract administration of CHP+ with expected expenditures. Some of the total fiscal impact is in the executive director's office, rather than the divisions discussed in this figure setting.

R17 SBIRT TRAINING: Staff does not recommend the requested decrease for the SBIRT training grants of $250,000 cash funds from the Marijuana Tax Cash Fund.

BA8 BEHAVIORAL HEALTH ADMINISTRATION: Staff does not recommend the requested $638,727 total funds, including $319,365 General Fund, for five new positions (4.8 FTE in the first year) to help implement the Behavioral Health Administration.

BA10 HCBS ARPA SPENDING AUTHORITY: Staff recommends an increase of $42.4 million cash funds from the HCBS Improvement Fund to implement the American Rescue Plan Act (ARPA) Home- and Community-based Services (HCBS) Spending Plan approved by the Centers for Medicare and Medicaid Services and the Joint Budget Committee in September 2021.

BA12 SAFETY NET PROVIDER PAYMENT: Staff recommends a decrease of $3.7 million total funds to align the appropriation with the expected Disproportionate Share Hospital (DSH) supplemental payment.

BA14 CENTRALIZED ELIGIBILITY VENDOR: Staff recommends a net decrease of $24,723 total funds to annualize the JBC's supplemental decision to update appropriations for contract eligibility and enrollment services provided to applicants and clients eligible for Medicaid and the Child Health Plan Plus based on a new federally-required cost allocation methodology.

TOBACCO FORECAST: Staff requests permission to update tobacco tax revenues available for both CHP+ and the Primary Care Fund as described below based on the March revenue forecast

FAMILY MEDICINE RESIDENCY TRAINING: Staff recommends an increase of $89,445 total funds, including $44,472 General Fund to restore funding for the Commission on Family Medicine that had been reduced during the pandemic.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: Staff recommends a net increase of $57.3 million total funds, including $8.6 million General Fund, to annualize prior year budget actions.

FEDERAL MATCH PUBLIC HEALTH EMERGENCY: Staff recommends an increase of $23.5 million total funds, including an increase of $56.4 million General Fund, to account for a change in the federal match rate when the federal public health emergency ends. The change is not net $0 because the change in the federal match rate impacts the state obligation for the Medicare Modernization Act without a corresponding change in federal funds.

FEDERAL MATCH FOR HCBS: Staff recommends a net $0 change in total funds, including an increase of $30.6 million General Fund, for the end of a short-duration increase in the federal match rate for home- and community-based services (HCBS) pursuant to the American Rescue Plan Act.

MAJOR DIFFERENCES FROM THE REQUEST

Almost all of the difference between the JBC staff recommendation and the Department request is attributable to the JBC staff using the Department's February 2022 forecast of expenditures for Behavioral Health, the Children's Basic Health Plan, and the Medicare Modernization Act.

Other notable non-technical differences include:

- R10 Provider rates – The staff recommendation is based on the JBC's common policy for a 2.0 percent increase, rather than the requested 0.5 percent increase.
- R17 SBIRT training – The JBC staff did not recommend the requested reduction of $250,000 from the Marijuana Tax Cash Fund.
- BA8 Behavioral health administration -- Staff does not recommend the requested $638,727 total funds, including $319,365 General Fund, for five new positions (4.8 FTE in the first year) to help implement the Behavioral Health Administration.

DECISION ITEMS

ENROLLMENT/UTILIZATION TRENDS

Requests R1 through R5 changes to both FY 2021-22 and FY 2022-23 based on a new forecast of caseload and expenditures under current law and policy. They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

On February 15, 2022, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2021 forecast used for the Governor's request incorporated data through June 2021. The February 2022 forecast incorporates data through December 2021.

A key assumption in the forecast requests is that the federal public health emergency will end in April 2022. During the public health emergency states are prohibited from disenrolling people from Medicaid if they want to access the higher federal match rate provided through the Families First Coronovirus Response Act. The additional federal match is 6.2 percent and it lasts until the last day of the fiscal quarter when the public health emergency ends. A change in when the public health emergency expires could change when the Department needs to begin redetermining eligibility and disenrolling people who no longer meet the criteria and/or when the additional federal match ends.

➔ R2 BEHAVIORAL HEALTH

REQUEST

The Department requests a change to the Behavioral Health Community Programs for both FY 21-22 and FY 22-23 based on a new forecast of caseload and expenditures under current law and policy. 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[1]. 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.

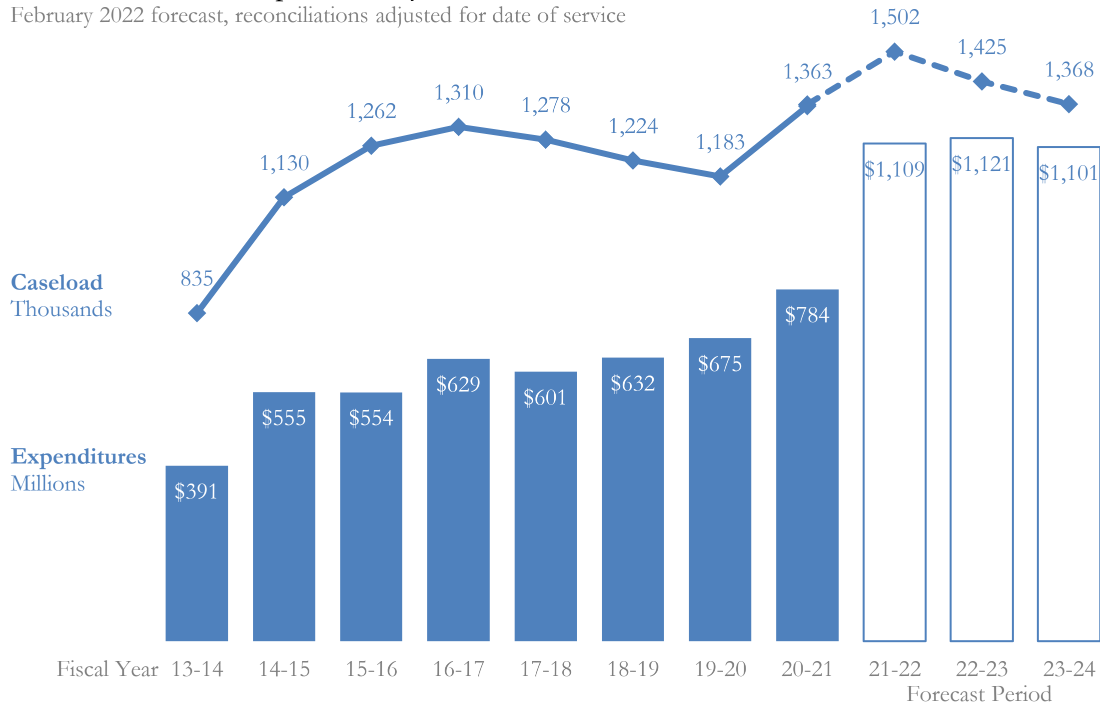
On February 15, 2022, the Department submitted an update to the R2 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. Compared to the Governor's request, the February 2022 forecast is lower in FY 21-22 by $22.6 million total funds, including a reduction of $22.4 million General Fund, and higher in FY 22-23 by $72.7 million total funds, including an increase of $12.7 million General Fund. The cumulative General Fund difference over the two years is $9.7 million lower than the Governor's November request.

RECOMMENDATION

Staff recommends using the Department's February 2022 forecast of enrollment and expenditures to modify both the FY 21-22 and FY 22-23 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the cumulative General Fund difference over the two years is $9.7 million lower than the Governor's November request. In the summary tables the JBC staff shows the changes attributable to the difference in the federal match rate for the public health emergency and for the home- and community-based services separately from the rest of the forecast adjustment to help identify the fiscal impact of these large financing changes.

The chart below summarizes trends in behavioral health capitation payments and caseload. To offer a better sense of the relationship between caseload and expenditures, reconciliation payments and savings have been adjusted to appear in the fiscal year when the service was provided. This is different from the way the money is appropriated, which is based on when the expenditures or savings impact the state's cash flow.

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



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.

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.

The $325 million increase from FY 20-21 to FY 21-22 is primarily due to higher rates ($104.4 million) driven by a higher percentage of Medicaid clients utilizing behavioral health services, the higher caseload ($83.1 million), and the ramp-up of the substance use disorder benefit ($73.8 million).

The rapid enrollment increase from FY 19-20 through FY 21-22 and the decrease from FY 21-22 through FY 23-24 is largely due to a provision of the federal Families First Coronavirus Response Act that gives continuous eligibility for Medicaid through the end of the federal public health emergency regardless of changes in family income. Once the federal public health emergency ends, the Department will go through a process to disenroll people from Medicaid who are no longer eligible. To disenroll people the Department must collect the necessary documentation to redetermine eligibility, notify the client, and then work through appeals. The process is expected to take several months before enrollment reaches a new baseline level. Although the Department expects to complete the disenrollments in FY 22-23, the fiscal year will still include some months of very high enrollment. The average enrollment for FY 22-23 is expected to be higher than the average enrollment for FY 23-24, even though the Department expects enrollment to begin growing again in FY 23-24.

FY 21-22

The table below shows the most significant factors driving the change in the forecast for FY 21-22. Note that this table displays changes from the appropriation and not changes from FY 20-21. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation. Also, note that this table shows the change from the supplemental rather than the change from the Governor's request.

FY 2021-22 Behavioral Health Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2021-22 Appropriation	$1,099,059,020	$218,082,748	$63,463,318	$817,512,954
Enrollment	14,352,655	3,482,013	379,567	10,491,075
Per capita	(3,626,050)	(870,766)	(442,430)	(2,312,854)
Substance use disorder risk corridor adj.	(33,301,437)	(8,438,979)	(2,102,426)	(22,760,032)
Federal match for public health emergency	0	(16,591,453)	(1,255,947)	17,847,400
TOTAL	**$1,076,484,188**	**$195,663,563**	**$60,042,082**	**$820,778,543**
Increase/(Decrease)	(22,574,832)	(22,419,185)	(3,421,236)	3,265,589
Percentage Change	-2.1%	-10.3%	-5.4%	0.4%

Enrollment

The enrollment forecast increased partly due to the extension of the continuous coverage requirement under the federal public health emergency and partly due to higher year-to-date actuals.

Per Capita

The forecast makes small true-ups to expected per capita costs.

Substance Use Disorder risk corridor adj.

The forecast includes a decrease of $33.3 million total funds, including a decrease of $8.4 million General Fund for the substance use disorder (SUD) benefit. The Department's contract with the Regional Accountable Entities (RAEs) includes a risk corridor for the SUD benefit. If actual costs for the SUD benefit are higher or lower than the risk corridor, then the rate is adjusted the next year. In FY 20-21 the actual costs for the SUD benefit were lower than the risk corridor, decreasing the rates in FY 21-22 by $33.3 million. During FY 21-22 the capacity of providers to offer the SUD benefit has increased faster than expected and that fiscal impact was captured in the supplemental bill. This adjustment to the forecast is for lower than expected costs in FY 20-21.

Federal match for public health emergency

The forecast includes a decrease of $16.6 million General Fund and a decrease in cash funds and a corresponding increase in federal funds associated with the extension of the federal public health emergency. Pursuant to the Families First Coronavirus Response Act states can draw an extra 6.2 percent federal match for Medicaid through the last fiscal quarter of the federal public health emergency.

FY 22-23

The next table shows the most significant factors driving the forecasted change in expenditures from FY 21-22 to FY 22-23. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2022-23 Behavioral Health Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Projection	$1,076,484,188	$195,663,563	$60,042,082	$820,778,543
Enrollment	(39,350,452)	(7,238,026)	(1,503,974)	(30,608,452)
Per capita	62,582,922	18,814,101	3,480,279	40,288,542
Annualize SUD risk corridor adj.	33,301,437	8,438,979	2,102,426	22,760,032
Federal match for HCBS	0	26,390,642	5,656,217	(32,046,859)
Federal match for public health emergency	0	30,627,165	14,494,458	(45,121,623)
TOTAL	**$1,133,018,095**	**$272,696,424**	**$84,271,488**	**$776,050,183**
Increase/(Decrease)	56,533,907	77,032,861	24,229,406	(44,728,360)
Percentage Change	5.3%	39.4%	40.4%	-5.4%

Enrollment

The projected enrollment decrease is due to the expected end of the federal public health emergency and the continuous coverage requirement.

Per capita

The forecast estimates a five 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.

Annualize SUD risk corridor adj.

The forecast includes a $33.3 million increase in total funds, including $8.4 million General Fund, for the end of a one-time risk corridor adjustment that reduced rates in FY 21-22 based on actual costs of the substance use disorder benefit in FY 20-21.

Federal match for HCBS

The forecast includes an increase of $26.4 million General Fund and an increase in cash funds and a corresponding decrease in federal funds associated with the end of a 10 percent enhanced federal match for home- and community-based services (HCBS). Pursuant to the American Rescue Plan Act, states can draw an extra 10.0 percent federal match for eligible HCBS. The enhanced federal match expires on March 31, 2022, requiring the federal funds to be refinanced with General Fund in the last quarter of FY 2021-22 and into FY 2022-23.

Federal match for public health emergency

The forecast includes an increase of $30.6 million General Fund and an increase in cash funds and a corresponding decrease in federal funds associated with the end of the federal public health emergency. Pursuant to the Families First Coronavirus Response Act states can draw an extra 6.2 percent federal match for Medicaid through the last fiscal quarter of the federal public health emergency.

➔ R3 CHILD HEALTH PLAN PLUS

REQUEST

The Department requests a change to the Child Health Plan Plus for both FY 21-22 and FY 22-23 based on a new forecast of caseload and expenditures under current law and policy 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[2] 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.

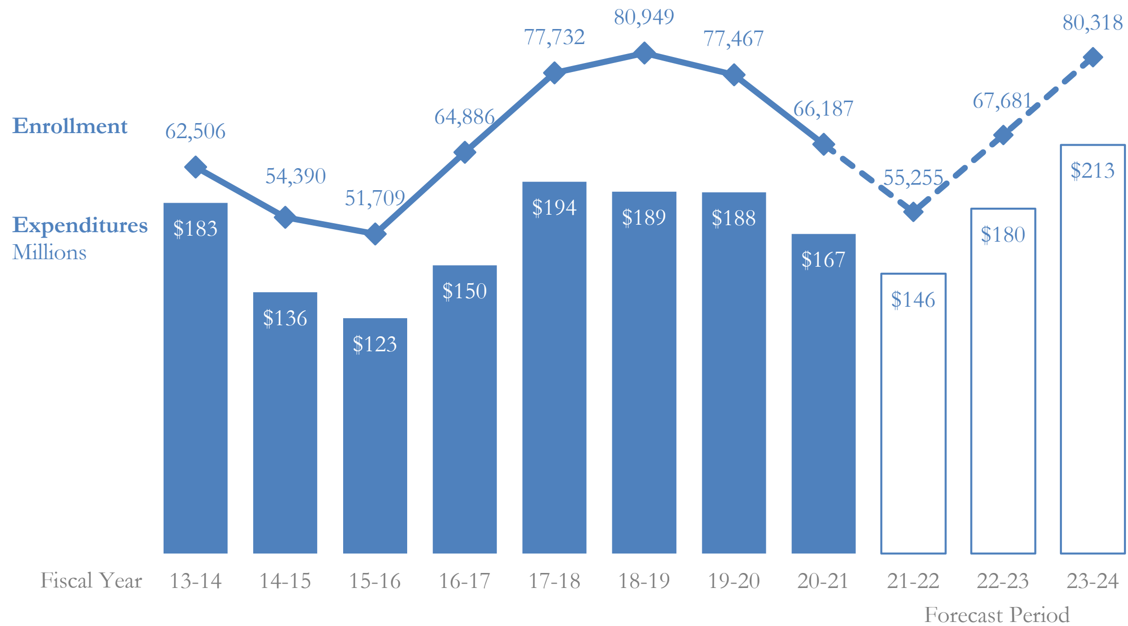
On February 15, 2022, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2022 forecast is lower than the forecast used for the Governor's request by $16.2 million total funds, including $4.7 million General Fund, in FY 21-22 and $32.6 million total funds, including $8.2 million General Fund, in FY 22-23. The cumulative General Fund difference over the two years is $12.8 million lower than the Governor's November request.

RECOMMENDATION

Staff recommends using the Department's February 2022 forecast of enrollment and expenditures to modify both the FY 21-22 and FY 22-23 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the cumulative General Fund difference over the two years is $12.8 million lower than the Governor's November request. In the summary tables the JBC staff shows the changes attributable to the difference in the federal match rate for the public health emergency separately from the rest of the forecast adjustment to help identify the fiscal impact of this large financing change.

The chart below summarizes the Department's forecast.

[2] 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.



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.

Due to the Medicaid continuous coverage requirement during the federal public health emergency, clients have not moved from Medicaid to CHP+. Also, there are few clients moving from CHP+ to private or no insurance, because the Department adopted rules providing continuous eligibility for children on CHP+ that mirror the federal requirements for continuous coverage on Medicaid during the federal public health emergency. However, there are children moving from CHP+ to Medicaid, which is more favorable coverage, resulting in a net decrease in CHP+ enrollment.

When the continuous coverage requirement during the public health emergency ends, the Department forecasts a rapid increase in CHP+ enrollment as clients move from Medicaid to CHP+.

FY 21-22

The table below shows the most significant factors driving the change in the Department's forecast for FY 21-22. Note that this table displays changes from the appropriation and not changes from FY 20-21. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2021-22 Children's Basic Health Plan Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2021-22 Appropriation	$161,976,673	$15,708,256	$37,883,046	$108,385,371
Enrollment	(17,562,024)	(2,928,080)	(2,456,436)	(12,177,508)
Per capita	4,037,088	295,652	944,288	2,797,148
Reconciliations	(2,655,766)	(194,493)	(619,765)	(1,841,508)
Federal match for public health emergency	0	(1,835,494)	(1,668,183)	3,503,677
TOTAL	**$145,795,971**	**$11,045,841**	**$34,082,950**	**$100,667,180**
Increase/(Decrease)	(16,180,702)	(4,662,415)	(3,800,096)	(7,718,191)
Percentage Change	-10.0%	-29.7%	-10.0%	-7.1%

The decreased enrollment in the forecast reflects lower-than-expected year-to-date enrollment. New enrollment to CHP+ is being offset by churn from CHP+ to Medicaid. During the public health emergency children are not being disenrolled from Medicaid and churning from Medicaid to CHP+.

The forecast makes small true ups to per capita assumptions and estimated reconciliations.

The forecast includes a decrease of $1.8 million General Fund and a decrease in cash funds and a corresponding increase in federal funds associated with the extension of the federal public health emergency. Pursuant to the Families First Coronavirus Response Act states can draw an enhanced federal match for CHP+ through the last fiscal quarter of the federal public health emergency.

FY 22-23

The next table shows the most significant factors driving the forecasted change in expenditures from FY 21-22 to FY 22-23. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2022-23 Children's Basic Health Plan Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2021-22 Projection	$145,795,971	$11,045,841	$34,082,950	$100,667,180
Enrollment	31,026,183	8,399,319	1,113,308	21,513,556
Per capita	2,885,474	136,505	748,181	2,000,788
Federal match for public health emergency	0	5,323,752	2,873,990	(8,197,742)
TOTAL	**$179,707,628**	**$24,905,417**	**$38,818,429**	**$115,983,782**
Increase/(Decrease)	33,911,657	13,859,576	4,735,479	15,316,602
Percentage Change	23.3%	125.5%	13.9%	15.2%

The forecast projects CHP+ enrollment will grow 39 percent, or 21,799 members from September 2022 to April 2023. This is primarily due to the end of the Medicaid continuous coverage requirement during the public health emergency and the associated expected transition of clients who have been "locked in" to Medicaid onto CHP+.

The forecast projects an increase in capitation rates, primarily for dental services.

The forecast includes an increase of $5.3 million General Fund and an increase in cash funds and a corresponding decrease in federal funds associated with the extension of the federal public health emergency. Pursuant to the Families First Coronavirus Response Act states can draw an enhanced federal match for CHP+ through the last fiscal quarter of the federal public health emergency.

➔ R4 Medicare Modernization Act

Request

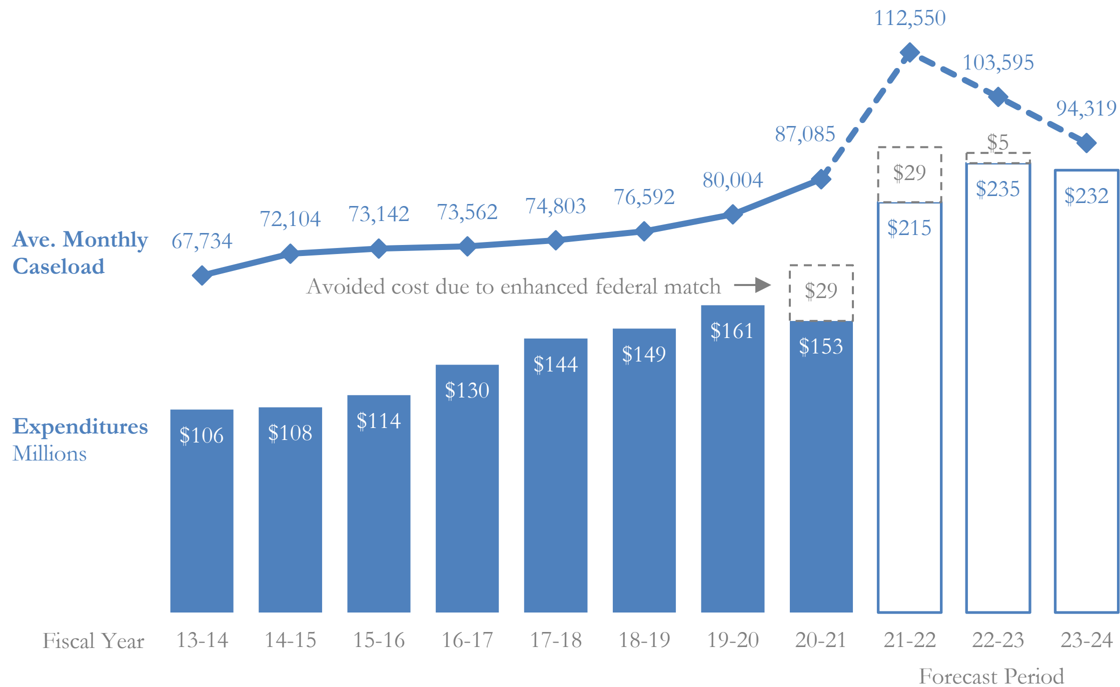
The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This is often referred to colloquially as the “clawback.” The size of the state's obligation under the federal formula is influenced by changes in the population that is dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices. This is a 100 percent state obligation with no matching federal funds.

On February 15, 2022, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2022 forecast is higher than the forecast used for the Governor's request by $17.8 million General Fund in FY 21-22 and $14.2 million General Fund in FY 21-22. The cumulative General Fund difference over the two years is $32.0 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2022 forecast of enrollment and expenditures to modify both the FY 21-22 and FY 22-23 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the cumulative General Fund difference over the two years is $32.0 million higher than the Governor's November request. In the summary tables the JBC staff shows the changes attributable to the difference in the federal match rate for the public health emergency separately from the rest of the forecast adjustment to help identify the fiscal impact of this large financing change.

The chart below summarizes the Department's forecast. The enhanced federal match through the federal Families First Coronavirus Response Act reduces the state obligation under the Medicare Modernization Act. As a result, the Department estimates Colorado is saving $29 million General Fund in FY 2020-21, including a credit of $6.6 million for payments in FY 2019-20, $29 million General Fund in FY 21-22, and another $5 million in FY 22-23. Even though the forecast assumes the federal public health emergency will end during FY 21-22, there is still an impact in FY 22-23 due to delays between the date of service and when payments are made to the federal government.



The rapid increase in caseload in FY 20-21 and FY 21-22 is due to a combination of the continuous coverage requirement during the public health emergency and a change in the methodology the Department uses to determine the caseload for purposes of calculating the MMA obligation. The decrease in caseload in FY 22-23 and FY 23-24 is similarly attributable to the end of the continuous coverage requirement during the public health emergency and the end of a one-time increase in invoiced caseload to account for member months over the last three years that were not captured under the old methodology for calculating the MMA obligation.

FY 21-22

The table below shows the most significant factors driving the change in the Department's forecast for FY 21-22. Note that this table displays changes from the appropriation and not changes from FY 20-21. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2021-22 Medicare Modernization Act	
	GENERAL FUND
FY 2021-22 Appropriation	$197,201,203
Enrollment	(1,873,076)
File cleanup	29,506,896
Federal match for public health emergency	(9,812,348)
TOTAL	**$215,022,675**
Increase/(Decrease)	17,821,472
Percentage Change	9.0%

Enrollment
The Department slightly decreased the base enrollment forecast.

File cleanup
The forecast includes a $29.5 million General Fund increase based on a change that was required by federal guidance in the methodology the Department uses to calculate the MMA obligation. The old methodology used a data source that contained many errors and did not capture the full MMA caseload. According to the Department, the errors in the data source did not impact eligibility, benefits, or payments of claims. They only impacted the calculation of the MMA obligation. The new methodology uses a more accurate data source. Some of the errors in the old data source were routinely captured and corrected after the fact through reconciliation procedures, so the transition to the new data source accurately identifies the state obligation more quickly. Other errors in the old data source went undetected, except that at a high level the federal government could tell something was amiss by comparing state reports to other data sets, so the new methodology is capturing caseload that was previously not counted. The new federal guidance requires states to use methodologies where there is less potential for error than the method Colorado previously used. When the Department first implemented the new methodology, the monthly caseload grew from 90,980 to 96,841 (6.4%). Not all of that growth is necessarily attributable to the change in methodology, as the Department expects monthly enrollment growth and fluctuations, but there was a level shift up in the caseload and MMA obligation. In FY 21-22 the Department also needs to make reconciliation payments to the federal government for inaccurate caseload counts over the last three years.

Federal match for public health emergency
The forecast includes a decrease of $9.8 million for the extension of the federal public health emergency. Although there are no federal matching funds in this line item, the enhanced federal match during the federal public health emergency reduces the state obligation under the MMA. This is because the federal formula for determining state obligations is trying to capture a portion of what states would have paid for pharmaceuticals for people dually eligible for Medicaid and Medicare prior to Medicare absorbing this cost and the amount states would have paid is influenced by the applicable federal match rate.

FY 22-23
The next table shows the most significant factors driving the forecasted change in expenditures from FY 21-22 to FY 22-23. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2022-23 Medicare Modernization Act	
	General Fund
FY 2022-23 Projection	$215,022,675
Enrollment	4,673,145
Per capita	14,330,778
Annualize file cleanup	(22,091,464)
End of enhanced federal match	23,537,158
TOTAL	**$235,472,292**
Increase/(Decrease)	20,449,617
Percentage Change	9.5%

Enrollment
The Department projects small year-over-year growth due to shifting out the disenrollment timeline and adjusting for the lag in MMA billing

Per capita
The Department projects an increase in per capita expenditures based on pharmaceutical inflation and the way the federal formula estimates drug inflation.

File cleanup
The forecast includes a decrease of $22.1 million for the end of a one-time reconciliation payment to the federal government in FY 21-22 for inaccurate caseload counts over the last three years.

Federal match for public health emergency
The forecast includes an increase of $22.1 million for the end of the federal public health emergency. Although there are no federal matching funds in this line item, the enhanced federal match during the federal public health emergency temporarily reduced the state obligation under the MMA. This is because the federal formula for determining state obligations is trying to capture a portion of what states would have paid for pharmaceuticals for people dually eligible for Medicaid and Medicare prior to Medicare absorbing this cost and the amount states would have paid is influenced by the applicable federal match rate.

BENEFITS/ELIGIBILITY ADJUSTMENTS

➔ STAFF INITIATED: DOC TRANSITIONS TO NURSING HOMES

Request
The Department of Corrections (DOC) requested $702,187 total funds, including $168,575 General Fund, to guarantee 10 beds in a privately run nursing facility for elderly and indigent parolees. There was no corresponding request in the Department of Health Care Policy and Financing.

RECOMMENDATION
During figure setting for the Department of Corrections the JBC staff recommended, and the JBC approved, an appropriation in the Department of Health Care Policy and Financing's budget of $938,820 total funds, including $405,208 General Fund, for nursing home services for Medicaid eligible parolees. A portion of the adjustment impacts behavioral community programs.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2022-23 APPROPRIATIONS FOR THE DEPARTMENT OF CORRECTIONS R3 BUDGET REQUEST						
LINE ITEM	TOTAL FUNDS	GENERAL FUND	CASH FUNDS[1]	REAPPROP. FUNDS	FEDERAL FUNDS	FTE
(2) Medical Services Premiums	$936,029	$403,813	$64,201	$0	$468,015	0.0
(3) Behavioral Health Community Programs	2,791	1,395	0	0	1,396	0.0
TOTAL FY 2022-23 APPROPRIATION, HCPF	$938,820	$405,208	$64,201	$0	$469,411	0.0

[1] From the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2)(a), C.R.S.

PROVIDER RATES

➔ R10 PROVIDER RATES

REQUEST

The Department submitted a request for a common policy provider rate increase of 0.5 percent plus a number of targeted rate adjustments and of that request $68,318 total funds, including $15,177 General Fund, for a 0.5 percent increase for behavioral health fee-for-services payments is relevant to the divisions discussed in this figure setting presentation.

RECOMMENDATION

Staff recommends an increase of $273,270 total funds, including $60,708 General Fund, for behavioral health fee-for-service, based on the JBC's decisions to adopt a 2.0 percent common policy community provider rate increase, rather than a 0.5 percent increase.

➔ R16 URBAN INDIAN HEALTH

REQUEST

The Department requests $48,025 General Fund for the FY 22-23 costs of 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.

RECOMMENDATION

Staff does not recommend the request. The JBC already sponsored H.B. 22-1190 to provide the funding summarized in the table below and no further appropriation is needed in the Long Bill.

H.B. 22-1190	
FISCAL YEAR	GENERAL FUND
FY 2021-22	$70,825
FY 2022-23	48,025
Cumulative Total	**$118,850**

ADMINISTRATION AND OTHER

➔ R8 COUNTY ADMINISTRATION

REQUEST

The Department requests a net decrease of $590,849 total funds, including an increase of $461,138 General Fund, and an increase of 5.9 FTE, to:

- Address an annual funding deficit for county administration of the Medicaid eligibility process;
- Increase funding for pay-for-performance through the County Incentives Program allocation;
- Hire addition Department staff to provide proper fiscal and programmatic oversight of county administration-related activities; and
- Reduce the amount of time it takes to conduct on-site compliance reviews.

A portion of the change impacts the Behavioral Health Community Programs and Child Health Plan Plus.

RECOMMENDATION

Consistent with the recommendations during figure setting for the Executive Director's Office, the staff recommendation includes a decrease of $2.9 million total funds, including a decrease of $620,457 General Fund, for associated impacts on behavioral health community programs and the Children's Basic Health Plan. *See the figure setting recommendations for the Executive Director's Office for more detail.*

➔ R11 ACC AND CHP ACCOUNTABILITY

REQUEST

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).

ACC Oversight

The Department says the Regional Accountable Entities (RAEs) are underperforming in key measures when implementing the ACC and specifically highlights:

- Suicide and self-inflicted injury visits to emergency rooms increased, particularly for children. There were 2,600 pediatric emergency department visits by Medicaid clients for suicide and self-inflicted injury in calendar year 2020. For children in foster care, more than 10 percent of emergency department visits are for suicide and self-inflicted injury, representing the number one reason for an emergency department visit.
- Utilization of preventative and therapeutic behavioral health services has decreased.
- Utilization of behavioral health services by people with unstable housing has decreased.

The proposed position would identify areas where the RAEs can improve their care coordination, thereby improving member health. As an example, the Department mentioned improved connections to step down services for people leaving the mental health institutes. The data analysis by the position would also inform the reprocurement of the RAEs that must occur by July 1, 2025, including potentially developing new and improved performance metrics. The Department says it is currently under-resourced to confidently answer critical strategic questions about the ACC such as whether the troubling behavioral health trends described above are a pandemic-related issue, resource issue, management issue, or something else entirely. The position would give the Department the resources needed to make periodic needed improvements to the ACC, such as standardizing the way regions define and count providers and assess network adequacy.

CHP+ Oversight

The Department indicates there are a number of compliance issues stemming from the slow resolution of reconciliations, inaccurate payments, and enrollments. To illustrate the problem, the Department provided the following list of backlogged issues:

- Five systems policy projects to correct enrollment & eligibility artifacts, which each individually drive adverse member experiences and inaccurate payments
- Nine systems policy projects to correct varied policy inaccuracies within MMIS, seven of which are directly related to implementing corrective measures/payment protections to prevent inaccurate payments
- Routine quarterly reconciliation processes went unaddressed and unmanaged by policy staff for several years starting in 2019 and attempts to restart this work has been slow to implement, taking the past year.
- Work on the recoupment of inaccurate payments made in 2017-2019 has yet to be resolved
- Proper and complete determination of the CHP+ Benefit at the individual code level to allow for the development of an accurate fee schedule
- State Plan Amendment-18-0027: MHPAEA Compliance—yet to be resolved since CMS requested additional information on 08/03/2018
- State Plan Amendment-20-0032: SUPPORT Act—Yet to be resolved since CMS requested additional information on 08/06/2020
- Rates/Payment Statutory Violation related to Specialty Drugs from May 2021 has yet to be resolved
- Colorado Code of Regulations update has yet to be finished with work spanning over the past 1.5 years on the effort to address issues such as
    - Correction of inconsistencies and inaccuracies of the program's premium and copayment policy between multiple authorities since 2020
    - As an example, still recognizes & references Food Stamps
- Detailed update to incorporate medical practice, coding, and diagnostic classification changes over the past decade remains ongoing after 1.5 years of resource investment with substantial work remaining—required for compliance and to accurately set all Managed Care rates
    - As an example, the CHP+ program still uses the DSM-IV for classification of behavioral health and substance use disorder benefits (ex. recognizes Autism, but not Autism Spectrum Disorders).

According to the Department, a lack of resources to regularly update CHP+ is causing state and federal compliance issues and putting the state at risk of federal penalties. As an example, the Department noted the CHP+ benefit plan has not kept pace with medical, coding, and diagnostic changes over the past decade. The poorly defined benefit package prevents the Department from excluding services above the minimum essential coverage from rate setting calculations, artificially inflating rates. Similarly, the Department's rules and regulations need to be reviewed and updated to ensure they align with current practice. The Department says the rules and regulations need a comprehensive one-time review, but they also need regular periodic review so they never get so out of date again.

The Department also identified issues with the accurate reporting of CMS Core Measures that the Department says are driven not by a lack of resources for the Managed Care Organizations but by slow guidance and technical assistance from the Department on what and how to report.

With the requested resources the Department hopes to become more proactive in managing CHP+. For example, the Department identified a need for better monitoring of plan performance on care coordination for the prenatal population, immunization rates, and call center and on-line portal metrics.

CHP+ Contract admin true-up

Contract administrative costs for CHP+ have decline, primarily due to a decline in the cost of eligibility reviews. While costs can fluctuate from year to year, the current baseline appropriation exceeds the Department's expected expenditures in FY 22-23. The Department proposes using the net savings to the CHP+ Trust from the decrease in contract administrative expenses and the increase for new staff to offset the need for General Fund in the CHP+ medical and dental services line item.

RECOMMENDATION

Staff recommends approval of the request, with modification to apply the JBC's common policies regarding new FTE. The Department has identified deficiencies in the current oversight of the ACC and CHP+ and a needed true-up to the appropriation for CHP+ contract administration.

R11 ACC & CHP+ ACCOUNTABILITY					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Personal Services	$140,724	$35,181	$24,627	$80,916	2.0
ACC Oversight	*70,362*	*35,181*	*0*	*35,181*	*1.0*
CHP+ Oversight	*70,362*	*0*	*24,627*	*45,735*	*1.0*
Operating Expenses	15,900	3,975	2,783	9,142	0.0
Leased Space	13,200	3,300	2,310	7,590	0.0
Subtotal - Department Staff	**$169,824**	**$42,456**	**$29,720**	**$97,648**	**2.0**
CHP+ Contract admin true-up	($1,258,319)	($410,692)	($29,720)	($817,907)	0.0
CHP+ Administration	(1,258,319)	0	(440,412)	(817,907)	0.0
CHP+ Services	0	(410,692)	410,692	0	0.0
TOTAL	**($1,088,495)**	**($368,236)**	**$0**	**($720,259)**	**2.0**

It is worth noting that this request addresses three separate issues that could each stand alone. The Department argues that the requests for ACC oversight and CHP+ oversight share a common theme of improving member health care through closer monitoring of contractual compliance, but the deficiencies driving the requests are particular to those programs. The Department views the CHP+ contract administration true up as related to the CHP+ oversight because the Department is proposing replacing one type of appropriation for administration with another type of appropriation for administration. However, if the JBC finds some of the arguments more compelling than others, the JBC could choose not to fund any of the three components without impacting the others.

LEVEL OF EVIDENCE PURSUANT TO S.B. 21-284

The Department indicates the proposed funding is for the implementation of a theory-informed program or practice as defined in S.B. 21-284 (Evidence-based evaluation for budget). The Department describes the program objective as improving member outcomes by increasing the equity,

quality, and accountability of program offerings in the ACC and CHP+. The Department indicates it will use the CMS Core Measures to evaluate pre- and post-implementation performance. Regarding the cost-benefit ratio the Department says the status quo will be higher than the cost of the request due to continued increases in utilization of high-cost health services.

The JBC staff's independent analysis concludes that the S.B. 21-284 definitions and requirements regarding evidence-based programs are "not applicable". This is a request for administrative resources to oversee the ACC and CHP+. There is no existing research to suggest that the additional staff will make the ACC and CHP+ more effective. The Department proposes measuring performance on the CMS Core Measures pre- and post-implementation, but it would be difficult to establish a causal relationship between these two FTE and the state's performance on the CMS Core Measures. Also, part of the impetus for the request is to improve the accuracy of CMS Core Measure reporting, which implies the current CMS Core Measure data is not a valid baseline of performance. The proposed staff would be involved in gathering data to support decision-making, so the request is related to collecting evidence, but it is not an evidence-based request and the JBC staff does not understand why the Department describes it as a theory-informed program or practice.

➔ R17 SBIRT TRAINING

REQUEST

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 projected 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[3] 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).

RECOMMENDATION

Staff does not recommend the request. The JBC staff agrees with the Department that this is a discretionary grant program that could be managed with less money. For this reason, funding for the program was reduced to help balance the budget in FY 2020-21. The proposed reduction would not change the funding for SBIRT services. Providers would just receive less grant-financed training. However, advocates and the General Assembly have repeatedly expressed concerns about the importance of this program in developing provider capacity. In FY 21-22 the JBC carved out money from the Marijuana Tax Cash Fund to partially restore the funding reductions in FY 20-21 and then S.B. 21-137 (Behavioral Health Recovery Act) added another one-time infusion of $250,000 from federal American Rescue Plan Act money deposited in the Behavioral and Mental Health Cash Fund. The JBC staff assumes the General Assembly would like to maintain a funding level of $750,000 assuming sufficient funds. If the March revenue forecast indicates a deficit in the Marijuana Tax Cash Fund, the JBC could consider refinancing the SBIRT Training Grants from the General Fund.

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

Pending balancing decisions, the JBC staff recommendation is to hold the funding for the SBIRT training grants constant.

The table below summarizes the funding history for the SBIRT training grants.

SBIRT Training Grants			
	Total Funds	Marijuana Tax Cash Fund	Behavioral and Mental Health Cash Fund
FY 16-17	$750,000	$750,000	$0
FY 17-18	750,000	750,000	0
FY 18-19	1,675,000	1,675,000	0
FY 19-20	1,500,000	1,500,000	0
FY 20-21	500,000	500,000	0
FY 21-22	1,000,000	750,000	250,000

Level of Evidence Pursuant to S.B. 21-284

The Department indicates the proposed funding is for the implementation of an evidence-informed program as defined in S.B. 21-284 (Evidence-based evaluation for budget). There is evidence to suggest that SBIRT services result in savings and better health outcomes[4], but the Department is saying that the request is supported by a lack of evidence regarding the effectiveness of the training grant program. The Department says it will measure the number of providers trained in SBIRT and the number of members screened for substance use disorders and referred to treatment to measure whether the reduction in funding has a negative impact.

The JBC staff's independent analysis concludes that the S.B. 21-284 definitions and requirements regarding evidence-based programs are "not applicable". This is a request for administrative resources to train providers to deliver SBIRT services.

➔ BA8 Behavioral health administration

Request

The Department requests $638,727 total funds, including $319,365 General Fund, for five new positions (4.8 FTE in the first year) to help implement the Behavioral Health Administration authorized by H.B. 22-1278. There are related requests by the Department of Human Services (a net $3.0 million total funds, including an increase of $3.6 million General Fund, for 26.5 FTE, annualizing to $10.4 million General Fund and 74.8 FTE in FY 23-24), the Department of Public Health and Environment ($8.8 million total funds, including $47,167 General Fund, for 11.2 FTE), and the Department of Regulatory Agencies (171,733 cash funds for 2.0 FTE for the Division of Insurance).

Although the Governor proposes that the Behavioral Health Administration will be housed in the Department of Human Services, other departments, including the Department of Health Care Policy and Financing, will need to provide support to the Behavioral Health Administration. The Department of Health Care Policy and Financing is the largest payer for behavioral health services, administers the contracts with the Regional Accountable Entities, maintains data on needs and utilization, and ensures state policies align with federal regulations.

[4] For example, Melek, S. P., Creten, N., Davenport, S., & Matthews, K. (2016). (rep.). SBIRT Analysis Financial impact for practices that implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use. Denver, CO: Millman Inc.

The Department describes the on-going staff currently devoted to the administration of behavioral health care services through Medicaid as 5.0 FTE, with 3.0 FTE devoted to working with the RAEs and 2.0 FTE providing technical expertise in establishing capitated behavioral health rates.

The specific new positions requested by the Department are summarized in the table below and described beneath the table.

BA8 Behavioral Health Administration				
	Total Funds	General Fund	Federal Funds	FTE
Personal Services	$474,767	$237,384	$237,383	4.5
Behavioral Health Programs Specialist	*101,046*	*50,523*	*50,523*	*0.9*
Child and Youth Behavioral Health Policy Specialist	*83,585*	*41,793*	*41,792*	*0.9*
Regulatory and Compliance Specialist	*101,046*	*50,523*	*50,523*	*0.9*
Rates Analyst	*101,046*	*50,523*	*50,523*	*0.9*
Behavioral Health Data and Research Analyst	*88,044*	*44,022*	*44,022*	*0.9*
Operating Expenses	39,750	19,875	19,875	0.0
Leased Space	33,000	16,500	16,500	0.0
Subtotal - First year costs for new FTE	**$547,517**	**$273,759**	**$273,758**	**4.5**
Estimated benefits	91,210	45,605	45,605	0.0
TOTAL	**$638,727**	**$319,364**	**$319,363**	**4.5**

Behavioral Health Programs Specialist

The position would ensure that BHA-led reforms are integrated into RAE contracts and that incentive payments and key performance indicators effectively drive RAE performance. The position would also play a key role in aligning data and claims processing across multi-department data and financial systems, including mapping provider and member processes, updating billing manuals, assessing regulatory impacts, and providing policy guidance.

Child and Youth Behavioral Health Policy Specialist

The position would play a leadership role in developing policies and practices that acknowledge the differences in providing behavioral health to children and youth versus adults. The position would strategically assess state policies and federal approvals related to child and youth behavioral health. The Department says it will look for an experienced program administrator with an understanding of the breadth and depth of system-level changes to support operational, contract, and payment reforms directed by the BHA.

Regulatory and Compliance Specialist

The position would ensure that all BHA-led reforms are approved and in compliance with relevant state and federal regulations. The position would work closely with the federal Centers for Medicare and Medicaid Services to shepherd through policy changes, solve approval problems, and maximize federal financial participation. The position would work with stakeholders to interpret goals into discrete regulatory action items. In addition, the position would focus on ensuring policies consider equity, diversity, and inclusion, consider whole-person care such that physical and behavioral health needs are met, and acknowledge co-occurring conditions.

RATES ANALYST

The position would analyze and model the impact of BHA-led reforms on capitated behavioral health payments and help implement those reforms. The Department says significant time would be spent coordinating with other departments to ensure coverage and payments do not overlap or interfere and to systemize payment mechanisms and coverage across departments and counties. A focus of the position would be on working with disparate data from multiple departments to ensure it is accurate and configuring the data to make it useable for rate setting considerations.

BEHAVIORAL HEALTH DATA AND RESEARCH ANALYST

The position would be responsible for consolidating and coordinating behavioral health data, conducting quantitative and qualitative analysis to produce descriptive statistics and predictive analytics, and communicating the findings. The position would use programming techniques to isolate behavioral health specific data within the larger department data storage and collection systems, document the coding, and ensure that the metrics are statistically sound.

RECOMMENDATION

Staff recommends that any money appropriated for these proposed positions be included in H.B. 22-1278 (Behavioral Health Administration) and scaled to the specific requirements of the bill, rather than included in the Long Bill. If the JBC wants to set aside funding for the bill, the JBC could use the request as an estimate for the amount needed, or wait to decide on an amount to set aside until the Legislative Council Staff Fiscal Note is ready. The bill was introduced 03/02/2022.

Although it is not the approach recommended by the JBC staff, the JBC could include the requested funding in the Long Bill. Pursuant to Section 27-60-203, C.R.S. (added by H.B. 21-1097), the Behavioral Health Administration "is established" on or before July 1, 2022, and there are minimum responsibilities identified in statute:

> *(3) The duties of the BHA, once established and fully operational, must include, but are not limited to:*
> - *(a) Serving as the single state agency responsible for state behavioral health programs that were identified as appropriate to transition into the BHA;*
> - *(b) Receiving, coordinating, and distributing appropriate community behavioral health funding throughout the state;*
> - *(c) Monitoring, evaluating, and reporting behavioral health outcomes across the state and within various jurisdictions, while maintaining tribal sovereignty; and*
> - *(d) Promoting a behavioral health system that supports a whole-person approach to ensure Coloradans have the best chance to achieve and maintain wellness. This approach includes:*
>   - *(I) Promoting an integrated approach to mental health and substance use treatment;*
>   - *(II) Strengthening the integration of behavioral and physical care;*
>   - *(III) Enhancing programmatic and funding opportunities in support of the overall well-being of the individual or family;*
>   - *(IV) Promoting culturally responsive, trauma-informed, and equitable behavioral health care; and*
>   - *(V) Promoting coordination of supportive services outside of the behavioral health system to address social determinants of health, and to connect people to services such as housing, transportation, and employment.*
>
> *(4) The state department shall work collaboratively with the department of health care policy and financing, community stakeholders, and other state departments, as appropriate, to promulgate rules*

for the BHA to provide adequate oversight of the quality of services and set standards of care for services for adults as well as children and youth.

Providing a list of minimum, broadly worded things that must be included within the duties of the BHA is an unusual statutory framework and it presents some challenges for a JBC staff analysis compared to a more typical statutory structure that identifies explicit functions an agency shall perform. The wording in Section 27-60-203 (3), C.R.S., is so broad that it could mean almost anything or nothing. There is very little statutory guidance for the JBC staff to work with to analyze the adequacy of the request.

For example, in subsection (3)(a) the BHA is to serve as the single state agency responsible for behavioral health programs that "were identified" as appropriate to transition to the BHA, but it is not clear who or what identified the programs to transition to the BHA or which specific programs are transitioning. Without this information it is hard to assess whether the Governor is requesting an appropriate number of FTE.

Similarly, in subsection (3)(b) the BHA is to receive, coordinate, and distribute "appropriate" community behavioral health funding, but there is nothing to indicate how to determine what is "appropriate". In subsection (3)(c) and (d) the BHA is supposed to monitor, evaluate, and report behavioral health outcomes across the state and promote a behavioral health system that supports a whole-person approach, but it is not clear if these requirements represent something more, less, or the same as what the Department of Human Services already does and, by extension, what the Department of Health Care Policy and Financing might need to do to support the BHA in the Department of Human Services.

This raises the question of what did the General Assembly expect to happen in response to Section 27-60-203, C.R.S., and it is useful to think about the natural courses of action implied by different possible interpretations of the General Assembly's expectations.

One possible interpretation is that the General Assembly was trying to delegate decision making authority to the Governor. In subsections (1) and (2) the Department of Human Services is charged with developing a plan for the BHA[5], so it is possible that (3)(a) is referring to the programs that "were identified" in that plan. In subsection (4) the BHA is empowered to start making rules. If the General Assembly was trying to tell the executive branch to figure out the BHA, then the JBC should probably just approve the request and move on, because the request is the Governor's plan.

Another possible interpretation is that the General Assembly expected the JBC to figure out the BHA through the budget process. The plan in subsections (1) and (2) is described as a series of recommendations with a report that goes to (among others) the JBC. The Governor submitted requests to implement the BHA through the budget process. The Legislative Council Staff Fiscal Note for H.B. 21-1097 said, "The fiscal note assumes that any increase in appropriations will be requested through the annual budget process." If the General Assembly expected the JBC to figure out the BHA through the appropriations, then the JBC staff believes that is problematic and it raises many questions about transparency and process:

[5] The plan can be found here: https://drive.google.com/file/d/13H2jGAApljrItLdeljywwB4PvjDNcv6-/view

1. Under this scenario, how would the BHA and the rest of the General Assembly know what the JBC decided? Would the BHA point to the non-statutory Long Bill Narrative as the basis of what it can and cannot do?
2. What if the rest of the General Assembly wanted to make modifications to the JBC's decisions? Would there be a series of amendments to the Long Bill with footnotes describing the General Assembly's intent, and would that be making substantive law through the Long Bill?
3. What is the role of the health committees of the House and Senate? If the JBC is expected to figure out the BHA through the budget, why did the statute require that those committees also receive copies of the plan?

A third possible interpretation is that the General Assembly expected a plan to flesh out and implement the BHA that it could approve or modify. That seems to be what the General Assembly is getting in the 232 page (as introduced) H.B. 22-1278. If this was the expectation, then it makes the most sense to connect the appropriations to the specific requirements of the bill and to put the appropriations in the bill. Then, if the General Assembly decides to modify any of the functions of the BHA in the bill, it could adjust the appropriations at the same time to scale with those modifications.

If the only basis for the JBC staff analysis is the request and Section 27-60-203, C.R.S., then the JBC staff cannot recommend the request. The Department did not make a sufficient argument that the provisions of Section 27-60-203, C.R.S., require the functions described in the request. Nor does the Department sufficiently explain how the requested FTE will address behavioral health problems or improve client outcomes. Everything is couched as supporting the BHA and BHA-led policies that are not defined. These BHA-led policies would presumably address behavioral health problems and improve client outcomes, but the request is not specific.

If the JBC staff expands the analysis to the specific functions assigned to the BHA in H.B. 22-1278 and the coordination requirements with HCPF, there are several provisions in the bill that suggest to the JBC staff that the Department would need additional FTE. The bill was introduced on 03/02/2022 and the JBC staff is not yet ready to estimate the number of FTE required to implement H.B. 22-1278, nor does the JBC staff want to presuppose what the Legislative Council Staff Fiscal Note will say. The JBC staff is working with Legislative Council Staff to analyze the fiscal impact of the bill, including FTE needs.

LEVEL OF EVIDENCE PURSUANT TO S.B. 21-284

The Department indicates the proposed funding is for the implementation of a theory-informed program or practice as defined in S.B. 21-284 (Evidence-based evaluation for budget). The Department describes the program objective as improving access and integration of behavioral health services statewide. The Department indicates the accountability metrics are still being finalized by the BHA. Regarding the cost-benefit ratio the Department says the status quo will be higher than the cost of the request due to continued increases in utilization of high-cost health services.

The JBC staff's independent analysis concludes that the S.B. 21-284 definitions and requirements regarding evidence-based programs are "not applicable". This is a request for administrative resources to support the BHA. There is no existing research to suggest that the additional staff will make the BHA more effective and the Department is not proposing any measures to evaluate the impact of the

additional staff. Some of the proposed staff would be involved in gathering data and evidence to support BHA decision-making, but trying to evaluate this request through the levels of evidence is likely a waste of time and the JBC staff cannot understand why the executive branch tried to make the connection or determined that that there was such a high level of evidence to support the request.

➔ BA12 Safety net provider payment

Request

The Department requests a net reduction of $3,735,404 total funds for the Safety Net Provider Payments line item, including a reduction of $16,360,790 cash funds from the Healthcare Affordability and Sustainability (HAS) Fee and an increase of $20,096,194 federal funds, to align the appropriation with the expected Disproportionate Share Hospital (DSH) supplemental payment.

Each state receives a Disproportionate Share Hospital allotment from the federal government to help offset the costs to hospitals that serve a large number of uninsured and underinsured clients. Colorado uses the DSH allotment for the Colorado Indigent Care Program (CICP). Hospitals participating in CICP agree to charge low-income uninsured patients on a sliding scale based on income. The funding is allocated through a formula based on uninsured hospital costs.

For the FY 2021-22 appropriation the JBC approved a true up to the expected DSH allotment, but the true up included some screw ups, including both math errors and miscommunications between the Department and the JBC staff. In addition, the federal American Rescue Plan Act changed the way the DSH allotment is calculated and the Department received new federal guidance on the timing of enhanced matching funds for DSH. The combination of technical errors and new data necessitated another correction to the FY 2021-22 appropriation that the JBC approved in the supplemental bill. This request annualizes the JBC's supplemental action.

Recommendation

Staff recommends the requested total for the Safety Net Provider Payments line item to match the projected federal DSH allotment. However, in the summary tables the JBC staff attributed a portion of the change (an increase of $1,049,512 from the HAS Fee and a decrease of $1,049,512 federal funds) to the end of the enhanced federal match during the public health emergency, rather than this decision item, in order to try and better capture the total impact of the change in the federal match rate.

➔ BA14 Centralized eligibility vendor

Request

The Department requests a net decrease of $24,723 total funds to annualize the JBC's supplemental decision to update appropriations for contract eligibility and enrollment services provided to applicants and clients eligible for Medicaid and the Child Health Plan Plus based on a new federally-required cost allocation methodology. The FY 21-22 appropriation included one-time money for a reconciliation payment related to services in the last quarter of FY 20-21 that goes away in FY 22-23.

Recommendation

Staff recommends approval of the Department’s request, consistent with the JBC's supplemental action, plus an adjustment to FY 21-22 to account for the extension of the federal public health

emergency. With the extension of the federal public health emergency, the FY 21-22 obligation from the CHP+ trust will decrease by $1,233 and the federal funds will increase by the same amount.

The centralized eligibility vendor provides a customer service center, eligibility determination and case maintenance for Medicaid Buy-in programs, administration of Medicaid Buy-In premium payments and CHP+ enrollment fees, and resolution of eligibility-related disputes. The centralized eligibility vendor is reimbursed according to a cost allocation methodology approved by CMS in the department's Public Assistance Cost Allocation Plan (PACAP) pursuant to 42 CFR 433.34. The methodology requires the vendor to report the direct cost of providing services including salaries, benefits, supplies, and travel. The direct cost is then inflated by an indirect cost rate to account for overhead and general administrative expenses. The Centers for Medicare and Medicaid Services (CMS) required the Department to change the vendor's cost allocation methodology and increase the indirect cost rate from 10 to 33 percent of the vendor's total direct costs. This indirect cost rate is determined by CMS and not by the Department.

➔ TOBACCO FORECAST

REQUEST

The Department's request and the February 2022 forecast of CHP+ included technical adjustments based on the OSPB forecast of tobacco tax revenues and the statutory formula allocation of those revenues.

RECOMMENDATION

Staff requests permission to update tobacco tax revenues available for both CHP+ and the Primary Care Fund as described below based on the March revenue forecast. For now, the summary table includes the adjustment estimated by the Department in the February 2022 forecast of CHP+.

Through the statutory allocation of tobacco tax revenues, the Primary Care Fund receives 19 percent of tobacco tax collections annually and the staff recommendation is to adjust the appropriations from the Primary Care Fund to match the expected available revenue. For CHP+ the statute requires 0.3 percent of the tobacco tax revenue be appropriated to the General Fund and then to CHP+ and so the staff recommendation is to adjust the appropriations to comply with this requirement. The total General Fund needed for CHP+ will not change, just the proportion from standard General Fund versus the special General Fund that originated from tobacco tax revenues.

➔ STAFF INITIATED: FAMILY MEDICINE RESIDENCY TRAINING

REQUEST

The Department did not request a change in funding.

RECOMMENDATION

Staff recommends an increase of $89,445 total funds, including $44,472 General Fund to restore funding for the Commission on Family Medicine that had been reduced during the pandemic. In FY 2021-22 the JBC voted to increase funding for the Commission on Family Medicine by $500,000 and to merge the appropriations for the Commission on Family Medicine into a single line item to avoid potential future confusion about the total support for family medicine residencies caused by dispersed funding. Based on the JBC's decisions, funding for the main line item for the Commission on Family

Medicine was restored to the pre-pandemic funding level, but the funding for the secondary line item was merged with the primary line item at the post-pandemic funding level. The recommended adjustment would fully restore funding to the pre-pandemic level.

(3) BEHAVIORAL HEALTH

This section provides funding for Medicaid clients' behavioral health care. Most mental health and substance use disorder services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program through which the Department contracts with "regional accountable entities" (RAEs) to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each RAE receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services and enrolled with that RAE. In addition to funding for capitation payments to RAEs, a separate appropriation covers fee-for-service payments for certain behavioral health services that are not covered by the capitation program. Behavioral health services are primarily supported by General Fund and federal funds. Cash fund sources include the Healthcare Affordability and Sustainability Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.

Behavioral Health Community Programs					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2021-22 Appropriation					
S.B. 21-205 (Long Bill)	$999,130,997	$230,963,159	$70,276,585	$697,891,253	0.0
Other Legislation	0	(26,708,125)	(15,336,964)	42,045,089	0.0
H.B. 22-1173 (Supplemental Bill)	99,928,023	13,827,714	8,523,697	77,576,612	0.0
Long Bill Supplemental	(22,574,831)	(22,419,185)	(3,421,235)	3,265,589	0.0
TOTAL	**$1,076,484,189**	**$195,663,563**	**$60,042,083**	**$820,778,543**	**0.0**
FY 2022-23 Recommended Appropriation					
FY 2021-22 Appropriation	$1,076,484,189	$195,663,563	$60,042,083	$820,778,543	0.0
R2 Behavioral health	12,832,408	13,857,322	701,478	(1,726,392)	0.0
R8 County administration	(2,255,022)	(477,044)	(127,413)	(1,650,565)	0.0
R10 Provide rates	273,270	60,708	17,829	194,733	0.0
DOC transitions to nursing homes	2,791	1,395	0	1,396	0.0
Annualize prior year budget actions	43,701,499	6,157,732	3,377,253	34,166,514	0.0
Federal match public health emergency	0	26,390,642	5,656,217	(32,046,859)	0.0
Federal match for HCBS	0	30,627,165	14,494,458	(45,121,623)	0.0
TOTAL	**$1,131,039,135**	**$272,281,483**	**$84,161,905**	**$774,595,747**	**0.0**
INCREASE/(DECREASE)	**$54,554,946**	**$76,617,920**	**$24,119,822**	**($46,182,796)**	**0.0**
Percentage Change	5.1%	39.2%	40.2%	(5.6%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$1,058,133,161**	**$259,496,330**	**$78,511,459**	**$720,125,372**	**0.0**
Request Above/(Below) Recommendation	($72,905,974)	($12,785,153)	($5,650,446)	($54,470,375)	0.0

LINE ITEM DETAIL

Behavioral Health Capitation Payments

This line item supports the provision of most behavioral health services to Medicaid clients. 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[6]. The Department used a competitive bid process to award RAE contracts for each region.

In order to receive services through behavioral health capitation, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. **Services for Medicaid clients that are managed by RAEs** are listed below, with the first group including services that are covered by the State Medicaid Plan, and the second group including services that are authorized under a federal waiver.

Covered State Plan Services

- school-based behavioral health services
- targeted case management
- drug screening and monitoring
- outpatient services, including:
  - physician services (including psychiatric care)
  - rehabilitative services (including: individual, group, and family behavioral health therapy; behavioral health assessment; pharmacologic management; day treatment; and emergency/crisis services)
- detoxification services
- medication-assisted treatment
- inpatient psychiatric hospital services, with some exceptions:
  - The federal Social Security Act bars states from receiving federal Medicaid funding for any services (medical or behavioral health) provided to individuals ages 21 through 64 who are patients in an "institution for mental disease" (IMD)[7]. However, if a state has implemented a managed care plan for behavioral health services, it is allowed to use Medicaid funding to pay for inpatient psychiatric services provided for those ages 21 through 64 who reside in an IMD as an "in lieu of" State Plan service. Recent revisions to federal managed care regulations limit these services to 15 days in a calendar month. Specifically, a Medicaid agency may make a monthly capitation payment for a Medicaid client ages 21 through 64 who resides in an IMD for a short-term stay of up to 15 days during the period of the monthly capitation payment. The Medicaid agency may use the utilization of these short-term inpatient psychiatric services when developing the capitation rate.
  - For individuals under age 21 and over age 64 who reside in an IMD, Medicaid covers inpatient psychiatric care without any limitation on the number of days of care[8].

Alternate Services Covered by the Federal "1915 (b)(3)" Waiver

- prevention/early intervention services
- vocational services
- clubhouse and drop-in center services

[6] Clients are attributed to RAEs based on the location of their primary care provider, rather than their own address.
[7] An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services [42 CFR 440.1009]. Thus, the State mental health institutes and private psychiatric hospitals are considered IMDs. However, a general hospital that provides inpatient psychiatric treatment for some patients (e.g., Denver Health and Porter Adventist Hospital) is not considered an IMD because psychiatric treatment is not the hospital's primary focus.
[8] HCPF previously limited these payments to 45 days, but this limitation has been removed.

- assertive community treatment
- intensive case management
- residential services (24-hour psychiatric care provided in a non-hospital, non-nursing home setting; excludes room and board), except that these services are not covered for a client for whom the primary diagnosis is a substance use disorder (SUD)[9].
- respite care
- recovery services

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. The Department adjusts these rates periodically based on historical rate experience and data concerning client service utilization. Currently, the Department divides the state into seven geographic regions for the provision of behavioral health services to the following **Medicaid eligibility categories**[10]:

- Adults age 65 and older;
- Children and adults with disabilities under age 65;
- Parents and caretakers;
- Pregnant adults;
- Adults without dependent children;
- Children;
- Children and young adults in or formerly in foster care (through age 26); and
- Adults served through the Breast and Cervical Cancer Treatment and Prevention Program.

Two Medicaid populations that are eligible for certain medical benefits are not eligible for behavioral health services through the Medicaid program: (1) Non-citizens; and (2) Partial dual-eligible individuals (i.e., individuals who are eligible for both Medicare and Medicaid benefits, but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments).

In addition, Medicaid-eligible clients who are enrolled in a Program of All-inclusive Care for the Elderly (PACE Program) are excluded from enrollment in a RAE.

Finally, in some instances **certain behavioral health services for Medicaid clients are not covered by Capitation**, and are instead covered through other appropriations to the Department of Health Care Policy and Financing (HCPF):

[9] Ibid.

[10] The Department renamed certain eligibility categories to be more consistent with terminology used in other states and to more accurately estimate expenditures by fund source. The term "MAGI" refers to the new federal Modified Adjusted Gross Income standard that states are required to use when determining income for purposes of Medicaid eligibility.

- *Services Provided Through Primary Care.* The Medical Service Premiums line item appropriation to HCPF covers short-term behavioral health services that a RAE-enrolled client receives by a licensed behavioral health clinician at their primary care medical provider's office. These expenditures are limited to six visits per client per state fiscal year. The services include:
    - diagnostic evaluation without medical services;
    - individual psychotherapy for up to 60 minutes; and
    - family psychotherapy.
- *Services for Children and Youth in the Custody of the Department of Human Services (DHS).* Children and youth in the custody of the DHS Division of Child Welfare or the DHS Division of Youth Services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, if one of these children or youth is placed in a psychiatric residential treatment facility (PRTF) or a residential childcare facility (RCCF), the behavioral health services provided by that facility are <u>not</u> covered by the RAE and these costs are <u>not</u> considered as part of the associated per-member-per-month capitation rate. Instead, these costs are covered by appropriations of Medicaid funds to HCPF that are transferred to the DHS Division of Child Welfare and the Division of Youth Services.
- *Services for Individuals with Intellectual and Developmental Disabilities (IDD).* Individuals with IDD are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, for individuals who reside in a facility that is licensed as an "intermediate care facility" for individuals with IDD, the behavioral health services provided by that facility are <u>not</u> covered by the RAE and these costs are <u>not</u> considered as part of the associated per-member-per-month capitation rate. Instead, these costs are billed on a fee-for-service basis and are covered by other appropriations. Specifically:
    - For the Wheat Ridge Regional Center and for some beds within the Grand Junction Regional Center that are also licensed as an intermediate care facility, residents' behavioral health care services are covered by appropriations of Medicaid funds to HCPF that are transferred to DHS for these Regional Centers. In contrast, for individuals with IDD who reside in "adult comprehensive waiver homes" connected with the Grand Junction or Pueblo Regional Centers, these services are covered by the Capitation program.
    - For individuals with IDD who reside in a private intermediate care facility (e.g., Bethesda Lutheran), the behavioral health services are included in the Medicaid per diem rate paid to that facility, similar to the Regional Centers. These costs are covered by the Medical Service Premiums line item appropriation to HCPF.

STATUTORY AUTHORITY: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]; C.R.S. Sections: 25.5-4-401.2 [Performance-based payments]; 25.5-4-403 [Reimbursement for community mental health centers and clinics]; 25.5-4-405 [Mental health managed care service providers]; 25.5-5-325 [Residential and inpatient substance use disorder treatment]; 25.5-5-402 to 410 [Statewide managed care system]; 25.5-5-415 [Medicaid payment reform and innovation pilot program]; 25.5-5-419 [Accountable Care Collaborative]

REQUEST: The Department requests *R2 Behavioral health*, *R8 County administration*, and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH CAPITATION PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$983,722,442	$227,833,272	$69,187,855	$0	$686,701,315	0.0
H.B. 22-1173 (Supplemental Bill)	$98,484,468	$13,853,982	$8,772,590	$0	$75,857,896	0.0
Other Legislation	$0	($26,708,125)	($15,336,964)	$0	$42,045,089	0.0
Long Bill Supplemental	(19,105,507)	(21,585,969)	(3,227,833)	0	5,708,295	0.0
TOTAL	**$1,063,101,403**	**$193,393,160**	**$59,395,648**	**$0**	**$810,312,595**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$1,063,101,403	$193,393,160	$59,395,648	$0	$810,312,595	0.0
R2 Behavioral health	13,513,783	14,195,115	804,977	0	(1,486,309)	0.0
Federal match public health emergency	0	25,505,843	5,370,753	0	(30,876,596)	0.0
Federal match for HCBS	0	30,627,165	14,494,458	0	(45,121,623)	0.0
R8 County administration	(2,255,022)	(477,044)	(127,413)	0	(1,650,565)	0.0
DOC transitions to nursing homes	2,791	1,395	0	0	1,396	0.0
Annualize prior year budget actions	43,705,516	6,154,354	3,377,239	0	34,173,923	0.0
TOTAL	**$1,118,068,471**	**$269,399,988**	**$83,315,662**	**$0**	**$765,352,821**	**0.0**
INCREASE/(DECREASE)	**$54,967,068**	**$76,006,828**	**$23,920,014**	**$0**	**($44,959,774)**	**0.0**
Percentage Change	5.2%	39.3%	40.3%	0.0%	(5.5%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$1,042,724,096**	**$256,073,133**	**$77,506,128**	**$0**	**$709,144,835**	**0.0**
Request Above/(Below) Recommendation	($75,344,375)	($13,326,855)	($5,809,534)	$0	($56,207,986)	0.0

BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

This line item supports certain "fee-for-service" payments for a limited set of behavioral health services to treat mental health conditions and diagnoses that are not covered by the behavioral health capitation program, including autism spectrum disorder and gender identity disorders. In addition, if "partial dual-eligible" individuals receive mental health services under their Medicare benefits package, this line item covers that portion of expenditures that would have been the responsibility of the client.

While the fee-for-service program does cover all Medicaid State Plan mental health and substance use disorder services, it does not cover services approved through the Department's federal 1915 (b)(3) waiver.

STATUTORY AUTHORITY: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]

REQUEST: The Department requests *R2 Behavioral health*, *R10 Provider rates*, and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$15,408,555	$3,129,887	$1,088,730	$0	$11,189,938	0.0
H.B. 22-1173 (Supplemental Bill)	$1,443,555	($26,268)	($248,893)	$0	$1,718,716	0.0
Long Bill Supplemental	(3,469,324)	(833,216)	(193,402)	0	(2,442,706)	0.0
TOTAL	**$13,382,786**	**$2,270,403**	**$646,435**	**$0**	**$10,465,948**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$13,382,786	$2,270,403	$646,435	$0	$10,465,948	0.0
R2 Behavioral health	(681,375)	(337,793)	(103,499)	0	(240,083)	0.0
Federal match public health emergency	0	884,799	285,464	0	(1,170,263)	0.0
R10 Provide rates	273,270	60,708	17,829	0	194,733	0.0
Annualize prior year budget actions	(4,017)	3,378	14	0	(7,409)	0.0
TOTAL	**$12,970,664**	**$2,881,495**	**$846,243**	**$0**	**$9,242,926**	**0.0**
INCREASE/(DECREASE)	**($412,122)**	**$611,092**	**$199,808**	**$0**	**($1,223,022)**	**0.0**
Percentage Change	(3.1%)	26.9%	30.9%	0.0%	(11.7%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$15,409,065**	**$3,423,197**	**$1,005,331**	**$0**	**$10,980,537**	**0.0**
Request Above/(Below) Recommendation	$2,438,401	$541,702	$159,088	$0	$1,737,611	0.0

(5) INDIGENT CARE PROGRAM

This division contains funding for the following programs: (1) Colorado Indigent Care Program (CICP), which partially reimburses providers for medical services to uninsured individuals with incomes up to 250 percent of the federal poverty level; (2) Children's Basic Health Plan; and (3) the Primary Care Grant Program. The sources of cash funds are the Hospital Provider Fee, tobacco tax money, tobacco settlement money, enrollment fees for the Children's Basic Health Plan, and recoveries and recoupments. The tobacco tax money primarily goes through the Primary Care Fund to provide primary care grants. The tobacco settlement money primarily goes through the Children's Basic Health Plan Trust.

INDIGENT CARE PROGRAM					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 Appropriation					
S.B. 21-205 (Long Bill)	$470,735,111	$26,107,686	$183,021,669	$261,605,756	0.0
Other Legislation	25,330,755	0	0	25,330,755	0.0
H.B. 22-1173 (Supplemental Bill)	(39,982,781)	(5,684,793)	(38,335,467)	4,037,479	0.0
Long Bill Supplemental	(4,651,071)	(4,662,415)	7,619,080	(7,607,736)	0.0
TOTAL	**$451,432,014**	**$15,760,478**	**$152,305,282**	**$283,366,254**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION					
FY 2021-22 Appropriation	$451,432,014	$15,760,478	$152,305,282	$283,366,254	0.0
R3 Child Health Plan Plus	18,265,219	7,894,419	(10,438,034)	20,808,834	0.0
R8 County administration	(686,972)	(143,413)	(97,026)	(446,533)	0.0
R11 ACC and CHP accountability	(1,258,319)	(410,692)	(29,720)	(817,907)	0.0
BA12 Safety net provider payment	(3,735,404)	0	15,311,278	(19,046,682)	0.0
BA14 Centralized eligibility vendor	(24,723)	0	(3,698)	(21,025)	0.0
Tobacco forecast	(35,188)	0	(35,188)	0	0.0
Annualize prior year budget actions	7,391,435	641,405	5,501,773	1,248,257	0.0
Federal match public health emergency	0	5,991,120	16,923,829	(22,914,949)	0.0
TOTAL	**$471,348,062**	**$29,733,317**	**$179,438,496**	**$262,176,249**	**0.0**
INCREASE/(DECREASE)	**$19,916,048**	**$13,972,839**	**$27,133,214**	**($21,190,005)**	**0.0**
Percentage Change	4.4%	88.7%	17.8%	(7.5%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$504,014,379**	**$37,909,429**	**$182,814,250**	**$283,290,700**	**0.0**
Request Above/(Below) Recommendation	$32,666,317	$8,176,112	$3,375,754	$21,114,451	0.0

LINE ITEM DETAIL – INDIGENT CARE PROGRAM

SAFETY NET PROVIDER PAYMENTS

This line item provides funding to partially reimburse hospitals for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to adults and emancipated minors with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services beyond emergency care that they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

The source of cash funds is the Healthcare Affordability and Sustainability Fee and the federal match rate is at the standard Medicaid match. Colorado draws the federal funds for Safety Net Provider Payments through a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients.

The Medicaid expansion authorized by S.B. 13-200 significantly reduced the number of people eligible for the CICP, but there is still a population with income above the effective Medicaid eligibility threshold for adults of 138 percent and the CICP eligibility income limit of 250 percent. Also, non-pregnant adult legal immigrants who have been in the United States for less than five years do not qualify for Medicaid, but do qualify for the CICP. Many people eligible for the CICP would also qualify for federal tax credits to purchase insurance through Connect for Health Colorado, but may not be able to meet out-of-pocket expenses.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests *BA12 Safety net provider payment* and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

INDIGENT CARE PROGRAM, SAFETY NET PROVIDER PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$257,909,481	$0	$119,466,874	$0	$138,442,607	0.0
H.B. 22-1173 (Supplemental Bill)	(30,838,397)	0	(40,145,496)	0	9,307,099	0.0
TOTAL	**$227,071,084**	**$0**	**$79,321,378**	**$0**	**$147,749,706**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$227,071,084	$0	$79,321,378	$0	$147,749,706	0.0
BA12 Safety net provider payment	(3,735,404)	0	15,311,278	0	(19,046,682)	0.0
Annualize prior year budget actions	3,274,628	0	4,622,659	0	(1,348,031)	0.0
Federal match public health emergency	0	0	14,049,839	0	(14,049,839)	0.0
TOTAL	**$226,610,308**	**$0**	**$113,305,154**	**$0**	**$113,305,154**	**0.0**
INCREASE/(DECREASE)	**($460,776)**	**$0**	**$33,983,776**	**$0**	**($34,444,552)**	**0.0**
Percentage Change	(0.2%)	0.0%	42.8%	0.0%	(23.3%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$226,610,308**	**$0**	**$113,305,154**	**$0**	**$113,305,154**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

CLINIC BASED INDIGENT CARE

This line item was similar in purpose to the Safety Net Provider Payments line item, except that instead of funding hospitals it partially reimbursed clinics for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people with income up to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. In FY 21-22 changes were made to the Primary Care Fund line item to draw additional federal funds for clinics and this line item was eliminated.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department did not request funding in FY 22-23.

RECOMMENDATION: Staff does not recommend funding.

PEDIATRIC SPECIALTY HOSPITAL

The line item provides supplemental payments to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides funding for the Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests adjustments to the fund sources to account for the change in the federal match rate with the expected end of the federal public health emergency.

RECOMMENDATION: Staff recommends the requested funding.

APPROPRIATION FROM TOBACCO TAX FUND TO GENERAL FUND

Section 24-22-117(1)(c)(I)(A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-

117(1)(c)(I)(B.5), C.R.S. requires that 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

STATUTORY AUTHORITY: Section 24-22-117(1)(c)(I)(A), C.R.S.; Section 24-22-117(1)(c)(I)(B.5), C.R.S.

REQUEST: The Department requests an adjustment for projected tobacco tax revenues.

RECOMMENDATION: Staff requests permission to adjust this amount based on the March revenue forecast and the statutory formula allocation of tobacco tax revenue.

PRIMARY CARE FUND

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The Primary Care Fund receives 19 percent of tobacco tax collections annually. A portion of the providers are not enrolled as Medicaid providers and are not eligible for federal matching funds.

STATUTORY AUTHORITY: Section 25.5-3-301 through 303, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff requests permission to adjust the funding based on the March forecast and the statutory allocation of tobacco tax revenues.

CHILDREN'S BASIC HEALTH PLAN (CHP+) ADMINISTRATION

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System.

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee.

STATUTORY AUTHORITY: Section 25.5-8-111 and 107, C.R.S.

REQUEST: The Department requests *R3 Child Health Plan Plus*, *R11 ACC/CHP+ Accountability*, *BA 14 Centralized eligibility vendor rate*, and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$5,033,274	$0	$1,652,424	$0	$3,380,850	0.0
H.B. 22-1173 (Supplemental Bill)	$114,173	$0	$36,238	$0	$77,935	0.0
Long Bill Supplemental	$0	$0	($110,455)	$0	$110,455	0.0
TOTAL	**$5,147,447**	**$0**	**$1,578,207**	**$0**	**$3,569,240**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$5,147,447	$0	$1,578,207	$0	$3,569,240	0.0
R3 Child Health Plan Plus	0	0	109,222	0	(109,222)	0.0
R11 ACC and CHP accountability	(1,258,319)	0	(440,412)	0	(817,907)	0.0
BA14 Centralized eligibility vendor	(24,723)	0	(3,698)	0	(21,025)	0.0
TOTAL	**$3,864,405**	**$0**	**$1,243,319**	**$0**	**$2,621,086**	**0.0**
INCREASE/(DECREASE)	**($1,283,042)**	**$0**	**($334,888)**	**$0**	**($948,154)**	**0.0**
Percentage Change	(24.9%)	0.0%	(21.2%)	0.0%	(26.6%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$3,864,405**	**$0**	**$1,352,541**	**$0**	**$2,511,864**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$109,222	$0	($109,222)	0.0

CHILDREN'S BASIC HEALTH PLAN (CHP+) MEDICAL AND DENTAL COSTS

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

If actual expenditures run higher than the forecast based on the eligibility criteria and plan benefits, the budget is usually adjusted. However, states have more options and flexibility under CHP+ rules to keep costs within the budget than under Medicaid rules. Correspondingly, the statutes provide less overexpenditure authority for CHP+ than for Medicaid. Pursuant to Section 24-75-109(1)(a.5), C.R.S. the Department can make unlimited overexpenditures from cash fund sources, including the CHP+ Trust Fund, but annual overexpenditures from the General Fund are capped at $250,000.

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no

federal match is provided for enrollment fees. The projected average federal match rate for state FY 2020-21 is 67.88 percent.

STATUTORY AUTHORITY: Section 25.5-8-107 et seq., C.R.S.

REQUEST: The Department requests *R3 Child Health Plan Plus*, *R8 County administration oversight and eligibility*, *R11 ACC/CHP+ Accountability*, *BA 14 Centralized eligibility vendor rate*, and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$171,235,230	$21,059,365	$36,109,255	$0	$114,066,610	0.0
H.B. 22-1173 (Supplemental Bill)	(9,258,557)	(5,351,109)	1,773,791	0	(5,681,239)	0.0
Long Bill Supplemental	(4,651,071)	(4,662,415)	7,729,535	0	(7,718,191)	0.0
TOTAL	**$157,325,602**	**$11,045,841**	**$45,612,581**	**$0**	**$100,667,180**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$157,325,602	$11,045,841	$45,612,581	$0	$100,667,180	0.0
R3 Child Health Plan Plus	18,265,219	7,894,419	(10,547,256)	0	20,918,056	0.0
Annualize prior year budget actions	4,116,807	641,405	879,114	0	2,596,288	0.0
R11 ACC and CHP accountability	0	(410,692)	410,692	0	0	0.0
Tobacco forecast	0	0	0	0	0	0.0
Federal match public health emergency	0	5,323,752	2,873,990	0	(8,197,742)	0.0
R8 County administration	(686,972)	(143,413)	(97,026)	0	(446,533)	0.0
TOTAL	**$179,020,656**	**$24,351,312**	**$39,132,095**	**$0**	**$115,537,249**	**0.0**
INCREASE/(DECREASE)	**$21,695,054**	**$13,305,471**	**($6,480,486)**	**$0**	**$14,870,069**	**0.0**
Percentage Change	13.8%	120.5%	(14.2%)	0.0%	14.8%	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$211,672,461**	**$32,527,424**	**$42,384,115**	**$0**	**$136,760,922**	**0.0**
Request Above/(Below) Recommendation	$32,651,805	$8,176,112	$3,252,020	$0	$21,223,673	0.0

(6) OTHER MEDICAL SERVICES

This division contains the funding for:

- The state's obligation under the Medicare Modernization Act for prescription drug benefits for people dually eligible for Medicare and Medicaid;
- The Old Age Pension State-Only Medical Program;
- Health training programs, including the Commission on Family Medicine and the University Teaching Hospitals; and
- Public School Health Services.

The sources of cash funds include certified public expenditures by school districts, the Old Age Pension Health and Medical Fund, and the Marijuana Tax Cash Fund. The source of reappropriated funds is transfers within the division from the Public School Health Services line item.

Other Medical Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2021-22 Appropriation						
S.B. 21-205 (Long Bill)	$386,925,808	$202,558,521	$90,232,686	$211,050	$93,923,551	0.0
Other Legislation	2,072,095	1,822,095	250,000	0	0	0.0
H.B. 22-1173 (Supplemental Bill)	17,064,058	3,525,610	8,015,103	(13,950)	5,537,295	4.0
Long Bill Supplemental	18,743,191	17,821,472	921,719	0	0	0.0
TOTAL	**$424,805,152**	**$225,727,698**	**$99,419,508**	**$197,100**	**$99,460,846**	**4.0**
FY 2022-23 Recommended Appropriation						
FY 2021-22 Appropriation	$424,805,152	$225,727,698	$99,419,508	$197,100	$99,460,846	4.0
R4 Medicare Modernization Act	(3,087,541)	(3,087,541)	0	0	0	0.0
R16 Urban Indian Health	0	0	0	0	0	0.0
R17 SBIRT training	0	0	0	0	0	0.0
BA10 HCBS ARPA spending authority	42,406,863	0	42,406,863	0	0	0.0
Family medicine residencies	89,445	44,722	0	0	44,723	0.0
Annualize prior year budget actions	6,248,417	1,792,395	4,946,936	0	(490,914)	0.0
Federal match public health emergency	23,537,158	24,067,103	5,245,873	52,900	(5,828,718)	0.0
TOTAL	**$493,999,494**	**$248,544,377**	**$152,019,180**	**$250,000**	**$93,185,937**	**4.0**
INCREASE/(DECREASE)	**$69,194,342**	**$22,816,679**	**$52,599,672**	**$52,900**	**($6,274,909)**	**0.0**
Percentage Change	16.3%	10.1%	52.9%	26.8%	(6.3%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$478,247,665**	**$234,337,271**	**$150,519,180**	**$250,000**	**$93,141,214**	**4.0**
Request Above/(Below) Recommendation	($15,751,829)	($14,207,106)	($1,500,000)	$0	($44,723)	0.0

LINE ITEM DETAIL – OTHER MEDICAL SERVICES

Old Age Pension State Medical Program

This line item funds health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases using a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund.

With the expansion of Medicaid that was authorized in S.B. 13-200, a large portion of the people eligible for an old age pension are also eligible for Medicaid. All $10.0 million of the constitutional allocation of sales tax is appropriated in this line item to ensure the funds are available to serve eligible people who do not qualify for Medicaid. Any funds left over are reappropriated to the Medical Services Premiums line item to offset the need for General Fund in that line item for people who are dually eligible for Medicaid and the Old Age Pension Health and Medical Program. For FY 2022-23 the Department is projecting $9.9 million will be available to offset General Fund in the Medical Services Premiums line item. If that forecast is off, the Medical Services Premiums line item has statutory authority to overexpend the appropriation.

The Department pays providers for the Old Age Pension Health and Medical Program based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation. With most of the clients now dually eligible for both Medicaid and the Old Age Pension Health and Medical Program, the Department has been able to pay for services at 100 percent of the Medicaid rates.

STATUTORY AUTHORITY: Article XXIV, Section 7, Colorado Constitution; Section 25.5-2-101, C.R.S.; Section 25.5-3-401 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

SENIOR DENTAL PROGRAM

This line item pays for grants to dental providers to serve low-income seniors who do not otherwise have access to dental care through Medicaid, the Old Age Pension Health and Medical Program, or private insurance. The grants for dental services through the Colorado Dental Program for Low-income Seniors are financed with General Fund and the Health Care Policy and Financing Fund.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

COMMISSION ON FAMILY MEDICINE

This line item provides payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). The funding in this line item goes directly to the residency programs, with the exception of funds to support and develop rural family medicine residency programs pursuant to S.B 14-144. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

STATUTORY AUTHORITY: Section 25-1-901 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

OTHER MEDICAL SERVICES, COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$9,400,725	$4,197,890	$0	$211,050	$4,991,785	0.0
H.B. 22-1173 (Supplemental Bill)	$0	($277,472)	$0	($13,950)	$291,422	0.0
TOTAL	**$9,400,725**	**$3,920,418**	**$0**	**$197,100**	**$5,283,207**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$9,400,725	$3,920,418	$0	$197,100	$5,283,207	0.0
Family medicine residencies	89,445	44,722	0	0	44,723	0.0
Federal match public health emergency	0	529,945	0	52,900	(582,845)	0.0
TOTAL	**$9,490,170**	**$4,495,085**	**$0**	**$250,000**	**$4,745,085**	**0.0**
INCREASE/(DECREASE)	**$89,445**	**$574,667**	**$0**	**$52,900**	**($538,122)**	**0.0**
Percentage Change	1.0%	14.7%	0.0%	26.8%	(10.2%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$9,400,725**	**$4,450,363**	**$0**	**$250,000**	**$4,700,362**	**0.0**
Request Above/(Below) Recommendation	($89,445)	($44,722)	$0	$0	($44,723)	0.0

MEDICARE MODERNIZATION ACT

This line item pays the state's obligation under the Medicare Modernization Act (MMA) 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 the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, in some prior years the General Assembly applied federal bonus payments received for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

STATUTORY AUTHORITY: Section 25.5-4-105, C.R.S.

REQUEST: The Department requests *R4 Medicare Modernization Act* to update the appropriation to match the forecasted state obligation and annualizations of prior year budget actions. Although there is no federal match for this line item, the federal match rate for a state affects the federal formula that calculates the state obligation.

RECOMMENDATION: Staff recommends adjusting both the FY 21-22 and FY 22-23 appropriations based on the updated February 2022 forecast. See the recommendation on *R4 Medicare Modernization Act* for more detail.

OTHER MEDICAL SERVICES, MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$193,398,121	$193,398,121	$0	$0	$0	0.0
Long Bill Supplemental	$17,821,472	$17,821,472	$0	$0	$0	0.0
H.B. 22-1173 (Supplemental Bill)	$3,803,082	$3,803,082	$0	$0	$0	0.0
TOTAL	**$215,022,675**	**$215,022,675**	**$0**	**$0**	**$0**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$215,022,675	$215,022,675	$0	$0	$0	0.0
R4 Medicare Modernization Act	(3,087,541)	(3,087,541)	0	0	0	0.0
Federal match public health emergency	23,537,158	23,537,158	0	0	0	0.0
TOTAL	**$235,472,292**	**$235,472,292**	**$0**	**$0**	**$0**	**0.0**
INCREASE/(DECREASE)	**$20,449,617**	**$20,449,617**	**$0**	**$0**	**$0**	**0.0**
Percentage Change	9.5%	9.5%	0.0%	0.0%	0.0%	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$221,261,883**	**$221,261,883**	**$0**	**$0**	**$0**	**0.0**
Request Above/(Below) Recommendation	($14,210,409)	($14,210,409)	$0	$0	$0	0.0

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION; AND PUBLIC SCHOOL HEALTH SERVICES

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children with disabilities who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under-, or uninsured children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts. The Public School Health Services line item represents the payments to the school districts and boards of cooperative education services.

STATUTORY AUTHORITY: Section 25.5-5-318 et seq., C.R.S.

REQUEST: The Department requests annualizations of prior year funding.

RECOMMENDATION: Staff recommends the request, based on the expected certified public expenditures.

There have been dramatic increases in recent expenditures, but predicting the increases has proven difficult. The Department attributes the increases to a combination of outreach efforts by the Department, school districts needing to pursue new revenue streams due to the economy, and an increase in Medicaid eligible students. The Department makes an initial payment during the fiscal year, but then makes a reconciliation payment in the next fiscal year. Some of the data points for that reconciliation payment are not available until the spring after the fiscal year when the service was provided, which is after the General Assembly's supplemental process.

OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$2,000,000	$1,000,000	$0	$0	$1,000,000	0.0
TOTAL	**$2,000,000**	**$1,000,000**	**$0**	**$0**	**$1,000,000**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$2,000,000	$1,000,000	$0	$0	$1,000,000	0.0
TOTAL	**$2,000,000**	**$1,000,000**	**$0**	**$0**	**$1,000,000**	**0.0**
Percentage Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$2,000,000**	**$1,000,000**	**$0**	**$0**	**$1,000,000**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$167,386,604	$0	$79,454,838	$0	$87,931,766	0.0
H.B. 22-1173 (Supplemental Bill)	$0	$0	($5,245,873)	$0	$5,245,873	0.0
TOTAL	**$167,386,604**	**$0**	**$74,208,965**	**$0**	**$93,177,639**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$167,386,604	$0	$74,208,965	$0	$93,177,639	0.0
Federal match public health emergency	0	0	5,245,873	0	(5,245,873)	0.0
Annualize prior year budget actions	4,706,022	0	5,196,936	0	(490,914)	0.0
TOTAL	**$172,092,626**	**$0**	**$84,651,774**	**$0**	**$87,440,852**	**0.0**
INCREASE/(DECREASE)	**$4,706,022**	**$0**	**$10,442,809**	**$0**	**($5,736,787)**	**0.0**
Percentage Change	2.8%	0.0%	14.1%	0.0%	(6.2%)	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$172,092,626**	**$0**	**$84,651,774**	**$0**	**$87,440,852**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TRAINING GRANT PROGRAM

This line item pays for grants to organizations to provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The source of cash funds is the Marijuana Tax Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-5-208 and 39-28.8-501(2)(b)(IV)(C), C.R.S.

REQUEST: The Department requests a reduction in funding in *R17 SBIRT training* and annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the requested annualization of prior year budget actions, but not the reduction for R17 SBIRT training. See the decision item descriptions for more detail.

OTHER MEDICAL SERVICES, SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT TRAINING GRANT PROGRAM						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2021-22 APPROPRIATION						
S.B. 21-205 (Long Bill)	$750,000	$0	$750,000	$0	$0	0.0
Other Legislation	$250,000	$0	$250,000	$0	$0	0.0
TOTAL	**$1,000,000**	**$0**	**$1,000,000**	**$0**	**$0**	**0.0**
FY 2022-23 RECOMMENDED APPROPRIATION						
FY 2021-22 Appropriation	$1,000,000	$0	$1,000,000	$0	$0	0.0
R17 SBIRT training	0	0	0	0	0	0.0
Annualize prior year budget actions	(250,000)	0	(250,000)	0	0	0.0
TOTAL	**$750,000**	**$0**	**$750,000**	**$0**	**$0**	**0.0**
INCREASE/(DECREASE)	**($250,000)**	**$0**	**($250,000)**	**$0**	**$0**	**0.0**
Percentage Change	(25.0%)	0.0%	(25.0%)	0.0%	0.0%	0.0%
FY 2022-23 EXECUTIVE REQUEST	**$500,000**	**$0**	**$500,000**	**$0**	**$0**	**0.0**
Request Above/(Below) Recommendation	($250,000)	$0	($250,000)	$0	$0	0.0

STATE UNIVERSITY TEACHING HOSPITALS – DENVER HEALTH AND HOSPITAL AUTHORITY UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

These two line items provided funding for the Denver Health and Hospital Authority and the University of Colorado Hospital Authority respectively for Graduate Medical Education (GME). Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helped to better track the costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in the Medical Services Premiums line item. The line items were eliminated over FY 20-21 and FY 21-22.

STATUTORY AUTHORITY: Section 25.5-4-106, C.R.S.

REQUEST: The Department did not request funding for FY 22-23

RECOMMENDATION: Staff does not request funding.

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

Staff recommends **CONTINUING** the following footnotes:

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. Section 25.5-5-208, C.R.S. required the Department to grant $1.5 million on or after July 1, 2018, and this long-standing footnote clarifies that the purpose of the appropriation is to continue that grant program after the initial round of funding.

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 long-standing 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.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUING AND MODIFYING** the following requests for 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: This is an on-going and long-standing report.

Staff recommends **DISCONTINUING** the following requests for information:

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: This was a one-time report the Department completed as requested. The JBC may want to consider whether the report fully addressed the concerns, or if the JBC would like to submit a modified request for information for FY 22-23. The Department's response to the request for information can be found here:

https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20FY%202021-22%20LRFI%20%233%20Department%20Role%20with%20Behavioral%20Health%20Providers.pdf

Appendix A: Numbers Pages

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
Kim Bimestefer, Executive Director						
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
Healthcare Affordability and Sustainability Cash Fund.						
Behavioral Health Capitation Payments	662,584,643	811,992,425	1,063,101,403	1,042,724,096	1,118,068,471	*
General Fund	174,001,702	173,123,597	193,393,160	256,073,133	269,399,988	
Cash Funds	37,151,063	52,718,658	59,395,648	77,506,128	83,315,662	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	451,431,878	586,150,170	810,312,595	709,144,835	765,352,821	
Behavioral Health Fee-for-service Payments	13,176,139	14,851,894	13,382,786	15,409,065	12,970,664	*
General Fund	2,445,911	2,692,858	2,270,403	3,423,197	2,881,495	
Cash Funds	798,999	989,215	646,435	1,005,331	846,243	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	9,931,229	11,169,821	10,465,948	10,980,537	9,242,926	
TOTAL - (3) Behavioral Health Community Programs	675,760,782	826,844,319	1,076,484,189	1,058,133,161	1,131,039,135	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	176,447,613	175,816,455	195,663,563	259,496,330	272,281,483	
Cash Funds	37,950,062	53,707,873	60,042,083	78,511,459	84,161,905	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	461,363,107	597,319,991	820,778,543	720,125,372	774,595,747	

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation	
(4) INDIGENT CARE PROGRAM						
Safety Net Provider Payments	301,481,948	135,548,026	227,071,084	226,610,308	226,610,308	*
General Fund	0	0	0	0	0	
Cash Funds	141,663,260	67,774,013	79,321,378	113,305,154	113,305,154	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	159,818,688	67,774,013	147,749,706	113,305,154	113,305,154	
Pediatric Specialty Hospital	13,455,012	10,764,010	10,764,010	10,764,010	10,764,010	
General Fund	6,310,401	4,714,636	4,714,637	5,382,005	5,382,005	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	7,144,611	6,049,374	6,049,373	5,382,005	5,382,005	
Appropriation from Tobacco Tax Fund to the General Fund	394,977	390,989	420,001	399,325	384,813	
General Fund	0	0	0	0	0	
Cash Funds	394,977	390,989	420,001	399,325	384,813	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Primary Care Fund	24,846,825	24,666,536	50,703,870	50,703,870	50,703,870	
General Fund	0	0	0	0	0	
Cash Funds	24,846,825	24,666,536	25,373,115	25,373,115	25,373,115	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	25,330,755	25,330,755	25,330,755	

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation	
Children's Basic Health Plan Administration	1,948,101	1,204,364	5,147,447	3,864,405	3,864,405	*
General Fund	0	0	0	0	0	
Cash Funds	386,067	370,894	1,578,207	1,352,541	1,243,319	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,562,034	833,470	3,569,240	2,511,864	2,621,086	
Children's Basic Health Plan Medical and Dental Costs	188,339,131	166,658,064	157,325,602	211,672,461	179,020,656	*
General Fund	0	2,761,239	10,625,840	32,128,099	23,966,499	
General Fund Exempt	391,683	390,989	420,001	399,325	384,813	
Cash Funds	35,542,120	44,010,133	45,612,581	42,384,115	39,132,095	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	152,405,328	119,495,703	100,667,180	136,760,922	115,537,249	
Clinic Based Indigent Care	6,039,386	6,039,386	0	0	0	
General Fund	2,832,472	2,645,251	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,206,914	3,394,135	0	0	0	
TOTAL - (4) Indigent Care Program	536,505,380	345,271,375	451,432,014	504,014,379	471,348,062	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	9,142,873	10,121,126	15,340,477	37,510,104	29,348,504	
General Fund Exempt	391,683	390,989	420,001	399,325	384,813	
Cash Funds	202,833,249	137,212,565	152,305,282	182,814,250	179,438,496	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	324,137,575	197,546,695	283,366,254	283,290,700	262,176,249	

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation	
(5) OTHER MEDICAL SERVICES						
Old Age Pension State Medical	141,443	23,557	10,000,000	10,000,000	10,000,000	
General Fund	0	0	0	0	0	
Cash Funds	141,443	23,557	10,000,000	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Senior Dental Program	3,572,551	2,987,821	3,990,358	3,990,358	3,990,358	
General Fund	3,572,551	2,962,510	3,962,510	3,962,510	3,962,510	
Cash Funds	0	25,311	27,848	27,848	27,848	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Commission on Family Medicine Residency Training Programs	8,196,518	7,130,420	9,400,725	9,400,725	9,490,170	
General Fund	3,844,167	3,123,124	3,920,418	4,450,363	4,495,085	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	197,100	250,000	250,000	
Federal Funds	4,352,351	4,007,296	5,283,207	4,700,362	4,745,085	
Medicare Modernization Act State Contribution Payment	161,064,826	151,204,900	215,022,675	221,261,883	235,472,292	*
General Fund	161,064,826	151,204,900	215,022,675	221,261,883	235,472,292	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation	
Public School Health Services Contract Administration	1,114,507	1,035,786	2,000,000	2,000,000	2,000,000	
General Fund	557,245	517,893	1,000,000	1,000,000	1,000,000	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	557,262	517,893	1,000,000	1,000,000	1,000,000	
Public School Health Services	124,811,816	127,813,978	167,386,604	172,092,626	172,092,626	
General Fund	0	0	0	0	0	
Cash Funds	59,889,935	57,869,729	74,208,965	84,651,774	84,651,774	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	64,921,881	69,944,249	93,177,639	87,440,852	87,440,852	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	1,499,997	500,000	1,000,000	500,000	750,000	*
General Fund	0	0	0	0	0	
Cash Funds	1,499,997	500,000	1,000,000	500,000	750,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Reproductive Health Care for Individuals Not Eligible for Medicaid	0	0	1,822,095	3,614,490	3,614,490	
General Fund	0	0	1,822,095	3,614,490	3,614,490	
Urban Indian Health Organizations State Only Payments	0	0	0	48,025	0	*
General Fund	0	0	0	48,025	0	

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation
ARPA HCBS State-only Funds	0	0	14,182,695 4.0	55,339,558 4.0	56,589,558 4.0 *
General Fund	0	0	0	0	0
Cash Funds	0	0	14,182,695	55,339,558	56,589,558
State University Teaching Hospitals University of Colorado Hospital	1,631,984	1,204,207	0	0	0
General Fund	538,075	330,343	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	225,000	197,100	0	0	0
Federal Funds	868,909	676,764	0	0	0
State University Teaching Hospitals Denver Health and Hospital Authority	2,804,714	0	0	0	0
General Fund	1,315,411	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,489,303	0	0	0	0
TOTAL - (5) Other Medical Services	304,838,356	291,900,669	424,805,152	478,247,665	493,999,494
FTE	0.0	0.0	4.0	4.0	4.0
General Fund	170,892,275	158,138,770	225,727,698	234,337,271	248,544,377
Cash Funds	61,531,375	58,418,597	99,419,508	150,519,180	152,019,180
Reappropriated Funds	225,000	197,100	197,100	250,000	250,000
Federal Funds	72,189,706	75,146,202	99,460,846	93,141,214	93,185,937

	FY 2019-20 Actual	FY 2020-21 Actual	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2022-23 Recommendation
TOTAL - Department of Health Care Policy and Financing	1,517,104,518	1,464,016,363	1,952,721,355	2,040,395,205	2,096,386,691
FTE	0.0	0.0	4.0	4.0	4.0
General Fund	356,482,761	344,076,351	436,731,738	531,343,705	550,174,364
General Fund Exempt	391,683	390,989	420,001	399,325	384,813
Cash Funds	302,314,686	249,339,035	311,766,873	411,844,889	415,619,581
Reappropriated Funds	225,000	197,100	197,100	250,000	250,000
Federal Funds	857,690,388	870,012,888	1,203,605,643	1,096,557,286	1,129,957,933