JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2023-24

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2021 and 2022 legislative sessions that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy22-23apprept.pdf

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

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

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

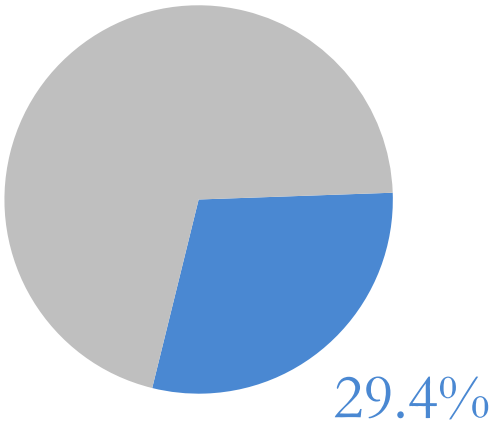
FUNDING SOURCE	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24 *
General Fund	$2,814,718,278	$3,058,051,411	$4,084,846,478	$4,430,841,585
Cash Funds	1,652,320,542	1,678,436,542	1,838,980,393	1,733,776,198
Reappropriated Funds	45,994,354	87,047,288	95,058,195	105,359,098
Federal Funds	7,563,106,406	8,637,872,527	8,202,179,331	8,624,193,930
TOTAL FUNDS	**$12,076,139,580**	**$13,461,407,768**	**$14,221,064,397**	**$14,894,170,811**
Full Time Equiv. Staff	557.2	654.9	741.8	752.9

*Requested appropriation.

Funding for the Department of Health Care Policy and Financing in FY 2022-23 consists of 29.7 percent General Fund, 11.7 percent cash funds, 0.7 percent reappropriated funds, and 57.9 percent federal funds.

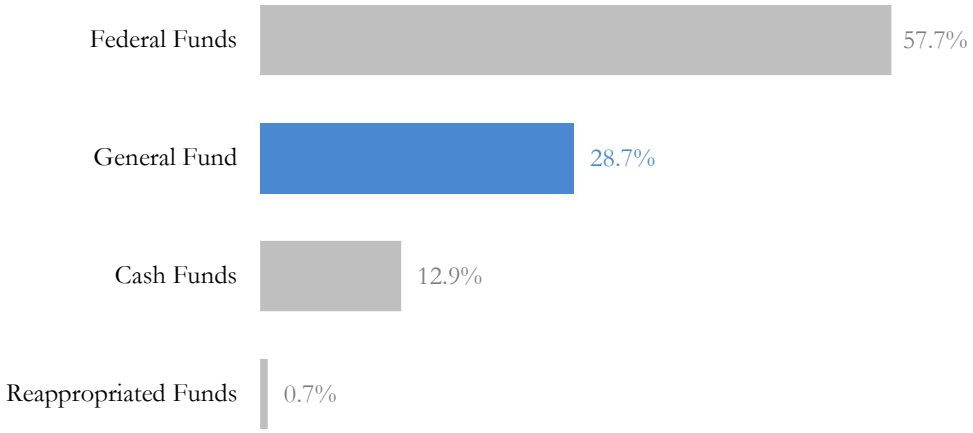
DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund



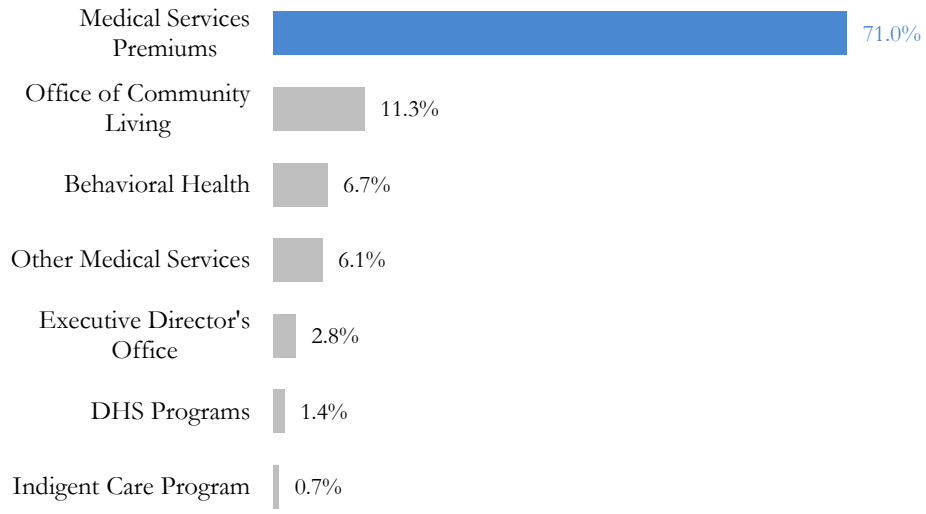
Based on the FY 2022-23 appropriation.

Department Funding Sources



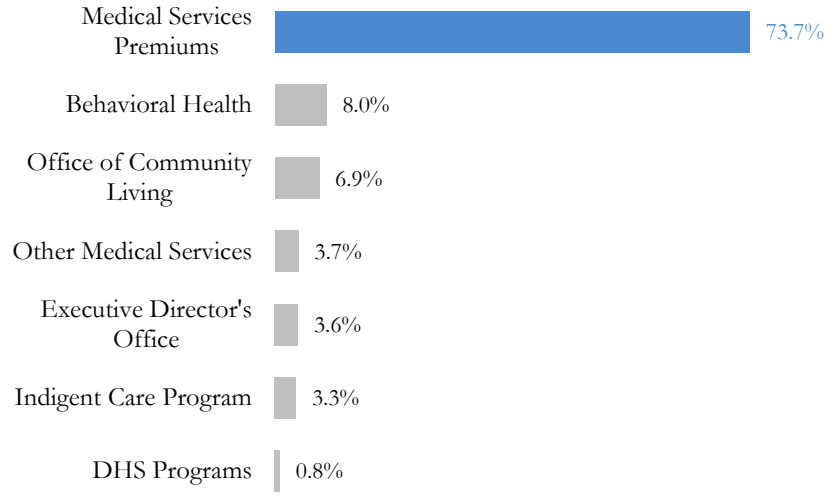
Based on the FY 2022-23 appropriation.

Distribution of General Fund by Division



Based on the FY 2022-23 appropriation.

Distribution of Total Funds by Division



Based on the FY 2022-23 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 29.7 percent General Fund, 11.7 percent cash funds, 0.7 percent reappropriated funds, and 57.9 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

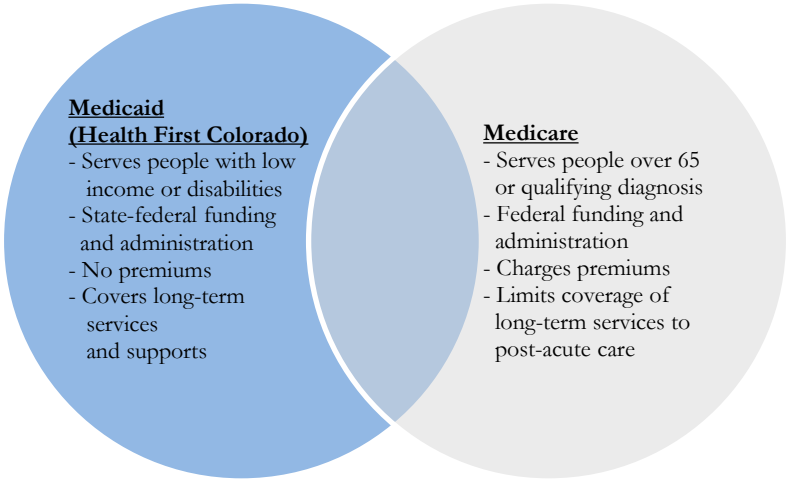
MEDICAID

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

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

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

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



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

For state fiscal year 2022-23 the average FMAP for the majority of Colorado Medicaid expenditures is 54.65 percent as a result of a temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act of 2020. The higher federal match is available for services from January 1, 2020 through the last quarter during which a disaster is declared by the federal Secretary of Health and Human Services. Based on the current disaster declaration, the higher federal match would expire at the end of March 2023, but the disaster declaration could be extended.

Standard Medicaid Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	50.00	50.00	50.00	50.00	50.00
FY 19-20	53.10	50.00	50.00	56.20	56.20
FY 20-21	56.20	56.20	56.20	56.20	56.20
FY 21-22	56.20	56.20	56.20	56.20	56.20
FY 22-23	54.65	56.20	56.20	56.20	*50.00*
FY 23-24	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*

Italicized figures are projections.

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

with income from 69 percent to 138 percent of the federal poverty guidelines.[2] The state share of costs for the "newly eligible" comes from the Healthcare Affordability and Sustainability (HAS) Fee on hospitals, so there is no General Fund.

ACA "Newly Eligible" Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	93.50	94.00	94.00	93.00	93.00
FY 19-20	91.50	93.00	93.00	90.00	90.00
FY 20-21	90.00	90.00	90.00	90.00	90.00
FY 21-22	90.00	90.00	90.00	90.00	90.00
FY 22-23	90.00	90.00	90.00	90.00	90.00
FY 23-24	90.00	90.00	90.00	90.00	90.00

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

After accounting for standard income disregards, Medicaid effectively covers people to 138 percent of the federal poverty guidelines, or $17,774 annual income for an individual and $30,305 annual income for a family of three. The Medicaid eligibility limits are slightly higher for children and pregnant women and if these populations earn income above the Medicaid limits they can still qualify for the Children's Basic Health Plan up to effectively 265 percent of the federal poverty guidelines, or $58,194 annual income for a family of three. In addition, there are special rules for the elderly, people with disabilities, and some smaller populations that are summarized in the table below.

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

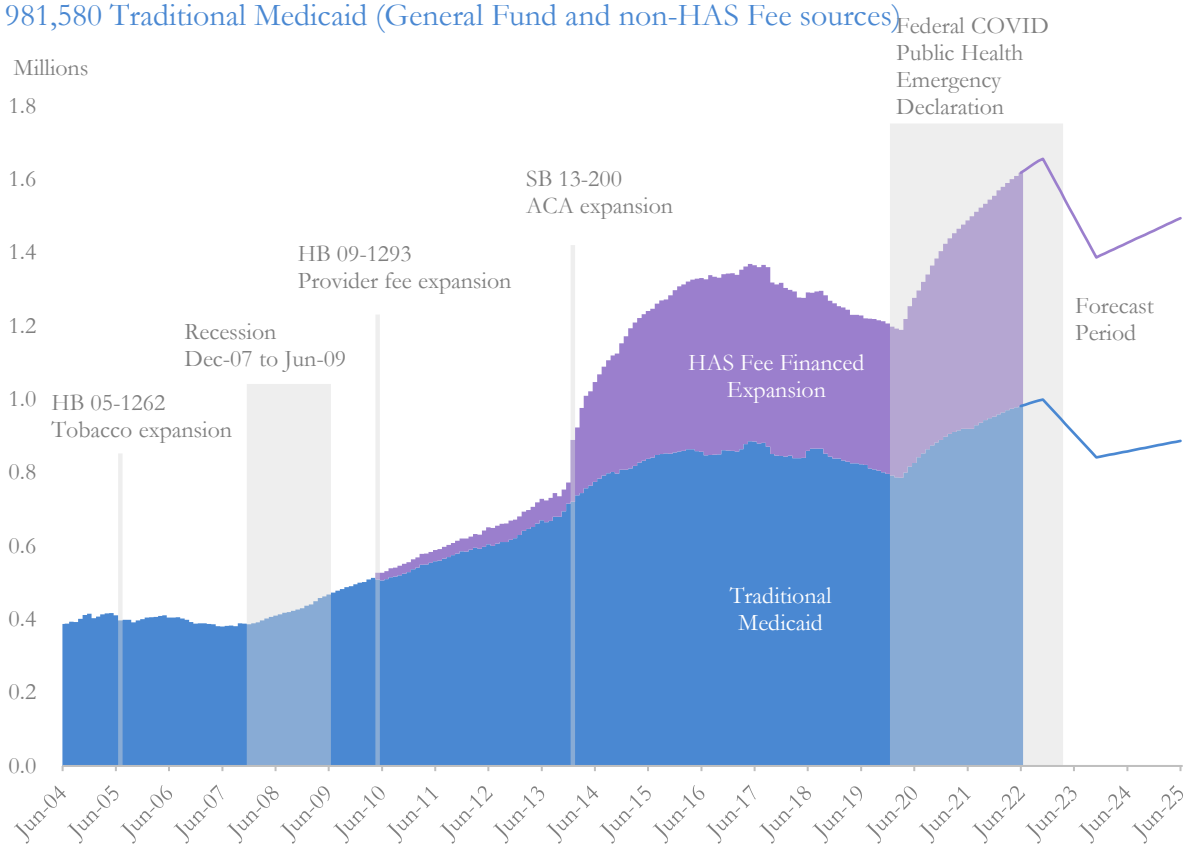
[2] In statute the income limit is 133 percent of the federal poverty guidelines, but with federally mandated standard income disregards, the effective income limit is 138 percent.
[3] See Section 24-75-109 (1)(a), C. R. S.

Family Size	Federal Poverty Guideline – 2022	SSI Annual Income Limit
1	$13,590	$10,092
2	$18,310	$15,132
3	$23,030	
4	$27,750	
More	add $4,720 each	

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

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

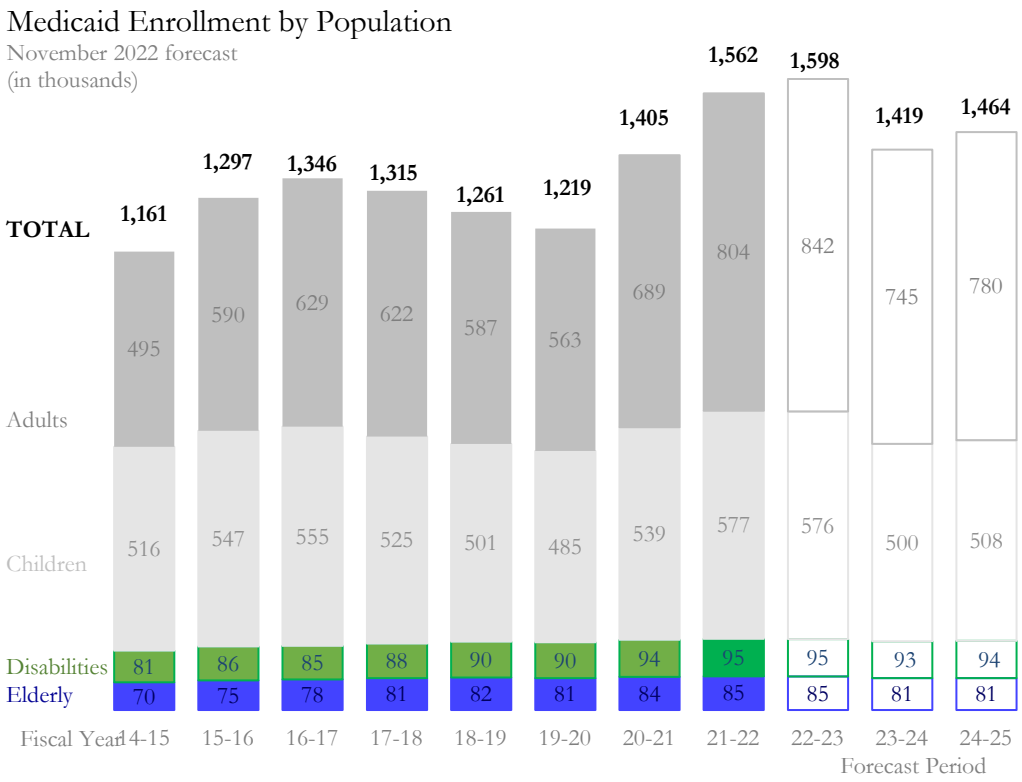
Medicaid Enrollment of 1,618,038 as of June 2022
636,458 Healthcare Affordability and Sustainability (HAS) Fee Expansion
981,580 Traditional Medicaid (General Fund and non-HAS Fee sources)



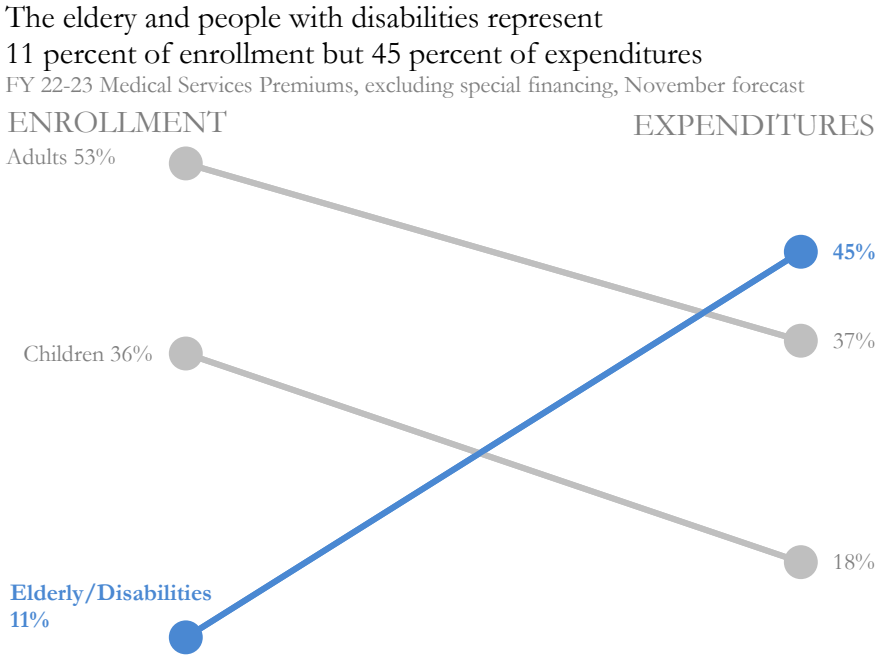
Appropriations for Medicaid are divided into six main components, not including administration: (1) Medical Services Premiums; (2) Behavioral Health Community Programs; (3) the Office of Community Living; (4) the Indigent Care Program; (5) the Medicare Modernization Act State Contribution; and (6) programs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

(1) Medical Services Premiums

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



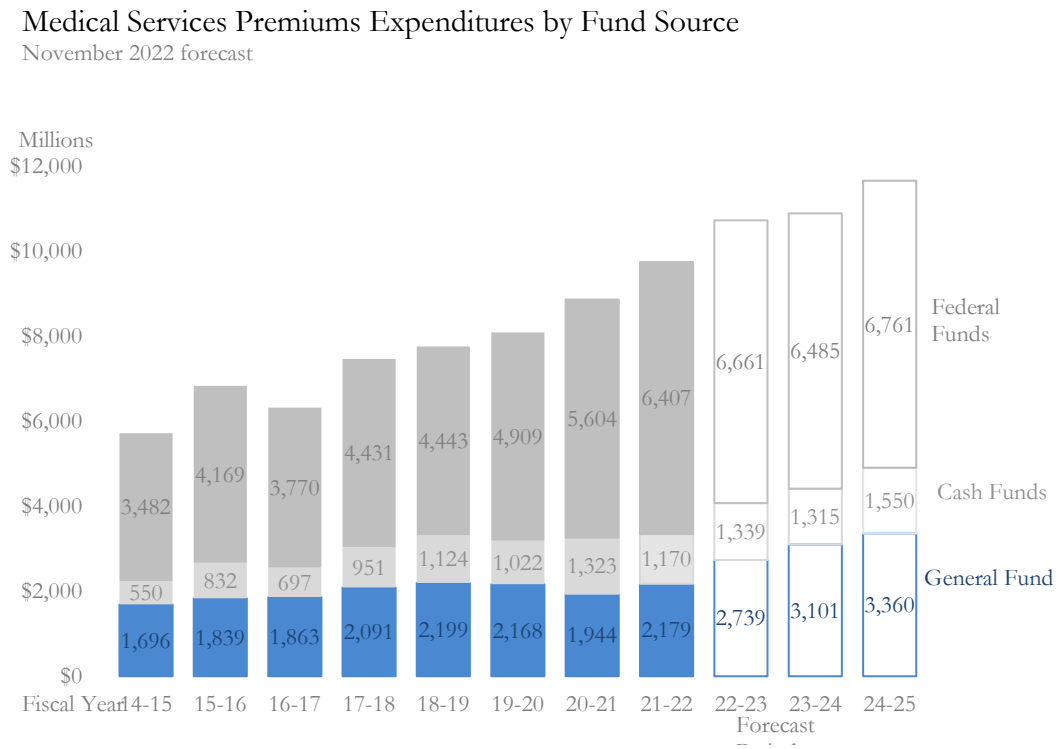
The adults and children, however, are relatively inexpensive compared to the elderly and people with disabilities served by Medicaid. The elderly and people with disabilities represent only 12 percent of the Medicaid enrollment but 46 percent of direct expenditures for services in Medical Services Premiums.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



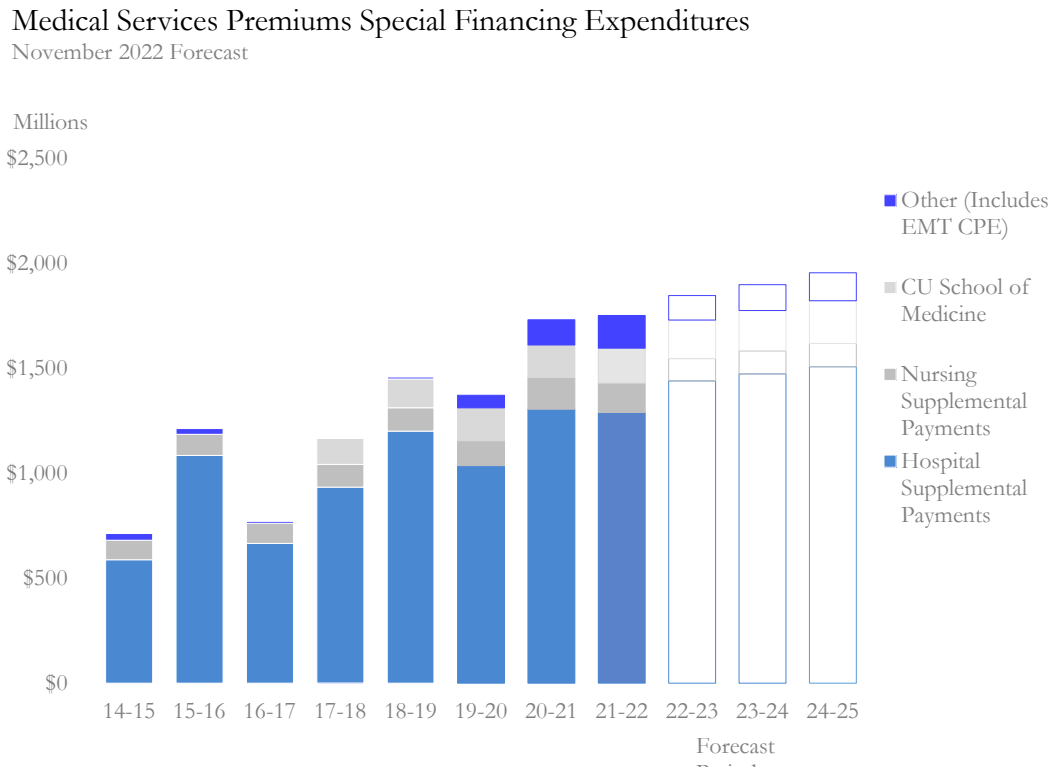
The elderly and people with disabilities are an even more disproportionate share of General Fund expenditures, due to the ways the state and federal government finance different populations and the services they use. For example, for nearly 70 percent of the adult enrollment there is no General Fund cost because they are expansion populations that qualify for an enhanced 90 percent federal match and the state match comes from the HAS Fee. As a result, the elderly and people with disabilities account for 13 percent of Medicaid enrollment but roughly 63 percent of direct General Fund expenditures for services in Medical Services Premiums.

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

When looking at Medical Services Premiums expenditures by fund source it becomes apparent that the General Fund trend is more commensurate with the enrollment of the elderly and people with disabilities than overall enrollment. The dips in General Fund in FY 2019-20 through FY 2021-22 are primarily attributable to the temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act of 2020 and temporary financing from the HAS Fee authorized by H.B. 20-1386.

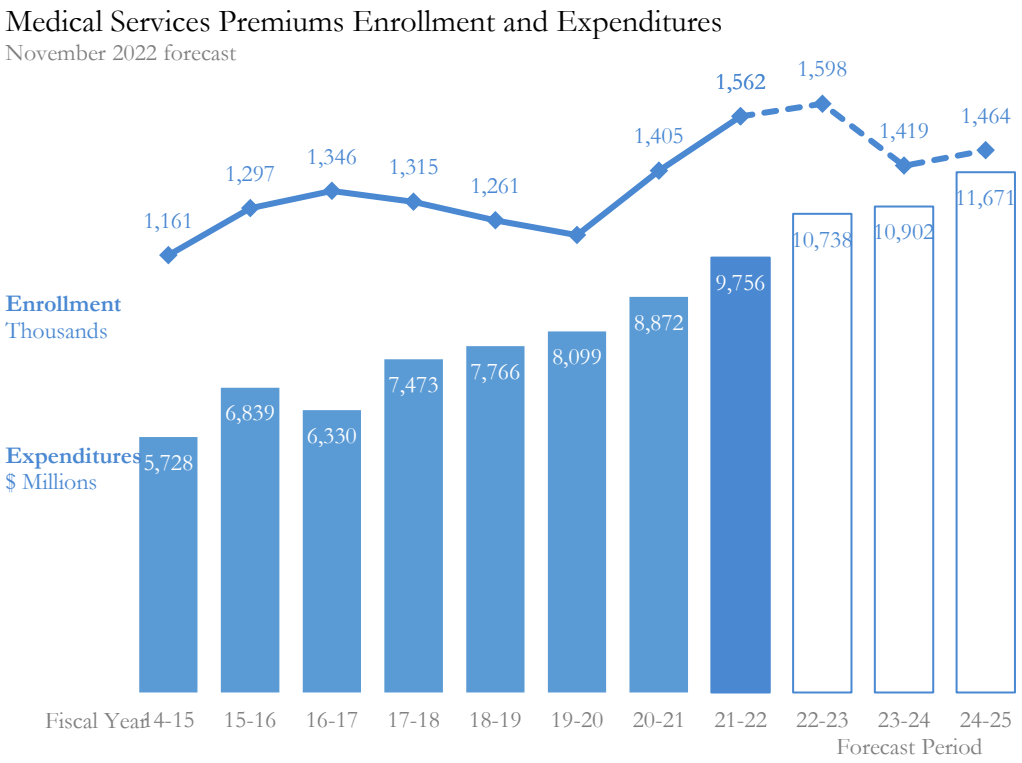


In addition to payments for direct services, the Medical Services Premiums section also includes indirect special financing through provider fees, certified public expenditures, and interagency transfers for providers like hospitals, nursing homes, and the physicians of the University of Colorado's School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



The chart below puts direct expenditures for services together with special financing and enrollment to show the full picture. As noted previously, enrollment is the most significant factor affecting overall Medicaid expenditures. In FY 2015-16 there was a spike in special financing, noted above, that helps explain why overall expenditures were higher in that year. In FY 2016-17 the Department implemented a new billing system that caused some payment delays and made expenditures shift from FY 2016-17 to FY 2017-18. From FY 2017-18 through FY 2019-20 the enrollment of expensive

populations of the elderly and people with disabilities continued to rise even though overall enrollment declined, helping to explain why expenditures increased when overall enrollment was falling.



SUMMARY: FY 2022-23 APPROPRIATION & FY 2023-24 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION:						
H.B. 22-1329 (Long Bill)	$14,175,863,675	$4,079,738,465	$1,805,089,552	$94,985,445	$8,196,050,213	711.7
Other Legislation	45,200,722	5,108,013	33,890,841	72,750	6,129,118	30.1
TOTAL	**$14,221,064,397**	**$4,084,846,478**	**$1,838,980,393**	**$95,058,195**	**$8,202,179,331**	**741.8**
FY 2023-24 REQUESTED APPROPRIATION:						
FY 2022-23 Appropriation	$14,221,064,397	$4,084,846,478	$1,838,980,393	$95,058,195	$8,202,179,331	741.8
R1 Medical Services Premiums	407,679,567	155,659,118	2,072,047	(895,544)	250,843,946	0.0
R2 Behavioral Health	(10,567,103)	(3,443,854)	(1,075,502)	0	(6,047,747)	0.0
R3 Child Health Plan Plus	28,740,043	8,051,152	2,163,953	0	18,524,938	0.0
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
R5 Office of Community Living	29,857,884	14,353,416	(37,375)	0	15,541,843	0.0
R6 Value-based payments	8,679,810	2,853,173	317,098	0	5,509,539	0.0
R7 Provider rates	24,200,145	8,630,707	1,135,954	0	14,433,484	0.0
R7 Targeted provider rates	168,049,010	61,200,272	14,188,764	0	92,659,974	0.0
R8 Cost and quality indicators	7,305,880	976,856	701,458	0	5,627,566	0.0
R9 Birthing equity	(702,853)	(357,242)	0	0	(345,611)	0.0
R10 Children with complex needs	3,938,944	200,043	1,769,429	0	1,969,472	3.7
R11 Compliance	(10,748,066)	(3,417,450)	(1,531,371)	0	(5,799,245)	7.4
R12 Non Medicaid BH eligibility & claims	2,889,302	2,889,302	0	0	0	8.4
R13 Case management redesign	3,602,309	168,000	1,533,155	0	1,901,154	0.0
R14 Convert contracts to FTE	(55,923)	(28,400)	440	0	(27,963)	3.7
R15 Administrative technical request	0	0	0	0	0	0.0
Centrally appropriated items	4,664,699	2,246,314	90,003	(79,760)	2,408,142	0.0
Annualize prior year budget actions	3,167,177	93,374,893	(126,457,433)	11,156,916	25,092,801	(12.1)
Human Services programs	3,057,977	1,456,094	0	0	1,601,883	0.0
Indirect cost recoveries	264,914	0	(76,093)	118,832	222,175	0.0
Transfers to other state agencies	12,782	4,853	1,278	459	6,192	0.0
Non-prioritized budget requests	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
TOTAL	**$14,894,170,811**	**$4,430,841,585**	**$1,733,776,198**	**$105,359,098**	**$8,624,193,930**	**752.9**
INCREASE/(DECREASE)	$673,106,414	$345,995,107	($105,204,195)	$10,300,903	$422,014,599	11.1
Percentage Change	4.7%	8.5%	(5.7%)	10.8%	5.1%	1.5%

DESCRIPTION OF INCREMENTAL CHANGES

R1 MEDICAL SERVICES PREMIUMS: The Department requests a net increase of $407.7 million total funds, including an increase of $155.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. *See the issue brief "Forecast Trends" for more information.*

R6 VALUE-BASED PAYMENTS: The Department requests an increase of $8.7 million total funds, including $2.9 million General Fund, for training and incentives for Primary Care Medical Providers (PCMPs) to transition to the alternative payment methodology. This program pays PCMPs a partial

capitation payment and allows PCMPs to earn incentive payments for managing care for members with chronic conditions. The Department indicates that funding is for the implementation of an evidence-informed practice.

SUPPORTING PCMPS WITH VALUE BASED PAYMENTS					
ITEM	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Contract/funding for training PCMPs	$1,020,000	$510,000	$0	$0	$510,000
Rate Increase for PCMPs	7,659,810	2,343,173	317,098	0	4,999,539
TOTAL REQUEST	**$8,679,810**	**$2,853,173**	**$317,098**	**$0**	**$5,509,539**

R7 PROVIDER RATES: The Department requests an increase of $24.2 million total funds, including $8.6 million General Fund, for a 0.5 percent increase in common policy provider rates for most providers. The Department indicates that funding is for the implementation of an evidence-informed practice. *See the issue brief "Provider Rates" for more information.*

R7 TARGETED PROVIDER RATES [REQUIRES LEGISLATION]: The Department requests an increase of $168.0 million total funds, including $61.2 million General Fund, for targeted adjustments to certain provider rates (see table below). The Department indicates that funding is for the implementation of an evidence-informed practice. *See the issue brief "Provider Rates" for more information.*

R7 PROVIDER RATE ADJUSTMENTS DEPARTMENT REQUEST FY 2023-24 FISCAL IMPACT						
RATE	CHANGE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	REQUIRES LEGISLATION?
ACROSS THE BOARD RATE ADJUSTMENT	0.5 percent increase	$24,200,145	$8,630,708	$1,135,953	$14,433,484	No
MPRRAC RECOMMENDATIONS						
Physician Services	rebalancing (between 80 and 100 percent)	19,311,361	5,907,439	799,446	12,604,476	No
Dialysis & Nephrology	increasing rates to 80 percent	427,077	92,379	26,460	308,238	No
Laboratory & Pathology	rebalancing (between 80 and 100 percent)	2,453,573	542,447	138,613	1,772,513	No
Eyeglasses and Vision	rebalancing (between 80 and 100 percent)	19,167,764	5,863,512	793,502	12,510,750	No
Injections & Miscellaneous J-Codes	rebalancing (between 80 and 100 percent)	86,238	26,381	3,571	56,286	No
SUBTOTAL MPRRAC RECOMMENDATIONS		$41,446,013	$12,432,158	$1,761,592	$27,252,263	
OTHER PROVIDER RATE ADJUSTMENTS						
Rural Hospital Technology Payments	incentive payments	4,220,000	2,110,000	0	2,110,000	No
Eliminating Member Copays	excluding non-emergent ER visits	9,295,824	1,821,702	565,243	6,908,879	yes, for pharmacy and outpatient copays
GRSS and NMT Rate Adjustments Comprehensive Waiver	incr. to align with other waivers	15,802,052	5,293,686	2,607,339	7,901,027	No

R7 Provider Rate Adjustments Department Request FY 2023-24 Fiscal Impact						
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds	Requires Legislation?
GRSS and NMT Rate Adjustments Supported Living Services Waiver	incr. to align with other waivers	1,785,095	598,006	294,541	892,548	No
Nursing Facility Rate Increase	$18.37/day incr. (on av.)	39,182,927	19,591,463	0	19,591,464	Yes
Minimum Wage Adjustments	incr. HCBS to $15.75 per hour/incr. min to $17.29 in Denver	56,953,319	19,477,936	8,998,735	28,476,648	No
Subtotal Other Adjustments		$127,239,217	$48,892,793	$12,465,858	$65,880,566	
TOTAL		**$192,885,375**	**$69,955,659**	**$15,363,403**	**$107,566,313**	

R8 Cost and quality indicators: The Department requests an increase of $7.3 million total funds, including $1.0 million General Fund, to sustain the data integration infrastructure for collecting and sharing relevant and reliable health care data among community partners, and to continue development of cost and quality indicators to determine trends in underlying data. The Department indicates that funding is for the implementation of a theory-informed practice.

Cost and Quality Indicators (R8)					
Description	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Data Acquisition & Sharing					
Identity Resolution Services	$1,000,000	$155,100	$100,900	$0	$744,000
Clinical Data for Care Management	1,428,040	221,489	144,089	0	1,062,462
Clinical Data for Core Measure Enhancement	1,247,000	105,096	80,327	0	1,061,577
Social Determinants of Health (SDoH) Supplemental Data	1,595,500	247,462	160,986	0	1,187,052
Immunization and Disease Reporting	106,090	16,454	10,705	0	78,931
Subtotal	$5,376,630	$745,601	$497,007	$0	$4,134,022
Hybrid Data Collection and Reporting					
Projected Costs of Vendor Contract	625,000	150,338	135,378	0	339,284
Hospital Cost and Quality Performance Indicators					
Projected Costs of Vendor Contract	1,304,250	80,916	69,073	0	1,154,261
Total	**$7,305,880**	**$976,855**	**$701,458**	**$0**	**$5,627,567**

R11 Compliance: The Department requests a decrease of $10.7 million total funds, including $3.4 million General Fund, and an increase of 7.4 FTE to expand and strengthen operational compliance and program oversight and accountability.

Compliance (R11)						
Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
MPRRAC Resources	$331,032	$99,310	$66,206	$0	$165,516	3.0
SB 21-131 Implementation and Compliance	25,000	7,500	5,000	0	12,500	0.0
CBMS Eligibility Interface and FDSH/Equifax	115,874	28,969	0	0	86,905	0.9
Third Party Liability (TPL) Expansion	(8,666,243)	(2,859,861)	(1,473,262)	0	(4,333,120)	1.8
Fraud, Waste, and Abuse (FWA) Compliance	(2,553,729)	(693,368)	(129,315)	0	(1,731,046)	1.8
Total Request	**($10,748,066)**	**($3,417,450)**	**($1,531,371)**	**$0**	**($5,799,245)**	**7.4**

R14 CONVERT CONTRACTS TO FTE: The Department requests a net decrease of $55,923 total funds, including a decrease of $28,400 General Fund, and an increase of 3.7 FTE to repurpose funding from contractor resources to hire FTE. The State employees will be responsible for communication with and outreach to external partners, facilitation of meetings and workgroups, conflict resolution and mediation, and the development of policy and process documents based on stakeholder feedback to provide insights and recommendations concerning Department programs. The Department indicates that funding is for the implementation of a theory-informed practice.

CONVERT CONTRACTOR RESOURCES TO FTE (R14)						
ITEM	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FTE and Operating Costs to Form Stakeholder Engagement Unit	$411,282	$135,725	$69,918	$0	$205,639	3.7
Stakeholder Engagement Contractor Cost Reductions	(467,205)	(164,125)	(69,478)	0	(233,602)	0.0
TOTAL REQUEST	**($55,923)**	**($28,400)**	**$440**	**$0**	**($27,963)**	**3.7**

R15 ADMINISTRATIVE TECHNICAL REQUEST: The Department requests a net zero adjustment to move funding for the Pharmacy Benefits Prescriber Tool from the General Professional Services line item to the Medicaid Management Information Systems (MMIS) line item; and to move funding for the Center for Improving Value in Health Care Health Information Technology project out of the MMIS line item and into the All-Payer Claims Database line item.

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

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

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

- The 3.0 percent common policy and other targeted provider rate adjustments;
- H.B. 22-1303 (Residential behavioral health beds) that funds an increase in the number of available behavioral health beds;
- Restoration of funding for the Medicaid Management Information System (MMIS) that was reduced for one year only as a result of the excess accumulation of roll-forward spending authority.

The largest decrease in General Fund is for the second year of FY 2022-23 R8 County Administration Oversight and Accountability to reflect the anticipated reduction in the claims paid for ineligible members.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 R10 Provider rates	$151,648,254	$72,442,817	$915,780	$0	$78,289,657	0.0
FY 2022-23 R14 MMIS fund. and contract. conv.	56,833,725	9,248,483	4,236,554	0	43,348,688	0.0
HB 22-1303 Residential behavioral health beds	22,772,319	11,386,159	0	0	11,386,160	0.2
HB 22-1289 Health benefits for child. and preg. ppl	11,679,567	4,361,194	(30,346)	0	7,348,719	5.0
SB 21-213 Use of increased Medicaid match	11,679,435	0	0	5,115,592	6,563,843	0.0
FY 2021-22 Restore funding for SB 19-195	8,801,690	4,518,133	0	0	4,283,557	(1.0)
FY 2021-22 667 IDD enrollments	6,107,288	3,053,644	0	0	3,053,644	0.0
FY 2022-23 prior year OIT	2,148,174	907,849	218,035	4,029	1,018,261	0.0
FY 2022-23 R6 Value-based payments	1,831,809	126,825	(27,304)	0	1,732,288	0.2
SB 21-025 Family planning services	1,074,673	65,713	17,462	0	991,498	0.0
FY 2021-22 R11 Connect 4 Health Colorado	506,796	0	199,413	0	307,383	0.0
SB 21-039 Elimination of subminimum wage	471,421	235,710	1	0	235,710	0.0
SB 21-038 Complementary and alternative medicine	464,592	134,610	97,686	0	232,296	0.0
HB 22-1325 Primary care alternative pmt models	254,250	254,250	0	0	0	0.0
FY 2022-23 BA9 eConsult program	208,706	71,385	85,789	0	51,532	0.0
HB 21-1085 Secure trans behavioral health crisis	192,768	88,869	7,515	0	96,384	0.0
SB 22-235 HUM County admin of pblc assist. prog.	80,000	24,060	15,940	0	40,000	0.0
FY 2021-22 R9 Patient access & interoperability	39,115	10,014	0	0	29,101	0.0
FY 2022-23 R13 Compliance FTE	14,114	10,158	(6,201)	0	10,157	1.0
FY 2022-23 R7 Utilization management	12,069	(2,565)	(11,615)	0	26,249	0.0
HB 22-1278 Behavioral Health Administration	10,368	5,184	0	0	5,184	0.5
FY 2022-23 Prior year salary survey	2,982	1,491	0	0	1,491	0.0
FY 2022-23 HUM Salesforce	1,726	863	0	0	863	0.0
SB 22-106 Public behavioral health conflict of int.	869	434	0	0	435	0.1
FY 2022-23 BA13 Connect 4 Health	0	0	27,124	0	(27,124)	0.0
FY 2022-23 BA10 HCBS ARPA spending authority	(177,840,562)	0	(94,181,473)	0	(83,659,089)	(17.2)
HB22-1302 Health care practice transformation	(35,250,000)	(50,000)	(34,750,000)	0	(450,000)	(2.3)
FY 2022-23 R8 County administration oversight	(16,519,749)	(3,838,321)	(935,408)	0	(11,746,020)	0.1
FY 2022-23 BA6 PHE county admin. resources	(15,207,916)	(2,210,944)	(2,193,450)	0	(10,803,522)	0.0
FY 2022-23 CUSOM adjustments	(13,413,166)	0	0	6,050,828	(19,463,994)	0.0
FY 2022-23 Nursing facilities – DOLA	(6,284,796)	(3,142,398)	0	0	(3,142,398)	0.0
FY 2022-23 BA17 CUSOM clinical revenue	(3,500,000)	(1,533,000)	0	0	(1,967,000)	0.0
HB 22-1333 Minimum wage for nursing homes	(3,071,863)	(1,535,932)	0	0	(1,535,931)	0.0
FY 2021-22 R6 Remote supports for HCBS prog.	(716,615)	(348,347)	(9,960)	0	(358,308)	0.0
FY 2021-22 BA10 PHE end resources	(415,764)	(132,826)	(75,055)	0	(207,883)	0.0
FY 2021-22 BA15 eConsult Program	(308,706)	(101,873)	(52,480)	0	(154,353)	0.0
FY 2006-07 DI8 Nursing facility appraisals	(279,746)	(139,873)	0	0	(139,873)	0.0
FY 2022-23 R12 Convert contractors to FTE	(274,786)	(117,182)	(2,873)	(13,099)	(141,632)	0.8
HB 22-1114 Transport. services Medicaid waivers	(146,758)	(52,129)	(2,567)	0	(92,062)	0.0
HB 21-1166 Behavioral health crisis resp. training	(135,360)	(135,360)	0	0	0	0.0
SB 22-068 All-payor claims database	(114,750)	(114,750)	0	0	0	0.0
SB 21-137 Behavioral health recovery act	(67,920)	(33,960)	0	0	(33,960)	0.0
HB 22-1190 Urban Indian Org. sup. pmts.	(48,025)	(48,025)	0	0	0	0.0
SB 22-196 Health needs in criminal justice system	(32,906)	(16,453)	0	0	(16,453)	0.3
FY 2022-23 HUM coordinated compensation	(16,984)	(8,492)	0	0	(8,492)	0.0
FY 2022-23 R9 OCL program enhancements	(9,325)	(4,663)	0	0	(4,662)	0.0
FY 2022-23 R11 ACC CHP accountability	(8,364)	(3,556)	0	0	(4,808)	0.0
FY 2022-23 HUM Prior year salary survey	(2,982)	(1,492)	0	0	(1,490)	0.0
FY 2022-23 HUM OIT package	(1,552)	(776)	0	0	(776)	0.0
HB 22-1397 Statewide equity office	(868)	0	0	(434)	(434)	0.2
HB 22-1290 Medicaid for wheelchair repairs	(70)	(35)	0	0	(35)	0.0
TOTAL	**$3,167,177**	**$93,374,893**	**($126,457,433)**	**$11,156,916**	**$25,092,801**	**(12.1)**

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

INDIRECT COST RECOVERIES: The Department requests $0.3 million total funds related to the assessment of indirect costs.

TRANSFERS TO OTHER STATE AGENCIES: The Department requests an increase of $12,782 total funds, including $4,853 General Fund, for transfers to programs administered by other departments.

NON-PRIORITIZED BUDGET REQUESTS: The Department request includes adjustments related to prioritized requests submitted by other State departments.

SUPPLEMENTALS

SET ASIDE FOR FORECAST-RELATED SUPPLEMENTALS: The Governor's budget letter includes a set aside for the Department of Health Care Policy and Financing for FY 2022-23 including a net decrease of $234.1 million General Fund for the most recent forecast of enrollment and expenditures.

FY 2022-23 SET-ASIDE FOR FORECAST-RELATED SUPPLEMENTALS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
R1 Medical Services Premiums	$255,702,393	($160,547,848)	($3,920,627)	$0	$420,170,868
R2 Behavioral Health	45,221,048	(11,570,183)	5,252,102	0	51,539,129
R3 Child Health Plan Plus	(31,177,243)	(16,311,787)	2,220,103	0	(17,085,559)
R4 Medicare Modernization Act	(6,613,654)	(6,613,654)	0	0	0
R5 Office of Community Living	(21,697,423)	(39,079,985)	633,347	0	16,749,215
TOTAL	**$241,435,121**	**($234,123,457)**	**$4,184,925**	**$0**	**$471,373,653**

ISSUE: FORECAST TRENDS (R1)

Request R1 through R5 from the Department of Health Care Policy and Financing are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. These requests explain what drives the budget, but they are non-discretionary, as they represent the expected State obligations. It would take a change to current law or policy to change these trends. This issue brief summarizes the forecast for R1 Medical Services Premiums.

SUMMARY

- Request R1 is based on the Department's most recent forecasts of Medical Services Premiums enrollment and expenditures under current law and policy. They are non-discretionary, as they represent the expected State obligations.
- The biggest factor impacting the forecast is the end of the federal public health emergency.
    - As a condition of accepting the 6.2 percent enhanced federal match that is available during the federal public health emergency, the Department cannot disenroll anyone from Medicaid or decrease their benefits due to a change in income. This drives an increase in Medicaid enrollment and a decrease in CHP+ enrollment for the duration of the federal public health emergency.
    - The FY 2022-23 appropriation assumed the enhanced federal match would be available through June 2022. The Department's R1 request reflects two additional quarters with the enhanced federal match through December 2022.
    - Since the request was submitted, the federal public health emergency was extended again so that the enhanced federal match is available through at least March 2023. The Department's February forecast will reflect this new information.
    - Each quarter the federal public health emergency is extended saves the State approximately $100 million General Fund across all Medicaid programs after accounting for the increase in enrollment and the decrease in the State match.
- Medical Services Premiums
    - Across FY 2022-23 and FY 2023-24, the projection is up a net $163.7 million total funds, including $362.6 million General Fund.
    - As compared with the current FY 2022-23 appropriation, the projection for FY 2022-23 is up a net $255.7 million total funds, including a decrease of $160.5 million General Fund. The overall increase is primarily due to increased caseload; the reduction in General Fund is from the extension of the public health emergency and the associated enhanced federal match. A portion of the caseload costs are offset by lower per capita costs that are reflective of the less expensive average cost of services for members that are locked into Medicaid pursuant to the federal Families First Coronavirus Response Act of 2020. The Department projects:
        - Caseload growth in FY 2022-23 as a result of changes in timing around disenrollment assumptions;
        - Lower acute care per capita costs due to lower expenditures for clients on continuous coverage, which are partially offset by a projected increase in specialty drug costs; and
        - Lower costs for nursing facilities, hospice, and PACE.

- Relative to the current FY 2022-23 appropriation, the Department projects expenditures will increase by a net $407.7 million total funds, including an increase of $155.7 million General Fund from FY 2022-23 to FY 2023-24, primarily due to increasing per capita costs and the end of the enhanced federal match through the federal Families First Coronavirus Response Act. The Department projects:
    - Caseload to decrease in FY 2023-24, with a 3 percent enrollment decline for the elderly and people with disabilities and a 12 percent enrollment decline for the ACA expansion populations;
    - Higher acute care per capita costs due to the disenrollment of clients on continuous coverage; and
    - Higher costs for nursing facilities and long-term services and supports (LTSS) waivers.

DISCUSSION

As a regular part of the November budget request, the Department of Health Care Policy and Financing submits five Medicaid prioritized requests (R1 through R5) that are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, **these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy.** The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2022. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2022. The mid-February forecasts come after deadlines for the Governor to submit supplemental budget requests and budget amendments. Typically, governors do not submit official revised requests based on the mid-February forecasts, neither do they submit official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the mid-February forecast for the budget, because it is the most recent data available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2022-23 expenditures. The requests for changes in FY 2022-23 will be officially submitted in January and until then the Governor's budget includes a placeholder for the FY 2022-23 fiscal impact of the forecasts. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2022-23 is the change from the appropriation and not the change from FY 2021-22 expenditures.

FY 2022-23					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Appropriation					
Medical Services Premiums	$10,482,357,710	$2,899,250,775	$1,252,446,475	$90,013,408	$6,240,647,052
Behavioral Health	1,131,039,135	272,281,483	84,161,905	0	774,595,747
Children's Basic Health Plan	179,073,696	24,514,105	38,226,690	0	116,332,901
Medicare Modernization Act	235,472,292	235,472,292	0	0	0
Office of Community Living	972,220,387	461,442,821	36,456,596	0	474,320,970
TOTAL	**$13,000,163,220**	**$3,892,961,476**	**$1,411,291,666**	**$90,013,408**	**$7,605,896,670**
FY 22-23 Projection (Nov)					
Medical Services Premiums	10,738,060,133	2,738,702,957	1,248,525,848	90,013,408	6,660,817,920
Behavioral Health	1,176,260,183	260,711,300	89,414,007	0	826,134,876
Children's Basic Health Plan	147,896,453	8,202,318	40,421,428	0	99,272,707
Medicare Modernization Act	228,858,638	228,858,638	0	0	0
Office of Community Living	950,522,964	422,362,836	37,089,943	0	491,070,185
TOTAL	**$13,241,598,371**	**$3,658,838,049**	**$1,415,451,226**	**$90,013,408**	**$8,077,295,688**
Difference Proj. to Approp.					
Medical Services Premiums	255,702,423	(160,547,818)	(3,920,627)	0	420,170,868
Behavioral Health	45,221,048	(11,570,183)	5,252,102	0	51,539,129
Children's Basic Health Plan	(31,177,243)	(16,311,787)	2,194,738	0	(17,060,194)
Medicare Modernization Act	(6,613,654)	(6,613,654)	0	0	0
Office of Community Living	(21,697,423)	(39,079,985)	633,347	0	16,749,215
TOTAL	**$241,435,151**	**($234,123,427)**	**$4,159,560**	**$0**	**$471,399,018**
Percent Change					
Medical Services Premiums	2.4%	(5.5%)	(0.3%)	0.0%	6.7%
Behavioral Health	4.0%	(4.2%)	6.2%	n/a	6.7%
Children's Basic Health Plan	(17.4%)	(66.5%)	5.7%	n/a	(14.7%)
Medicare Modernization Act	(2.8%)	(2.8%)	n/a	n/a	n/a
Office of Community Living	(2.2%)	(8.5%)	1.7%	n/a	3.5%
TOTAL	**1.9%**	**(6.0%)**	**0.3%**	**0.0%**	**6.2%**

FY 2023-24					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 22-23 Projection (Nov)					
Medical Services Premiums	$10,738,060,133	$2,738,702,957	$1,248,525,848	$90,013,408	$6,660,817,920
Behavioral Health	1,176,260,183	260,711,300	89,414,007	0	826,134,876
Children's Basic Health Plan	147,896,453	8,202,318	40,421,428	0	99,272,707
Medicare Modernization Act	228,858,638	228,858,638	0	0	0
Office of Community Living	950,522,964	422,362,836	37,089,943	0	491,070,185
TOTAL	**$13,241,598,371**	**$3,658,838,049**	**$1,415,451,226**	**$90,013,408**	**$8,077,295,688**
FY 23-24 Projection (Nov)					
Medical Services Premiums	10,901,776,800	3,101,301,792	1,215,049,322	100,294,784	6,485,130,902
Behavioral Health	1,118,269,449	268,379,626	82,960,676	0	766,929,147
Children's Basic Health Plan	206,610,970	32,223,327	40,155,512	0	134,232,131
Medicare Modernization Act	238,758,096	238,758,096	0	0	0
Office of Community Living	1,013,845,470	509,479,529	8,621,081	0	495,744,860
TOTAL	**$13,479,260,785**	**$4,150,142,370**	**$1,346,786,591**	**$100,294,784**	**$7,882,037,040**
Difference FY 22-23 to FY 23-24					
Medical Services Premiums	163,716,667	362,598,835	(33,476,526)	10,281,376	(175,687,018)
Behavioral Health	(57,990,734)	7,668,326	(6,453,331)	0	(59,205,729)

FY 2023-24					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Children's Basic Health Plan	58,714,517	24,021,009	(265,916)	0	34,959,424
Medicare Modernization Act	9,899,458	9,899,458	0	0	0
Office of Community Living	63,322,506	87,116,693	(28,468,862)	0	4,674,675
TOTAL	**$237,662,414**	**$491,304,321**	**($68,664,635)**	**$10,281,376**	**($195,258,648)**
Percent Change					
Medical Services Premiums	1.5%	13.2%	(2.7%)	11.4%	(2.6%)
Behavioral Health	(4.9%)	2.9%	(7.2%)	n/a	(7.2%)
Children's Basic Health Plan	39.7%	292.9%	(0.7%)	n/a	35.2%
Medicare Modernization Act	4.3%	4.3%	n/a	n/a	n/a
Office of Community Living	6.7%	20.6%	(76.8%)	n/a	1.0%
TOTAL	**1.8%**	**13.4%**	**(4.9%)**	**11.4%**	**(2.4%)**

FEDERAL MATCH RATES

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

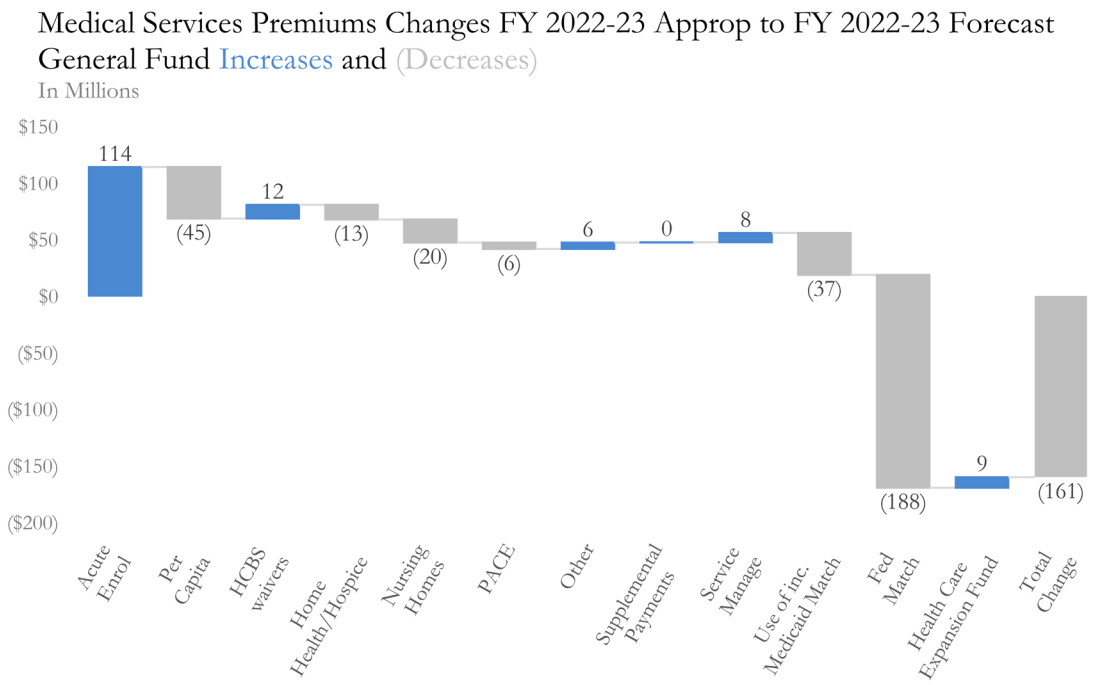
As of the November 1st submission date for the FY 2023-24 budget request, the state was eligible for the enhanced FMAP through December 31, 2022. **The November forecast reflects an assumed 56.2 percent federal match rate for the first two quarters of state FY 2022-23 (an average FMAP of 53.1 for the entire year).** The Department was notified in November that the public health emergency has been extended into January of 2023, resulting in the extension of the enhanced FMAP through March 31, 2023 and an average FY 2022-23 FMAP of 54.65 percent. The updated February 2023 forecast will reflect the FMAP bump for the third quarter of state FY 2022-23. The Department projects that this three-month extension of the FMAP bump into the third quarter of FY 2022-23 will result in a decrease of approximately $100 million General Fund with an offsetting increase in federal funds.

The FY 2023-24 forecast is based on an assumed match rate of 50.0 percent for standard Medicaid and HCBS programs.

R1 MEDICAL SERVICES PREMIUMS

FY 2022-23

The projection for FY 2022-23 is up a net $252.7 million total funds, including a decrease of $160.5 million General Fund. The graph below shows the major contributors to the General Fund change from the FY 2022-23 appropriation to the Department's November 2022 forecast for FY 2022-23. It does not show differences from FY 2021-22 expenditures. Aside from the federal match, the majority of the decrease is related to decreased per capita costs for acute care.



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

FY 2022-23 Medical Services Premiums Enrollment/Utilization Trends (from FY 2022-23 appropriation)				
	Total Funds	General Fund	Other State Funds	Federal Funds
FY 2022-23 Appropriation	$10,482,357,710	$2,899,250,775	$1,342,459,883	$6,240,647,052
Acute Care				
Enrollment	456,613,027	113,624,791	22,936,344	320,051,892
Per capita	(148,040,421)	(45,358,754)	(4,591,882)	(98,089,785)
Subtotal - Acute Care	*308,572,606*	*68,266,037*	*18,344,462*	*221,962,107*
Long-term Services and Supports				
HCBS waivers	23,872,887	11,936,443	0	11,936,444
Long-Term Home Health/PDN/Hospice	(30,424,327)	(12,942,050)	(2,864,382)	(14,617,895)
Nursing homes	(40,034,120)	(20,435,859)	490,725	(20,088,986)
PACE	(11,248,638)	(5,624,319)	0	(5,624,319)
Other	(2,171,907)	(1,190,907)	0	(981,000)
Subtotal – LTSS	*(60,006,105)*	*(28,256,692)*	*(2,373,657)*	*(29,375,756)*
Supplemental Payments	(22,164,949)	425,745	(41,470,743)	18,880,049
Health Care Expansion Fund	0	9,298,820	(9,298,820)	0
Service management	29,875,556	8,050,636	3,631,598	18,193,322
SB 21-213 Use of Increased Medicaid Match	0	(37,034,803)	37,034,803	0
Federal match	0	(188,216,971)	(11,778,253)	199,995,224
Financing	(574,715)	6,919,380	1,989,982	(9,484,077)
TOTAL	**$10,738,060,103**	**$2,738,702,927**	**$1,338,539,255**	**$6,660,817,921**
Increase/(Decrease)	$255,702,393	($160,547,848)	($3,920,628)	$420,170,869
Percentage Change	2.4%	(5.5%)	(0.3%)	6.7%

ACUTE CARE

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

Enrollment

While the Department overestimated FY 2022-23 enrollment for elderly and disabled population in its February 2022 forecast, the Department underestimated FY 2022-23 parents and pregnant women, children, and expansion population enrollment due to an earlier than realized end date for the COVID-19 public health emergency. Extension of the public health emergency into the second quarter of the state fiscal year, resulted in an update in the November 2022 forecast reflecting application of the enhanced FMAP of 6.2 percent through December 2022. In mid-November 2022, the public health emergency was extended into January of 2023, resulting in the continuation of the 6.2 percent enhanced FMAP into the third quarter of state FY 2022-23. The resulting refinance of General Fund will be reflected in the February 2023 forecast.

In addition to application of the enhanced FMAP for an additional two quarters, the Department lowered its projection of the number of members who will be disenrolled based on year-to-date actuals for the continuous coverage population. The November 2022 forecast assumes that 530,476 members will be locked into Medicaid by December 31, 2022, and that just over 315,000 people will be disenrolled from Medicaid when the public health emergency ends. The Department anticipates that eligibility redetermination for those locked into Medicaid will continue for twelve months upon conclusion of the public health emergency. Caseload adjustments for the continuous coverage members related to the extension of the public health emergency will be reflected in the February 2023 forecast.

Per Capita

FY 2021-22 actual per capita expenditures were lower than expected, due to the number of members locked into continuous coverage. As a result the Department decreased the projected FY 2022-23 per capita expenditures. The Department anticipates that the per capita costs will gradually increase with the conclusion of the public health emergency, at this time the increases are expected to occur through FY 2024-25.

COVID-19, RSV, and Flu Treatment costs

The forecast includes a projected total cost to treat COVID-19, RSV, and the flu of $148.3 million. Of this amount $135.6 million is for hospitalizations related to COVID-19. This is a decrease of $29.8 million total funds below the amount identified in the February 2022 forecast.

Specialty Drugs

The FY 2022-23 forecast includes an adjustment for specialty drugs which tend to cost significantly more than standard pharmaceuticals. The FY 2022-23 adjustment includes $274.9 million total funds, including $27.5 million General Fund, based on the assumption that 10 percent of members with qualifying conditions will utilize these drugs.

IMPACT OF SPECIALTY DRUGS (FY 2022-23)						
DRUG NAME (DIAGNOSIS)	PROJECTED ANNUAL GROSS COSTS	ONE-TIME USE?	REBATES	ESTIMATED APPROVAL DATE	ADJUSTMENT TO PRORATE FY 2022-23	IMPACT
Skysona (Cerebral Adrenoleukodystrophy)	$4,000,000	Yes	17.1%	09/16/22	78.6%	$2,607,375
teplizumab (Type I Diabetes)	$3,500,000	Yes (14 days)	17.1%	11/17/22	61.6%	1,788,596
Roctavian (Hemophilia A)	$183,000,000	Yes	23.1%	10/01/22	74.5%	104,870,532
EtranaDez (Hemophilia B)	$27,000,000	Yes	23.1%	11/24/22	59.7%	12,400,915
Hepcludex (Hepatitis D)	$5,000,000	No	23.1%	09/30/22	75.0%	2,883,750
cipaglucosidase alfa (Pompe Disease)	$3,600,000	No	17.1%	10/29/22	66.9%	1,995,051
trofinetide (Rhett Syndrome)	$10,000,000	No	17.1%	01/01/23	50.0%	4,145,000
nirsevimab (RSV)	$40,000,000	No	17.1%	07/01/23	0.0%	0
LentiGlobin (Sickel Cell Disease)	$106,000,000	Yes	17.1%	08/19/22	86.3%	75,836,466
Zynteglo (Transfusion Dependent Beta Thalassemia)	$95,000,000	Yes	17.1%	08/17/22	86.9%	68,398,178
					TOTAL	$274,925,863
Utilization Adjustment – percent of members with qualifying conditions anticipated to utilize drugs						10.0%
					TOTAL ANNUAL IMPACT	**$27,492,586**
					GENERAL FUND IMPACT	**9,223,436**

LONG-TERM SERVICES AND SUPPORTS

Long-term care costs are projected to reflect an overall decrease in expenditures primarily due to reductions in Private Duty Nursing and Hospice utilization. These reductions are partially offset with increased in-home services and supports utilization on the Children's Home- and Community-based Services (CHCBS) waiver.

CHCBS waiver

Utilization of in-home services and supports on the Children's HCBS waiver and the average cost per utilizer have been steadily growing. The forecast reflects an assumption that the growth will continue.

Home Health/PDN/Hospice

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

The Department projects lower expenditures in FY 2022-23 as a result of reductions in PDN and Hospice utilization.

Nursing homes

The Department indicates that patient days for nursing facilities remains low.

PACE

PACE enrollment continues to decline as a result of the InnovAge enrollment freeze in December 2021. The Department expects growth to rebound in December 2022 and continue to grow based on historical trends after that.

OTHER

Supplemental payments

The forecast includes adjustments for supplemental payments for hospitals due to the extension of the enhanced federal match, for nursing facilities due to a reduction in the number of patient days, and for emergency medical transportation due to lower than anticipated payments.

Healthcare Expansion Fund

The forecast includes a true-up related to anticipated Health Care Expansion Fund revenue, which revenue originates from the Tobacco Tax Cash Fund.

Service management

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

S.B. 21-213 Use of increased federal match

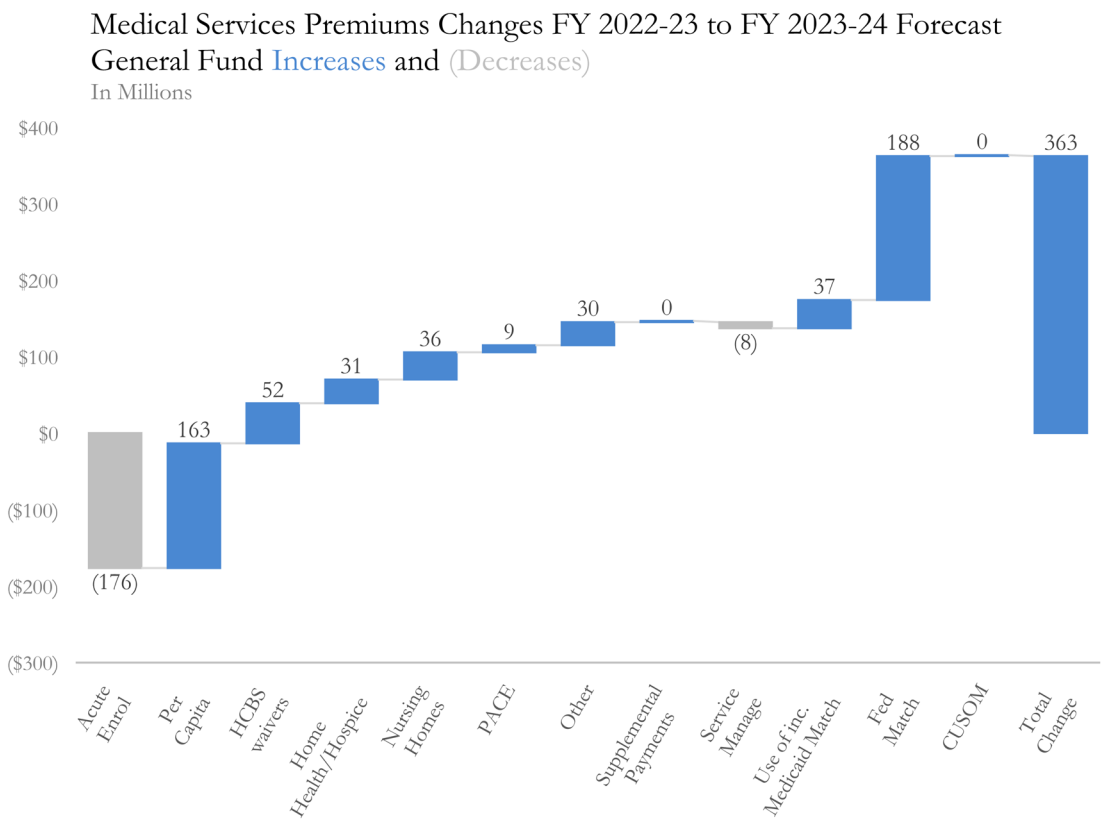
The forecast includes an adjustment related to two additional quarters of the 6.2 enhanced federal match, reflecting the offset of General Fund with federal funds for supplemental payments.

Federal match rate

The appropriation assumed that the public health emergency would conclude in the fourth quarter of state FY 2021-22, therefore the additional 6.2 percent federal match would be available through June of 2022. The request reflects the extension of the public health emergency into the second quarter of FY 2022-23. The Department has since been notified that the public health emergency was has been further extended into January 2023, thereby extending the duration of the enhanced federal match. The February 2023 forecast will reflect the associated adjustments.

FY 2023-24

The Department projects expenditures will increase a net $163.7 million total funds, including an increase of $362.6 million General Fund from FY 2022-23 to FY 2023-24. The graph below shows the major contributors to the General Fund change. As illustrated, the biggest driver of the General Fund increase is a change in the federal match rate.



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

FY 2023-24 Medical Services Premiums Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State Funds	Federal Funds
FY 2023-24 Projection	$10,738,060,103	$2,738,702,927	$1,338,539,255	$6,660,817,921
Acute Care				
Enrollment	(622,407,988)	(176,323,042)	(30,277,956)	(415,806,990)
Per capita	515,765,725	163,259,784	21,124,790	331,381,151
Subtotal - Acute Care	*(106,642,263)*	*(13,063,258)*	*(9,153,166)*	*(84,425,839)*
Long-term Services and Supports				
HCBS waivers	105,486,349	51,922,061	877,717	52,686,571
Long-Term Home Health/PDN/Hospice	62,510,416	31,255,208	0	31,255,208
Nursing homes	72,659,735	35,608,121	23,625	37,027,989
PACE	18,722,706	9,181,463	0	9,541,243
Other	(9,576,787)	33,527,216	(38,950,375)	(4,153,628)
Subtotal – LTSS	*249,802,419*	*161,494,069*	*(38,049,033)*	*126,357,383*
Supplemental Payments	33,333,353	0	40,290,683	(6,957,330)
CUSOM payments	9,786,069	0	10,281,376	(495,307)
Service management	(27,541,867)	(8,038,271)	(2,378,969)	(17,124,627)
SB 21-213 Use of Increased Medicaid Match	0	37,034,803	(37,034,803)	0
Federal match	0	188,216,971	11,778,253	(199,995,224)
Financing	4,977,956	(3,046,014)	1,069,509	6,954,461
TOTAL	**$10,901,775,770**	**$3,101,301,227**	**$1,315,343,105**	**$6,485,131,438**
Increase/(Decrease)	$163,715,667	$362,598,300	($23,196,150)	($175,686,483)
Percentage Change	1.5%	13.2%	(1.7%)	(2.6%)

ACUTE CARE

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

Enrollment

The Department projects overall enrollment decrease of 11 percent resulting from the forecasted end of the public health emergency. This includes a 3 percent enrollment decline for the elderly and people with disabilities, 6 percent enrollment decline for parents and pregnant women, 13 percent enrollment decline for children, and 12 percent enrollment decline for the ACA expansion populations.

Per capita

The Department projects a 14 percent year-over-year growth based on historical trends and due to disenrollment of lower cost continuous coverage members.

Specialty Drugs

The FY 2023-24 forecast includes an adjustment for specialty drugs which tend to cost significantly more than standard pharmaceuticals. The FY 2023-24 adjustment includes $382.6 million total funds, including $38.3 million General Fund, based on the assumption that 10 percent of members with qualifying conditions will utilize these drugs.

IMPACT OF SPECIALTY DRUGS (FY 2023-24)						
DRUG NAME (DIAGNOSIS)	PROJECTED ANNUAL GROSS COSTS	ONE-TIME USE?	REBATES	ESTIMATED APPROVAL DATE	ADJUSTMENT TO PRORATE FY 2022-23	IMPACT
Skysona (Cerebral Adrenoleukodystrophy)	4,000,000	Yes	17.1%	09/16/22	78.6%	$3,316,000
teplizumab (Type I Diabetes)	3,500,000	Yes (14 days)	17.1%	11/17/22	61.6%	2,901,500
Roctavian (Hemophilia A)	183,000,000	Yes	23.1%	10/01/22	74.5%	140,727,000
EtranaDez (Hemophilia B)	27,000,000	Yes	23.1%	11/24/22	59.7%	20,763,000
Hepcludex (Hepatitis D)	5,000,000	No	23.1%	09/30/22	75.0%	3,845,000
cipaglucosidase alfa (Pompe Disease)	3,600,000	No	17.1%	10/29/22	66.9%	2,984,400
trofinetide (Rhett Syndrome)	10,000,000	No	17.1%	01/01/23	50.0%	8,290,000
nirsevimab (RSV)	40,000,000	No	17.1%	07/01/23	0.0%	33,160,000
LentiGlobin (Sickel Cell Disease)	106,000,000	Yes	17.1%	08/19/22	86.3%	87,874,000
Zynteglo (Transfusion Dependent Beta Thalassemia)	95,000,000	Yes	17.1%	08/17/22	86.9%	78,755,000
					TOTAL	$382,615,900
					Utilization Adjustment – 10% of members with qualifying conditions will utilize drugs	10.0%
					TOTAL ANNUAL IMPACT	$38,261,590
					GENERAL FUND IMPACT	$13,319,834

LONG-TERM SERVICES AND SUPPORTS

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

HCBS Waivers

Home- and Community-Based Services (HCBS) assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube. The Department projects a combined increase of 11 percent for enrollment and per capita growth.

Home Health/PDN/Hospice

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

The Department projects lower expenditures in FY 2022-23 as a result of reductions in PDN and Hospice utilization.

Nursing homes

The Department indicates that patient days for nursing facilities remains low.

PACE

PACE enrollment continues to decline as a result of the InnovAge enrollment freeze in December 2021. The Department expects growth to rebound in December 2022 and continue to grow based on historical trends after that.

OTHER

Supplemental payments

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

CUSOM payments

The Department projects an increase in University of Colorado School of Medicine payments resulting from the expiration of the enhanced FMAP.

Service management

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

S.B. 21-213 Use of increased federal match

The forecast includes an adjustment related to two additional quarters of the 6.2 enhanced federal match, reflecting the offset of General Fund with federal funds for supplemental payments.

Federal match rate

The Department projects a large increase in General Fund and decrease in federal funds for the end of the temporary extra 6.2 percent federal match provided through the federal Families First Coronavirus Response Act of 2020. The higher federal match is available for services from January 1, 2020 through the last quarter when a disaster is declared by the federal Secretary of Health and Human Services. Based on the current disaster declaration, the higher federal match would expire at the end of March 2023, but the disaster declaration could be extended further.

ISSUE: PROVIDER RATES (R7)

Through R7 Provider Rate Adjustments the Department requests adjustments to member contributions for copayments, several targeted rate increases, and an across-the-board rate adjustment for providers not receiving the targeted rate adjustments. The FY 2023-24 request is for an increase of $192.2 million total funds, including $69.8 million General Fund.

SUMMARY

- Through the process authorized by S.B. 15-228 (Medicaid Provider Rate Review) provider rates are reviewed at least once every five years.
- Rate categories reviewed in 2022 are included in the targeted rate adjustment portion of the Department's FY 2023-24 R7 Provider Rate Adjustments budget request.
- The Department requests $41.4 million total funds, including $12.4 million General Fund, to adjust rates reviewed in the Medicaid Provider Rate Review Advisory Committee (MPRRAC) process. Funding would move rates that fall below 80.0 percent of the appropriate benchmark up to 80.0 percent of the benchmark and reduce rates identified as above 100 percent of the benchmark down to 100 percent of the benchmark.
- The Department requests $127.2 million total funds, including $48.9 million General Fund, to adjust additional rates for which the Department performed a rate analysis, independent of the MPRRAC process.
- For rates not subject to the requested targeted adjustments, the Department requests $24.2 million total funds, including $8.6 million General Fund, to provide an across-the-board increase of 0.5 percent.

DISCUSSION

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

In developing it R7 Provider Rate Adjustments budget request, the Department leaned on recommendations from the provider rate review process created by S.B. 15-228 (Medicaid Provider Rate Review). The JBC sponsored S.B. 15-228 to assist the legislature in evaluating rate change proposals. As Medicaid became an increasingly important payer for medical services, complaints concerning the insufficiency of reimbursement rates were often shared with JBC members. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) process established by S.B. 15-228 was intended to address these issues by providing data to support rate setting decisions, and by establishing formal procedures for the Department to engage with providers regarding rate setting priorities. While the process has resulted in some improvements concerning rate setting, balancing the budget on an annual basis continues to be a limiting factor in the development of provider rate requests. The process has been modified through subsequent legislation (S.B. 22-236), however, the intent and overall requirements remain the same.

Concurrent with the passage of S.B. 15-228, the federal government issued new rules requiring states to conduct periodic rate reviews. The federal rules require states to review certain rates at least once every three years. There is some overlap between the rate reviews required by federal regulation and those required by S.B. 15-228. The federal rules emphasize analysis of regional variations in access, so the Department has incorporated a discussion of regional access in the MPRRAC process.

Significantly, the federal rules require an analysis of the expected effect on member access to services prior to any reduction in Medicaid rates.

EVALUATING RATE SUFFICIENCY

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

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

The Department just completed Year 2 of the Second Five-Year Review Cycle, including:

- Physician Services
- Dialysis and Nephrology
- Eyeglasses and Vision
- Laboratory and Pathology
- Injections and Miscellaneous J-Codes

The Department submitted the Medicaid Provider Rate Review Analysis Report to the JBC on May 2, 2022. The report contains analyses, rate comparisons, and sufficiency assessments for the sets of services identified above. Recommendations are summarized in the Recommendation Report submitted on November 1 2022. Links to these reports can be found here: Rate Review Reports | Colorado Department of Health Care Policy & Financing

R7 PROVIDER RATE ADJUSTMENTS

The Department requests several adjustments to provider rates, including an across-the-board increase of 0.5 percent for most providers and targeted rate adjustments for others. For most services, the request is based on the assumption that the requested rate adjustments will be effective July 1, 2023. The table below summarizes the cost of rate changes requested in the Department's FY 2023-24 R7 Provider Rate Adjustments budget request.

R7 Provider Rate Adjustments Department Request FY 2023-24 Fiscal Impact						
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds	Requires Legislation?
Across the board rate adjustment	0.5 percent increase	$24,200,145	$8,630,708	$1,135,953	$14,433,484	no
MPRRAC Recommendations						
Physician Services	rebalancing (between 80 and 100 percent)	19,311,361	5,907,439	799,446	12,604,476	no
Dialysis & Nephrology	increasing rates to 80 percent	427,077	92,379	26,460	308,238	no
Laboratory & Pathology	rebalancing (between 80 and 100 percent)	2,453,573	542,447	138,613	1,772,513	no
Eyeglasses and Vision	rebalancing (between 80 and 100 percent)	19,167,764	5,863,512	793,502	12,510,750	no
Injections & Miscellaneous J-Codes	rebalancing (between 80 and 100 percent)	86,238	26,381	3,571	56,286	no
Subtotal MPRRAC Recommendations		$41,446,013	$12,432,158	$1,761,592	$27,252,263	
Other Provider Rate Adjustments						
Rural Hospital Technology Payments	incentive payments	4,220,000	2,110,000	0	2,110,000	no
Eliminating Member Copays	excluding non-emergent ER visits	9,295,824	1,821,702	565,243	6,908,879	yes, for pharmacy and outpatient copays
GRSS and NMT Rate Adjustments Comprehensive Waiver	incr. to align with other waivers	15,802,052	5,293,686	2,607,339	7,901,027	no
GRSS and NMT Rate Adjustments Supported Living Services Waiver	incr. to align with other waivers	1,785,095	598,006	294,541	892,548	no
Nursing Facility Rate Increase	$18.37/day incr. (on av.)	39,182,927	19,591,463	0	19,591,464	yes
Minimum Wage Adjustments	incr. HCBS to $15.75 per hour/incr. min to $17.29 in Denver	56,953,319	19,477,936	8,998,735	28,476,648	no
Subtotal Other Adjustments		$127,239,217	$48,892,793	$12,465,858	$65,880,566	
TOTAL		**$192,885,375**	**$69,955,659**	**$15,363,403**	**$107,566,313**	

R7 Provider Rate Adjustments Department Request FY 2024-25 Fiscal Impact (annualization)						
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds	Requires Legislation?
Across the board rate adjustment	0.5 percent increase	$26,400,158	$9,415,317	$1,239,222	$15,745,619	no
MPRRAC Recommendations						
Physician Services	rebalancing (between 80 and 100 percent)	21,066,939	6,444,479	872,123	13,750,337	no
Dialysis & Nephrology	increasing rates to 80 percent	465,902	100,777	28,865	336,260	no

R7 PROVIDER RATE ADJUSTMENTS DEPARTMENT REQUEST FY 2024-25 FISCAL IMPACT (ANNUALIZATION)						
RATE	CHANGE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	REQUIRES LEGISLATION?
Laboratory & Pathology	rebalancing (between 80 and 100 percent)	2,676,626	591,762	151,214	1,933,650	no
Eyeglasses and Vision	rebalancing (between 80 and 100 percent)	20,910,288	6,396,558	865,639	13,648,091	no
Injections & Miscellaneous J-Codes	rebalancing (between 80 and 100 percent)	94,078	28,779	3,896	61,403	no
SUBTOTAL MPRRAC RECOMMENDATIONS		$45,213,833	$13,562,355	$1,921,737	$29,729,741	
OTHER PROVIDER RATE ADJUSTMENTS						
Rural Hospital Technology Payments	incentive payments	4,220,000	2,110,000	0	2,110,000	no
Eliminating Member Copays	excluding non-emergent ER visits	9,295,824	1,821,702	565,243	6,908,879	yes, for pharmacy and outpatient copays
GRSS and NMT Rate Adjustments Comprehensive Waiver	incr. to align with other waivers	17,238,601	8,619,301	0	8,619,300	no
GRSS and NMT Rate Adjustments Supported Living Services Waiver	incr. to align with other waivers	1,947,377	973,689	0	973,688	no
Nursing Facility Rate Increase	$18.37/day incr. (on av.)	44,039,550	22,019,775	0	22,019,775	yes
Minimum Wage Adjustments	incr. to $15.75 per hour/$17.29 in Denver	62,130,893	30,873,618	191,837	31,065,438	no
SUBTOTAL OTHER ADJUSTMENTS		$138,872,245	$66,418,085	$757,080	$71,697,080	
TOTAL		**$210,486,236**	**$89,395,757**	**$3,918,039**	**$117,172,440**	

ACROSS THE BOARD RATE ADJUSTMENT

The Department requests a 0.5 percent increase in provider rates for those providers for which targeted rate increases are not requested. The Governor's FY 2023-24 budget request includes a 3.0 percent provider rate increase for most community providers, however, the Department of Health Care Policy and Financing adjusts the common policy provider rate downward to make funding available to cover targeted rate increases. Independent of its decision concerning requests for targeted rate adjustments, the JBC typically applies the common policy provider rate adjustment across all departments.

The Department requests $24.2 million total funds, including $8.6 million General Fund, to increase rates for certain providers by 0.5 percent. The amount is calculated based on 11 months in order to account for the cash basis accounting of claims processing.

PROVIDERS EXEMPT FROM ACROSS-THE-BOARD RATE INCREASES

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

- A portion of the expenditure related to non-medical emergency transportation services as services are rendered under a fixed price contract;
- Dental administrative payments, as payment rates were agreed upon during a competitively procured contract process;

- Pharmaceutical reimbursements, as they are based on a methodology that reflects the actual costs of purchasing and dispensing medications;
- Rural health clinics, as rates are based on actual costs or the Medicare upper payment limit;
- Physical health managed care programs, as rates are negotiated within the parameters of their respective rate setting methodology;
- Medicaid and CHP risk-based physical health managed care programs and regional accountable entities, as rates are set in accordance with federal regulation and actuarial standards which do not generally permit general provider rate increases; and
- Services receiving targeted rate adjustments.

MEDICAID PROVIDER RATE REVIEW ADJUSTMENTS

PHYSICIAN SERVICES

For the majority of the rates in the physician services category, the Department recommends rebalancing rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark. This includes: cardiology, cognitive capabilities assessment, ear, nose and throat (ENT) services, gastroenterology, health education, ophthalmology, primary care/evaluation and management (E&M) services, radiology, respiratory, vascular services, women's health and family planning, other physician services. The Department recommends only increasing rates for vaccines and immunizations that are below 80 percent of the benchmark up to 80 percent of the benchmark. The Department requests $19.3 million total funds, including $5.9 million General Fund, in FY 2023-24 to adjust rates commiserate with the recommendation.

DIALYSIS AND NEPHROLOGY SERVICES

The Department found that the average payment rate for dialysis facility-based services was 78.5 percent of the benchmark and recommends increasing both facility-based and professional dialysis rates to 80 percent of the benchmark. The Department requests $0.4 million total funds, including $0.1 million General Fund, in FY 2023-24 to adjust rates commiserate with the recommendation.

LABORATORY AND PATHOLOGY SERVICES

The Department found the payment rate for laboratory and pathology (laboratory) services was 93.7 percent of the benchmark and recommends rebalancing laboratory service rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark. The Department requests $2.5 million total funds, including $0.5 million General Fund, to adjust rates commiserate with the recommendation.

EYEGLASSES AND VISION SERVICES

The Department found the payment rate for eyeglasses & vision services was 57.4 percent of the benchmark and recommends rebalancing vision service rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark. The Department also recommends increasing eyeglasses and frames rates for children and adults who have had a qualifying surgery to 80 percent of the benchmark. The Department requests $19.2 million total funds, including $5.9 million General Fund, to adjust rates commiserate with the recommendation.

INJECTIONS AND MISCELLANEOUS J-CODES

The Department found the payment rate for injections and miscellaneous J-codes was 95.6 percent of the benchmark and recommends rebalancing injection and miscellaneous J-code rates that were

identified to be below 80 percent of the benchmark and above 100 percent of the benchmark. The Department requests $86,238 total funds, including $26,381 General Fund, to adjust rates commiserate with the recommendation.

OTHER PROVIDER RATE ADJUSTMENTS

RURAL HOSPITAL TECHNOLOGY PAYMENTS

The Department reports that approximately 72 percent of Colorado's health care providers and hospitals are currently connected to one of Colorado's two recognized Health Information Exchanges (HIEs) – Colorado Regional Health Information Organization (CORHIO) and the Quality Heath Network (QHN). The majority of the health care providers that are not connected to the health IT infrastructure are located in rural communities, and many of these rural providers do not have the financial resources, technical expertise, or capacity to connect to Colorado's health IT infrastructure. The Department requests $4.2 million total funds, including $2.1 million General Fund, to provide one-time incentive payments to rural health providers assist them in continued participation in the health information exchange. The Department intends to subsidize fees and provide technical assistance to ensure easy connections, establishing and expanding data connections to make holistic patient and business data available in one place, and using technology to optimize workflows, reduce provider burden, and improve reporting capabilities.

ELIMINATING MEMBER COPAYS [REQUIRES LEGISLATION]

Member copayments are required on several services, including non-emergent outpatient hospital services, physician services, telemedicine services, rural health clinic services, pharmacy, optometry services, podiatry services, durable medical equipment, laboratory services, and radiology services. The cost of copayments is based on the services rendered and the income of the member. Pursuant to federal law, copayments may not exceed 5.0 percent of the total income of a Medicaid member. The Department's request includes $9.3 million total funds, including $1.8 million General Fund, in order to eliminate member copays for most services, excluding hospital outpatient emergency room visits for non-emergent care in order to discourage improper use of emergency services. Federal matching funds are available for the increased costs. Elimination of copayments will result in increased provider income. Currently, Section 25.5-4-209(1)(b)(I), C.R.S., requires a Medicaid recipient to pay a portion of the cost for pharmacy and outpatient hospital services, therefore a statutory change will be necessary to implement this policy change.

GRSS AND NMT RATE ADJUSTMENTS

Group Residential Services and Supports (GRSS) and Non-Medical Transportation (NMT) are two services that are offered on the Comprehensive and Supported Living Services waivers for individuals with intellectual and developmental disabilities. GRSS benefits provide 24/7 residential services and offers training and hands on assistance for self-advocacy, independent living, money management, decision making, and emergency assistance. The Department requests funding to increase rates to cover the additional costs associated with additional staff to support individuals with higher acuity. NMT benefits allow members to gain access to non-medical community services and supports as required by the care plan in order to prevent institutionalization. The Department requests funding to increase rates in order to align with NMT service offered on other waivers. The Department's FY 2023-24 request includes cash funds HCBS Improvement Fund for the state share through October 31, 2023. General Fund will be required to continue the rate increases for the remainder of the fiscal year.

The Department requests $17.6 million total funds, including $5.9 million General Fund, to increase GRSS and NMT rates.

NURSING FACILITY RATE INCREASE [REQUIRES LEGISLATION]

Pursuant to rate methodology prescribed in section 25.5-6-202, C.R.S., the Department is required to annually adjust nursing facility rates based on changes in provider costs. As part of that methodology, nursing facility rates are limited to no more than 3.0 percent growth each year. Given recent inflation, the statutory rate adjustment may not be adequate to keep pace with rising wages. Nursing facilities are currently experiencing significant staffing shortages, cost increases, and drops in overall utilization.

The Department requests funding to increase the FY 2023-24 per diem rate for all nursing facilities by 5.86 percent. In addition, nursing facilities with Medicaid utilization rates of 85-100 percent would receive a supplemental payment equivalent to $10.00 per diem, and nursing facilities with Medicaid utilization of 75-84.99 percent would receive a supplemental payment equivalent to $5.00 per diem.

The Department requests $39.2 million total funds, including $19.6 million General Fund, to increase the nursing facility rate in FY 2023-24. This adjustment requires a statutory change.

MINIMUM WAGE ADJUSTMENTS

Home and Community-Based Service (HCBS) waiver members can receive care in their home or community with services such as personal care, residential care, day habilitation services and behavioral services. These types of services allow individuals to receive essential care and remain in a community setting. With a significant direct care workforce shortage already occurring, the need for professionals is anticipated to grow by 40 percent between 2018 and 2028. In FY 2021-22, through enhanced funding pursuant to the American Rescue Plan Act of 2021, the Department increased rates for certain HCBS services with a mandated wage pass through for providers to pay at least $15 per hour base wage for frontline staff providing direct hands-on care.

The Department requests $57.0 million total funds, including $19.5 million General Fund, to increase the minimum wage for the HCBS direct support professionals from $15 per hour to $15.75 per hour, and to increase the Denver minimum wage up to $17.29 per hour. The Department requests the use of funding from the HCBS Improvement Fund for the state share through October 31, 2023. General Fund is required for the state share through the remainder of the fiscal year.

ONE-TIME FUNDING AUTHORIZED IN RECENT LEGISLATIVE SESSIONS

During the 2021 and 2022 legislative sessions, the General Assembly allocated significant one-time funding to the Department of Health Care Policy and Financing that included $18.0 million originating as state General Fund and $45.0 million originating as federal Coronavirus State Fiscal Recovery funds (ARPA funds).

RECOMMENDATION

Staff recommends that the Committee seek updates from all departments during their budget hearings on the use of significant one-time allocations of federal and state funding.

DISCUSSION

During the 2021 and 2022 legislative sessions, the General Assembly allocated $63.1 million in one-time funding to the Department of Health Care Policy and Financing through appropriations and transfers. To assist the Committee in tracking the use of these funds, the tables below show the sum of allocations provided for FY 2020-21, FY 2021-22, and FY 2022-23 and expenditures through FY 2021-22 by the original source of the funds (General Fund, federal Coronavirus State Fiscal Recovery Funds, and other funds).

ALLOCATION AND EXPENDITURE OF ONE-TIME GENERAL FUND

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING ONE-TIME GENERAL FUND			
BILL NUMBER AND SHORT TITLE	APPROPRIATION / TRANSFER OF FUNDS	ACTUAL EXPENDITURE OF FUNDS THROUGH FY 2022	BRIEF DESCRIPTION OF PROGRAM AND ANTICIPATED USE OF THE FUNDS
H.B. 22-1247 Additional Requirements Nursing Facility Funding	$17,000,500	$10,700,000	Provides supplemental payments to Medicaid Class I nursing facilities for FY 2021-22.
TOTAL	**$17,000,500**	**$10,700,000**	

ALLOCATION AND EXPENDITURE OF ONE-TIME FEDERAL CORONAVIRUS STATE FISCAL RECOVERY FUNDS (ARPA FUNDS)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING ONE-TIME ARPA FUNDS			
BILL NUMBER AND SHORT TITLE	APPROPRIATION / TRANSFER OF FUNDS	ACTUAL EXPENDITURE OF FUNDS THROUGH FY 2022	BRIEF DESCRIPTION OF PROGRAM AND ANTICIPATED USE OF THE FUNDS
H.B. 22-1302 Primary Care Behavioral Health Integrations	$31,750,000	$0	Appropriated in Other Medical Services for the Primary Care and Behavioral Health Statewide Integration Grant Program.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING ONE-TIME ARPA FUNDS			
BILL NUMBER AND SHORT TITLE	APPROPRIATION / TRANSFER OF FUNDS	ACTUAL EXPENDITURE OF FUNDS THROUGH FY 2022	BRIEF DESCRIPTION OF PROGRAM AND ANTICIPATED USE OF THE FUNDS
H.B. 22-1302 Primary Care Behavioral Health Integrations	3,000,000	0	Appropriated to Executive Director's Office for a universal contract for behavioral health services.
S.B. 21-137 Behavioral Health Recovery Act	250,000	250,000	Screening, brief intervention, and referral to treatment (SBIRT) for substance use
S.B. 22-200 Rural Provider Stimulus Grant	10,000,000	0	Total is transferred to new Rural Provider Access and Affordability Fund, which is continuously appropriated to the Department of Health Care Policy and Financing. Of the total $4.8 million is for grants for health-care affordability projects, $4.8 million is for grants for health-care access projects, and up to $400,000 is for administration.
TOTAL	**$45,000,000**	**$250,000**	

ALLOCATION AND EXPENDITURE OF ONE-TIME OTHER FUNDS

Department of Health Care Policy and Financing One-time Other Funds			
Bill Number and Short Title	Appropriation / Transfer of Funds	Actual Expenditure of Funds through FY 2022	Brief Description of Program and Anticipated Use of the Funds
HB 22-1329 Long Bill	$400,000,000	n/a	The amount reflected is for state FY 2021-22 only. HCPF projects the GF savings due to the enhanced FMAP of 6.2 percent (pursuant to the FFCRA of 2020) to be (net) approximately $100 million GF PER QUARTER. The enhanced FMAP began in January 2020 and extends through March 2023. It is possible (probably likely at this point) that the public health emergency will be extended again, providing an additional $100 million GF savings to the already $300 million we already have for FY 2022-23. The state has received an additional $1.1 billion since the pandemic began (it was retroactive to January 2020) through October 31, 2022. The enhanced FMAP is contingent upon the state NOT reducing benefits for or disenrolling (unless they die or ask to be disenrolled) anyone enrolled on Medicaid at the time the public health emergency began or anyone added to the membership during the public health emergency. Once the public health emergency ends, the state will have 12 months to redetermine the continuously enrolled population.
HB 22-1329 Long Bill	700,000,000	n/a	Additional amounts for other years/quarters, based on description above
TOTAL	**$1,100,000,000**	**n/a**	

IMPLEMENTATION UPDATES AND ITEMS OF NOTE

H.B. 22-1247 ADDITIONAL REQUIREMENTS NURSING FACILITY FUNDING: Provides $27.0 million, including $10.0 million General Fund, for supplemental payments to nursing facilities negatively impacted by reduced census requirements related to the federal public health emergency in FY 2021-22 and requires reporting and result tracking requirements related to the payments.

STATUS UPDATE

A total of $24.4 million has been paid to nursing facilities of the total $27.0 million appropriated, including $10.7M in general fund. The remaining funds were rolled forward into FY 2022-23 and will be paid out to nursing homes that admit members who are discharged from hospitals and/or the Department of Corrections. The payment per nursing facility was calculated based on a nursing facility's percent of statewide aggregate Medicaid days. The average payment made to all Medicaid enrolled nursing facilities was approximately $148,700. 164 facilities have received a payment.

H.B. 22-1302 PRIMARY CARE BEHAVIORAL HEALTH INTEGRATIONS: The bill:

- Created the Primary Care and Behavioral Health Statewide Integration Grant Program administered by the Department of Health Care Policy and Financing and appropriates $31.75 million from the Behavioral and Mental Health Cash Fund
- Requires the Department of Health Care Policy and Financing in collaboration with the Behavioral Health Administration to develop universal contracting provisions and appropriates $3.0 million from the Behavioral and Mental Health Cash Fund
- Appropriates $250,000 from the Behavioral and Mental Health Cash Fund for the University of Colorado for the Regional Health Connector Workforce Program
- Requires the Department of Health Care Policy and Financing to transform processes for clients attempting to receive long-term care in the community and provides $1,603,916 total funds, including $6136,968 General Fund and $986,948 federal funds and 12.0 FTE

STATUS UPDATE

Grant payments have not yet gone out to providers. The Department expects the maximum award will be $400,000 and the average amount will be $200,000 and the Department anticipates up to 150 sites will apply for grants. The Department emailed stakeholders last week with updates related to the grant program and application and is following this implementation timeline:

- Request for Application release: January 2023
- Submission Deadline: March 2023
- Project and Award Announcement: April – May 2023
- Contracting and Pre-Grant Training: May – June 2023
- Funding Distribution: July 1, 2023
- Award Period: July 1, 2023 – December 30, 2026

The Department and the Behavioral Health Administration are in the "final stages" of developing draft universal contract provisions for stakeholder consideration and input. The Department did not provide an estimated time frame. The universal contract will establish uniform standards across different agencies when contracting for behavioral health services. Specifically, providers can expect the same standards with regard to the quality of care and expectations of services across all state agencies. The funds are being used to contract with Health Management Associates to conduct statewide stakeholder work and for the Regional Accountable Entities to make modifications to their contracts and provide the necessary technical assistance to their provider network.

S.B. 21-137 BEHAVIORAL HEALTH RECOVERY ACT:

The bill extends, modifies, and finances behavioral health programs throughout state government. Specific to the Department of Health Care Policy and Financing and to the one-time federal funds,

the bill appropriated $250,000 from the Behavioral and Mental Health Fund for training health care professionals in substance use Screening, Brief Intervention, and Referral to Treatment.

STATUS UPDATE
The Department spent all of the one-time federal funds appropriated for FY 2021-22 for SBIRT training grants.

S.B. 22-200 RURAL PROVIDER STIMULUS GRANT:
As part of the grant program, the state department may award grants for projects that modernize the affordability solutions and the information technology of health-care providers in rural communities (rural providers) and projects that expand access to health care in rural communities. The types of rural providers eligible for grants under the grant program are rural hospitals that have a lower net patient revenue or fund balance than other rural hospitals in the state, as determined by the medical services board (state board) by rule.

STATUS UPDATE
The Rural Provider Access and Affordability Advisory Committee met to develop recommendations on grant eligibility, use of funds, criteria for determining grant awards and amounts, and grant procedures, timelines, and reporting requirements. The proposed rules will be considered by the Medical Services Board on December 9, 2022. The Department provided the following estimated timeline for the grant program:

- March 2023 grant application opens
- April 2023 applications due
- April-May 2023 review committee reviews applications and makes recommendations to the Department's executive director
- May-June 2023 grant agreements executed
- July 2023-June 2024 grant funds disbursed

The draft rules, including the criteria for grant qualification, are available under the November 18, 2022, advisory committee meeting here:
https://hcpf.colorado.gov/rural-provider-access-and-affordability-stimulus-advisory-committee

Updates on the status of the grant program will be posted here:
https://hcpf.colorado.gov/rural-provider-access-and-affordability-stimulus-grant-program

HB 22-1329 LONG BILL ENHANCED FEDERAL MATCH: The Department projects the General Fund savings due to the enhanced federal match of 6.2 percent (pursuant to the federal Families First Coronavirus Response Act of 2020) to be (net) approximately $100 million General Fund per quarter. The enhanced match began in January 2020 and extends through March 2023. The State has received an additional $1.1 billion from January 2020 through September 30, 2022, and is anticipated to receive another $200.0 million from October 1, 2022 through March 31, 2023. The enhanced FMAP is contingent upon the State not reducing benefits for or disenrolling anyone enrolled on Medicaid at the time the public health emergency began or anyone added to the membership during the public health emergency, unless the individual passes away, moves out of state, or asks to be disenrolled. Once the public health emergency ends, the State will have 12 months to redetermine the continuously enrolled population. The General Fund savings resulting from the enhanced federal match was not available to the Department, but factored into balancing the State budget in each affected fiscal year.

APPENDIX A
NUMBERS PAGES
(DIGITAL ONLY)

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Kim Bimestefer, Executive Director

(1) EXECUTIVE DIRECTOR'S OFFICE

Primary functions: Provides all of the administrative, audit and oversight functions for the Department.

(A) General Administration

Personal Services	47,513,817	51,242,435	57,919,026	61,134,921	*
FTE	573.0	600.5	693.0	706.4	
General Fund	15,160,759	16,861,340	21,353,128	23,454,062	
Cash Funds	3,931,315	4,699,898	6,314,203	6,035,097	
Reappropriated Funds	1,543,625	1,772,301	2,273,021	2,454,437	
Federal Funds	26,878,118	27,908,896	27,978,674	29,191,325	
Health, Life, and Dental	5,264,801	7,071,991	9,269,011	10,048,726	*
General Fund	1,342,322	2,642,297	3,552,746	4,101,072	
Cash Funds	548,313	660,834	860,931	673,370	
Reappropriated Funds	138,532	166,554	229,292	185,344	
Federal Funds	3,235,634	3,602,306	4,626,042	5,088,940	
Short-term Disability	72,366	104,617	95,356	99,206	*
General Fund	26,778	50,803	35,944	40,102	
Cash Funds	5,695	10,843	8,492	6,658	
Reappropriated Funds	1,607	3,300	2,119	1,505	
Federal Funds	38,286	39,671	48,801	50,941	
S.B. 04-257 Amortization Equalization Disbursement	2,188,905	2,428,087	2,980,995	3,310,590	*
General Fund	810,157	924,349	1,123,363	1,336,412	
Cash Funds	172,037	211,103	266,467	223,344	

Reappropriated Funds	48,635	52,920	66,241	50,107
Federal Funds	1,158,076	1,239,715	1,524,924	1,700,727
S.B. 06-235 Supplemental Amortization Equalization Disbursement	**2,188,905**	**2,428,087**	**2,980,996**	**3,310,590** *
General Fund	810,157	924,349	1,123,363	1,336,411
Cash Funds	172,037	211,103	266,467	223,345
Reappropriated Funds	48,635	52,920	66,241	50,107
Federal Funds	1,158,076	1,239,715	1,524,925	1,700,727
Salary Survey	**0**	**1,273,930**	**1,739,584**	**3,665,128**
General Fund	0	474,954	701,453	1,410,419
Cash Funds	0	98,663	117,370	269,626
Reappropriated Funds	0	29,439	32,730	53,934
Federal Funds	0	670,874	888,031	1,931,149
PERA Direct Distribution	**0**	**1,077,010**	**668,598**	**187,621**
General Fund	0	430,205	0	73,824
Cash Funds	0	83,411	75,591	13,754
Reappropriated Funds	0	24,889	21,079	2,869
Federal Funds	0	538,505	571,928	97,174
Temporary Employees Related to Authorized Leave	**0**	**0**	**5,978**	**5,978**
General Fund	0	0	0	2,411
Cash Funds	0	0	5,978	403
Reappropriated Funds	0	0	0	112
Federal Funds	0	0	0	3,052
Worker's Compensation	**128,527**	**160,590**	**194,996**	**182,211**
General Fund	53,287	64,817	88,614	67,163
Cash Funds	10,976	14,502	16,622	19,898

Reappropriated Funds	0	976	6,497	7,142
Federal Funds	64,264	80,295	83,263	88,008
Operating Expenses	**1,788,412**	**2,528,896**	**3,115,868**	**2,943,591** *
General Fund	862,725	1,209,995	1,258,892	1,228,023
Cash Funds	221,951	233,675	270,625	283,378
Reappropriated Funds	13,297	13,297	59,204	18,830
Federal Funds	690,439	1,071,929	1,527,147	1,413,360
Legal Services	**1,251,687**	**1,172,759**	**959,008**	**1,714,709**
General Fund	398,303	384,389	372,957	603,063
Cash Funds	222,539	206,798	95,041	187,075
Reappropriated Funds	0	0	21,289	67,216
Federal Funds	630,845	581,572	469,721	857,355
Administrative Law Judge Services	**735,806**	**807,180**	**890,065**	**600,498**
General Fund	305,065	330,731	284,141	221,344
Cash Funds	62,838	70,687	79,076	65,574
Reappropriated Funds	0	2,172	117,685	23,540
Federal Funds	367,903	403,590	409,163	290,040
Payment to Risk Management and Property Funds	**110,332**	**173,686**	**383,339**	**255,071**
General Fund	45,744	68,525	137,893	94,019
Cash Funds	9,422	16,390	46,044	27,854
Reappropriated Funds	0	1,928	20,172	9,999
Federal Funds	55,166	86,843	179,230	123,199
Leased Space	**2,559,590**	**1,363,822**	**3,745,236**	**3,765,040** *
General Fund	1,051,765	443,581	1,384,850	1,458,542
Cash Funds	228,030	238,330	434,705	391,163

Reappropriated Funds	0	0	31,842	31,842
Federal Funds	1,279,795	681,911	1,893,839	1,883,493
Capitol Complex Leased Space	**591,064**	**651,086**	**624,633**	**0**
General Fund	245,055	266,637	256,287	0
Cash Funds	50,477	57,078	54,157	0
Reappropriated Funds	0	1,828	1,172	0
Federal Funds	295,532	325,543	313,017	0
Payments to OIT	**8,298,082**	**5,765,418**	**9,004,795**	**11,706,454**
General Fund	3,218,758	1,971,816	3,515,604	4,627,522
Cash Funds	930,283	910,893	914,415	1,192,836
Reappropriated Funds	0	0	16,675	42,401
Federal Funds	4,149,041	2,882,709	4,558,101	5,843,695
CORE Operations	**184,939**	**112,780**	**169,033**	**137,018** *
General Fund	81,743	56,303	65,526	50,505
Cash Funds	15,794	5,835	15,313	14,962
Reappropriated Funds	0	0	6,740	5,371
Federal Funds	87,402	50,642	81,454	66,180
General Professional Services and Special Projects	**8,992,784**	**15,288,124**	**69,154,379**	**54,685,530** *
General Fund	2,368,910	3,837,133	8,779,012	12,624,277
Cash Funds	1,227,887	2,892,967	25,419,903	11,886,875
Reappropriated Funds	150,000	69,000	81,000	81,000
Federal Funds	5,245,987	8,489,024	34,874,464	30,093,378
Universal Contract for Behavioral Health Services	**0**	**0**	**3,000,000**	**0**
Cash Funds	0	0	3,000,000	0

Statewide training	**0**	**0**	**0**	**10,086** *	
General Fund	0	0	0	3,719	
Cash Funds	0	0	0	1,100	
Reappropriated Funds	0	0	0	395	
Federal Funds	0	0	0	4,872	
Paid Family and Medical Leave Insurance	**0**	**0**	**0**	**0**	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Merit Pay	**0**	**0**	**0**	**0**	
General Fund	0	0	0	0	
Total Funds - (A) General Administration	**81,870,017**	**93,650,498**	**166,900,896**	**157,762,968**	**(5.5%)**
FTE	**573.0**	**600.5**	**693.0**	**706.4**	**1.9%**
General Fund	26,781,528	30,942,224	44,033,773	52,732,890	19.8%
Cash Funds	7,809,594	10,623,010	38,261,400	21,516,312	(43.8%)
Reappropriated Funds	1,944,331	2,191,524	3,052,999	3,086,151	1.1%
Federal Funds	45,334,564	49,893,740	81,552,724	80,427,615	(1.4%)

(B) Transfers to Other Departments

Public School Health Services Administration, Education	**120,652**	**182,668**	**191,731**	**192,794**
General Fund	60,326	91,334	95,865	96,397
Federal Funds	60,326	91,334	95,866	96,397

Early Intervention, Early Childhood	**0**	**0**	**8,127,382**	**8,127,382**
General Fund	0	0	4,063,691	4,063,691
Federal Funds	0	0	4,063,691	4,063,691
Nurse Home Visitor Program, Human Services	**173,642**	**193,475**	**3,010,000**	**3,010,000**
Reappropriated Funds	67,019	73,254	1,505,000	1,505,000
Federal Funds	106,623	120,221	1,505,000	1,505,000
Host Home Regulation, Local Affairs	**118,747**	**89,070**	**133,882**	**133,882**
General Fund	59,373	44,535	66,941	66,941
Federal Funds	59,374	44,535	66,941	66,941
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	**265,698**	**296,990**	**306,796**	**306,796**
General Fund	132,849	148,495	153,398	153,398
Federal Funds	132,849	148,495	153,398	153,398
Facility Survey and Certification, Public Health and Environment	**6,930,318**	**7,065,278**	**8,651,460**	**8,651,460**
General Fund	2,346,574	2,445,321	3,218,674	3,218,674
Federal Funds	4,583,744	4,619,957	5,432,786	5,432,786
Prenatal Statistical Information, Public Health and Environment	**5,888**	**5,888**	**5,887**	**5,887**
General Fund	2,944	2,944	2,944	2,944
Federal Funds	2,944	2,944	2,943	2,943
Nurse Aide Certification, Regulatory Agencies	**324,040**	**324,041**	**324,041**	**324,041**
General Fund	147,369	147,369	147,369	147,369
Reappropriated Funds	14,651	14,652	14,652	14,652
Federal Funds	162,020	162,020	162,020	162,020

Reviews, Regulatory Agencies	**0**	**0**	**3,750**	**3,750**	
General Fund	0	0	1,875	1,875	
Federal Funds	0	0	1,875	1,875	
Regulation of Medicaid Transportation Providers, Regulatory Agencies	**41,540**	**0**	**0**	**0**	
General Fund	20,770	0	0	0	
Federal Funds	20,770	0	0	0	
Local Public Health Agencies, Public Health and Environment	**364,052**	**0**	**0**	**0**	
General Fund	364,052	0	0	0	
Total Funds - (B) Transfers to Other Departments	**8,344,577**	**8,157,410**	**20,754,929**	**20,755,992**	**0.0%**
FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0%**
General Fund	3,134,257	2,879,998	7,750,757	7,751,289	0.0%
Reappropriated Funds	81,670	87,906	1,519,652	1,519,652	0.0%
Federal Funds	5,128,650	5,189,506	11,484,520	11,485,051	0.0%

(C) Information Technology Contracts and Projects

Medicaid Management Information System Maintenance and Projects	**15,864,583**	**10,393,942**	**47,502,581**	**113,348,612**	*
General Fund	0	0	2,908,573	16,737,687	
Cash Funds	2,098,574	1,135,444	11,386,476	14,299,891	
Reappropriated Funds	12,204	0	12,204	12,204	
Federal Funds	13,753,805	9,258,498	33,195,328	82,298,830	
Colorado Benefits Management Systems, Operating and Contract Expenses	**41,210,186**	**41,290,899**	**49,903,812**	**50,884,469**	*
General Fund	4,984,722	5,741,240	9,821,039	10,751,349	
Cash Funds	4,562,697	4,784,644	5,981,077	5,981,432	

Reappropriated Funds	473	147	1,654	1,654
Federal Funds	31,662,294	30,764,868	34,100,042	34,150,034
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	**1,633,016**	**1,893,968**	**2,005,074**	**2,005,074**
General Fund	536,552	608,896	634,715	634,715
Cash Funds	279,590	328,882	354,194	354,194
Reappropriated Funds	20	6	73	73
Federal Funds	816,854	956,184	1,016,092	1,016,092
Office of eHealth Innovations Operations	**6,556,066**	**4,385,240**	**6,465,845**	**6,465,845**
FTE	0.1		3.0	3.0
General Fund	660,675	2,296,332	3,372,367	3,372,367
Federal Funds	5,895,391	2,088,908	3,093,478	3,093,478
All-Payer Claims Database	**3,938,816**	**4,733,994**	**5,160,403**	**5,562,903** *
General Fund	2,962,231	2,962,231	4,327,136	4,598,136
Federal Funds	976,585	1,771,763	833,267	964,767
Health Information Exchange Maintenance and Projects	**8,901,743**	**0**	**0**	**0**
General Fund	981,083	0	0	0
Federal Funds	7,920,660	0	0	0
State Innovation Model Operations	**0**	**0**	**0**	**0**
FTE				
General Fund	0	0	0	0
Connect for Health Colorado Systems	**0**	**0**	**0**	**0**
General Fund	0	0	0	0

Total Funds - (C) Information Technology Contracts and Projects	**78,104,410**	**62,698,043**	**111,037,715**	**178,266,903**	**60.5%**
FTE	0.1	0.0	3.0	3.0	0.0%
General Fund	10,125,263	11,608,699	21,063,830	36,094,254	71.4%
Cash Funds	6,940,861	6,248,970	17,721,747	20,635,517	16.4%
Reappropriated Funds	12,697	153	13,931	13,931	0.0%
Federal Funds	61,025,589	44,840,221	72,238,207	121,523,201	68.2%

(D) Eligibility Determinations and Client Services

Contracts for Special Eligibility Determinations	2,932,388	0	12,039,555	12,039,555	
General Fund	856,390	0	1,129,071	1,129,071	
Cash Funds	232,019	0	4,343,468	4,343,468	
Federal Funds	1,843,979	0	6,567,016	6,567,016	
County Administration	76,847,916	79,214,462	123,622,889	108,997,329	*
General Fund	12,476,154	14,337,301	20,061,678	18,007,480	
Cash Funds	14,975,853	14,734,326	27,113,119	25,012,929	
Federal Funds	49,395,909	50,142,835	76,448,092	65,976,920	
Medical Assistance Sites	843,705	825,542	1,531,968	1,531,968	
Cash Funds	402,384	402,419	402,984	402,984	
Federal Funds	441,321	423,123	1,128,984	1,128,984	
Administrative Case Management	729,944	1,752,340	869,744	869,744	
General Fund	364,972	876,170	434,872	434,872	
Federal Funds	364,972	876,170	434,872	434,872	

Customer Outreach	**2,520,295**	**2,623,526**	**3,486,071**	**3,461,519**
General Fund	936,784	992,812	1,406,415	1,394,139
Cash Funds	323,363	318,951	336,621	336,621
Federal Funds	1,260,148	1,311,763	1,743,035	1,730,759
Centralized Eligibility Vendor Contract Project	**4,845,249**	**6,731,692**	**6,122,400**	**6,122,400**
Cash Funds	1,541,955	2,347,766	2,279,719	2,279,719
Federal Funds	3,303,294	4,383,926	3,842,681	3,842,681
Connect for Health Colorado Eligibility Determination	**15,945,067**	**10,220,546**	**10,135,914**	**10,642,710**
Cash Funds	6,762,934	5,343,099	4,530,754	4,757,291
Federal Funds	9,182,133	4,877,447	5,605,160	5,885,419
Eligibility Overflow Processing Center	**0**	**740,475**	**1,904,677**	**1,904,677**
General Fund	0	110,923	285,320	285,320
Cash Funds	0	74,196	190,849	190,849
Federal Funds	0	555,356	1,428,508	1,428,508
Returned Mail Processing	**818,170**	**1,337,726**	**3,298,808**	**3,298,808**
General Fund	240,653	418,000	985,808	985,808
Cash Funds	50,124	100,758	244,919	244,919
Reappropriated Funds	23,329	31,303	111,942	111,942
Federal Funds	504,064	787,665	1,956,139	1,956,139
Work Number Verification	**21,516**	**1,500,105**	**3,305,114**	**3,305,114**
General Fund	7,085	502,685	1,089,815	1,089,815
Cash Funds	3,548	247,367	545,013	545,013
Federal Funds	10,883	750,053	1,670,286	1,670,286

Medical Identification Cards	**218,898**	**1,650,386**	**0**	**0**	
General Fund	74,470	481,831	0	0	
Cash Funds	34,561	343,362	0	0	
Federal Funds	109,867	825,193	0	0	
Total Funds - (D) Eligibility Determinations and Client Services	**105,723,148**	**106,596,800**	**166,317,140**	**152,173,824**	**(8.5%)**
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	14,956,508	17,719,722	25,392,979	23,326,505	(8.1%)
Cash Funds	24,326,741	23,912,244	39,987,446	38,113,793	(4.7%)
Reappropriated Funds	23,329	31,303	111,942	111,942	0.0%
Federal Funds	66,416,570	64,933,531	100,824,773	90,621,584	(10.1%)

(E) Utilization and Quality Review Contracts

Professional Service Contracts	**14,826,120**	**19,970,962**	**26,961,574**	**27,236,877** *	
General Fund	7,299,182	6,803,020	7,236,040	7,301,755	
Cash Funds	857,869	995,697	2,032,069	2,112,987	
Federal Funds	6,669,069	12,172,245	17,693,465	17,822,135	
Total Funds - (E) Utilization and Quality Review Contracts	**14,826,120**	**19,970,962**	**26,961,574**	**27,236,877**	**1.0%**
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	7,299,182	6,803,020	7,236,040	7,301,755	0.9%
Cash Funds	857,869	995,697	2,032,069	2,112,987	4.0%
Federal Funds	6,669,069	12,172,245	17,693,465	17,822,135	0.7%

(F) Provider Audits and Services

Professional Audit Contracts	**3,148,703**	**3,507,957**	**4,655,865**	**4,281,019**	
General Fund	1,361,059	1,524,776	1,816,102	1,645,679	
Cash Funds	281,124	346,850	582,801	565,801	
Federal Funds	1,506,520	1,636,331	2,256,962	2,069,539	
Total Funds - (F) Provider Audits and Services	**3,148,703**	**3,507,957**	**4,655,865**	**4,281,019**	**(8.1%)**
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,361,059	1,524,776	1,816,102	1,645,679	(9.4%)
Cash Funds	281,124	346,850	582,801	565,801	(2.9%)
Federal Funds	1,506,520	1,636,331	2,256,962	2,069,539	(8.3%)

(G) Recoveries and Recoupment Contract Costs

Estate Recovery	**843,618**	**749,055**	**700,000**	**700,000**	
Cash Funds	421,809	374,527	350,000	350,000	
Federal Funds	421,809	374,528	350,000	350,000	
Third-Party Liability Cost Avoidance Contract	**7,134,460**	**4,622,500**	**17,248,905**	**8,417,842** *	
General Fund	2,523,513	1,465,509	5,692,139	2,777,888	
Cash Funds	1,043,717	845,741	2,932,314	1,431,033	
Federal Funds	3,567,230	2,311,250	8,624,452	4,208,921	
Total Funds - (G) Recoveries and Recoupment Contract Costs	**7,978,078**	**5,371,555**	**17,948,905**	**9,117,842**	**(49.2%)**
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,523,513	1,465,509	5,692,139	2,777,888	(51.2%)
Cash Funds	1,465,526	1,220,268	3,282,314	1,781,033	(45.7%)
Federal Funds	3,989,039	2,685,778	8,974,452	4,558,921	(49.2%)

(H) Indirect Cost Assessment

Indirect Cost Assessment	**855,070**	**1,143,073**	**790,162**	**922,619**	
Cash Funds	364,495	132,859	274,461	198,368	
Reappropriated Funds	0	106,490	121,263	107,638	
Federal Funds	490,575	903,724	394,438	616,613	

Total Funds - (H) Indirect Cost Assessment	**855,070**	**1,143,073**	**790,162**	**922,619**	**16.8%**
FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0%**
Cash Funds	364,495	132,859	274,461	198,368	(27.7%)
Reappropriated Funds	0	106,490	121,263	107,638	(11.2%)
Federal Funds	490,575	903,724	394,438	616,613	56.3%

Total Funds - (1) Executive Director's Office	**300,850,123**	**301,096,298**	**515,367,186**	**550,518,044**	**6.8%**
FTE	**573.1**	**600.5**	**696.0**	**709.4**	**1.9%**
General Fund	66,181,310	72,943,948	112,985,620	131,630,260	16.5%
Cash Funds	42,046,210	43,479,898	102,142,238	84,923,811	(16.9%)
Reappropriated Funds	2,062,027	2,417,376	4,819,787	4,839,314	0.4%
Federal Funds	190,560,576	182,255,076	295,419,541	329,124,659	11.4%

(2) MEDICAL SERVICES PREMIUMS

Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.

Medical and Long-Term Care Services for Medicaid Eligible Individuals	**8,876,769,374**	**9,756,293,144**	**10,482,357,710**	**11,060,213,331** *	
General Fund	1,944,486,087	2,179,055,708	1,810,303,236	2,070,434,921	
General Fund Exempt	0	0	1,088,947,539	1,088,947,539	
Cash Funds	1,282,521,053	1,087,673,430	1,252,446,475	1,224,537,542	
Reappropriated Funds	40,766,832	82,610,308	90,013,408	100,294,784	
Federal Funds	5,608,995,402	6,406,953,698	6,240,647,052	6,575,998,545	

Total Funds - (2) Medical Services Premiums	**8,876,769,374**	**9,756,293,144**	**10,482,357,710**	**11,060,213,331**	**5.5%**
FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0%**
General Fund	1,944,486,087	2,179,055,708	1,810,303,236	2,070,434,921	14.4%
General Fund Exempt	0	0	1,088,947,539	1,088,947,539	0.0%
Cash Funds	1,282,521,053	1,087,673,430	1,252,446,475	1,224,537,542	(2.2%)
Reappropriated Funds	40,766,832	82,610,308	90,013,408	100,294,784	11.4%
Federal Funds	5,608,995,402	6,406,953,698	6,240,647,052	6,575,998,545	5.4%

Total Funds - Department of Health Care Policy and Financing	**9,177,619,497**	**10,057,389,442**	**10,997,724,896**	**11,610,731,375**	**5.6%**
FTE	**573.1**	**600.5**	**696.0**	**709.4**	**1.9%**
General Fund	2,010,667,397	2,251,999,656	1,923,288,856	2,202,065,181	14.5%
General Fund Exempt	0	0	1,088,947,539	1,088,947,539	0.0%
Cash Funds	1,324,567,263	1,131,153,328	1,354,588,713	1,309,461,353	(3.3%)
Reappropriated Funds	42,828,859	85,027,684	94,833,195	105,134,098	10.9%
Federal Funds	5,799,555,978	6,589,208,774	6,536,066,593	6,905,123,204	5.6%

APPENDIX B
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

The General Assembly includes footnotes in the annual Long Bill to: (a) set forth purposes, conditions, or limitations on an item of appropriation; (b) explain assumptions used in determining a specific amount of an appropriation; or (c) express legislative intent relating to any appropriation. Footnotes to the 2021 Long Bill (S.B. 21-205) can be found at the end of each departmental section of the bill at https://leg.colorado.gov/bills/HB22-1329. The Long Bill footnotes relevant to this document are listed below.

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

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

17 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects -- Of this appropriation, the $22,439,275 cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2023-24 state fiscal year.

Comment: The use of the funds from the Home- and Community-based Services (HCBS) Improvement Fund is described in the American Rescue Plan Act HCBS Spending Plan developed pursuant to S.B. 21-286 (Distribution of Federal Funds for HCBS).

18 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects -- Of this appropriation, the $7,509,302 cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2023-24 state fiscal year.

Comment: The use of the funds from the Home- and Community-based Services (HCBS) Improvement Fund is described in the American Rescue Plan Act HCBS Spending Plan developed pursuant to S.B. 21-286 (Distribution of Federal Funds for HCBS).

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

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

20 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2023-24 state fiscal year.

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

21 Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- Of this appropriation, the $40,944,853 cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2023-24 state fiscal year.

22 Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- This line item includes $1,044,059 total funds, including $500,000 General Fund, for the purpose of expanding the non-invasive pre-natal testing benefit.

UPDATE ON LONG BILL REQUESTS FOR INFORMATION

The Joint Budget Committee annually submits requests for information to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2022-23 Report):

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

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

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

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

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

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

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

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

APPENDIX C
DEPARTMENT ANNUAL PERFORMANCE REPORT

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

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2023-24 budget request, the FY 2021-22 Annual Performance Report and the FY 2022-23 Performance Plan can be found at the following link:

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