JOINT
BUDGET
COMMITTEE

STAFF FIGURE SETTING
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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HOW TO USE THIS DOCUMENT

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

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

In some of the analysis of decision items in this document, you may see language denoting certain 'levels of evidence', e.g. theory-informed, evidence-informed, or proven. For a detailed explanation of what is meant by 'levels of evidence', and how those levels of evidence are categorized, please refer to Section 2-3-210 (2), C.R.S.

DEPARTMENT OVERVIEW

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

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

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

SUMMARY OF STAFF RECOMMENDATIONS

In the table below, the items shaded in yellow will be discussed during figure setting for Behavioral Health or the Office of Community Living rather.

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	255,337,083	(226,654,689)	(7,154,037)	46,276	489,099,533	30.1
Recommended Long Bill Add-on	230,058,964	(199,264,983)	59,855,587	0	369,468,360	0.0
TOTAL	**$14,661,259,722**	**$3,653,818,793**	**$1,857,791,102**	**$95,031,721**	**$9,054,618,106**	**741.8**
FY 2023-24 Recommended Appropriation						
FY 2022-23 Appropriation	$14,661,259,722	$3,653,818,793	$1,857,791,102	$95,031,721	$9,054,618,106	741.8
Enrollment/utilization trends						
R1 Medical Services Premiums	160,173,584	459,048,342	(23,454,035)	(6,310,453)	(269,110,270)	0.0
R2 Behavioral Health	76,203,576	45,426,079	(1,413,228)	0	32,190,725	0.0
R3 Child Health Plan Plus	46,988,338	19,576,972	(571,891)	0	27,983,257	0.0
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
R5 Office of Community Living	52,858,713	67,353,095	(291,256)	0	(14,203,126)	0.0
BA9 Public school health services	8,828,258	0	9,518,849	0	(690,591)	0.0
Subtotal - Enrollment/utilization trends	*348,338,273*	*594,690,292*	*(16,211,561)*	*(6,310,453)*	*(223,830,005)*	*0.0*
Benefits/eligibility adjustments						
R9 Perinatal services	1,670,879	818,373	0	0	852,506	0.0
R10a Skilled respite for children	3,274,471	0	1,637,236	0	1,637,235	0.0
Subtotal - Benefits/eligibility adjustments	*4,945,350*	*818,373*	*1,637,236*	*0*	*2,489,741*	*0.0*

Department Of Health Care Policy And Financing						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Provider rates						
R6 Value-based payments	8,897,109	2,871,558	326,112	0	5,699,439	0.0
R7a Provider rates	163,656,476	61,534,993	6,364,320	0	95,757,163	0.0
R7b Targeted provider rates	124,590,841	40,289,535	13,810,844	0	70,490,462	0.0
BA19 Alternative payment model	2,750,667	735,028	157,297	0	1,858,342	0.0
Subtotal - Provider rates	*299,895,093*	*105,431,114*	*20,658,573*	*0*	*173,805,406*	*0.0*
R8 Cost and quality indicators	7,305,880	976,856	701,458	0	5,627,566	0.0
R10b Children with complex needs	648,645	192,129	132,193	0	324,323	3.6
R11 Compliance	(9,611,364)	(3,101,499)	(1,502,994)	0	(5,006,871)	6.4
R12 Non Medicaid BH eligibility & claims	2,738,635	2,738,635	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	(107,195)	(45,322)	(8,276)	0	(53,597)	3.7
R15 Transfers between lines	0	0	0	0	0	0.0
BA6 Eligibility redeterminations	12,891,024	3,176,828	1,278,762	0	8,435,434	0.0
BA7 Community based access to services	6,341,474	175,000	2,974,232	0	3,192,242	0.0
BA8 ARPA HCBS adjustments	37,376,530	0	19,420,499	0	17,956,031	5.7
BA10 Provider enrollment fee & estate recoveries	0	85,525	(517,603)	0	432,078	0.0
BA11 Behavioral health crisis response	338,400	338,400	0	0	0	0.0
BA12 eConsult technical adjustment	0	0	0	0	0	0.0
BA20 Clinical navigation services	271,904	135,953	0	0	135,951	1.9
NP Promoting equity through technology	3,475,761	487,674	204,431	374,415	2,409,241	4.6
NP Statewide operating inflation	326,891	136,797	24,356	4,649	161,089	0.0
NP Local Affairs housing vouchers	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
Centrally appropriated items	9,622,759	4,337,030	435,760	(64,564)	4,914,533	5.0
Human Services programs	2,575,472	1,268,980	0	0	1,306,492	0.0
Indirect cost recoveries	264,914	0	(76,093)	118,832	222,175	0.0
Annualize prior year budget actions	(7,674,075)	87,991,062	(133,505,086)	11,156,916	26,683,033	(12.1)
Transfers to other state agencies	1,063	532	0	0	531	0.0
Tobacco forecast	(53,250)	(26,625)	(26,625)	0	0	0.0
Technical adjustment	0	0	0	0	0	0.0
TOTAL	**$15,380,558,327**	**$4,451,686,583**	**$1,754,943,519**	**$100,311,516**	**$9,073,616,709**	**769.0**
Increase/(Decrease)	**$719,298,605**	**$797,867,790**	**($102,847,583)**	**$5,279,795**	**$18,998,603**	**27.2**
Percentage Change	4.9%	21.8%	(5.5%)	5.6%	0.2%	3.7%
FY 2023-24 Executive Request	**$14,970,628,423**	**$4,439,026,247**	**$1,756,542,318**	**$105,752,975**	**$8,669,306,883**	**785.5**
Request Above/(Below) Recommendation	($409,929,904)	($12,660,336)	$1,598,799	$5,441,459	($404,309,826)	16.5

DESCRIPTION OF INCREMENTAL CHANGES

FY 23-24

Recommended Long Bill Add-on: Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast and technical corrections. See the descriptions of R1 through R5 for more information.

FY 24-25

ENROLLMENT/UTILIZATION TRENDS

R1 MEDICAL SERVICES PREMIUMS: Staff recommends a net increase of $160.1 million total funds, including $459.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item.

R3 CHILD HEALTH PLAN PLUS: Staff recommends a net increase of $47.0 million total funds, including $19.6 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan.

R4 MEDICARE MODERNIZATION ACT: Staff recommends a net increase of $3.3 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

BA9 PUBLIC SCHOOL HEALTH SERVICES: Staff recommends a net increase of $8.8 million total funds for public school health services based on an updated projection of certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

BENEFITS/ELIGIBILITY ADJUSTMENTS

R9 PERINATAL SERVICES [INCLUDES LEGISLATION]: Staff recommends an increase of $1.7 million total funds, including $818,373 General Fund, for a new doula benefit and new donor milk benefit. In addition, staff recommends the JBC sponsor legislation to authorize the Department to operate a doula training and scholarship program and provide $100,000 General Fund for that purpose.

PROVIDER RATES

R6 VALUE-BASED PAYMENTS: Staff recommends $8.9 million total funds, including $2.9 million General Fund, for training and incentives for primary care providers to transition to an Alternative Payment Model (APM). This APM will pay primary care providers a partial capitation payment and allow them to earn incentives for performance in managing the care of members with chronic conditions.

R7A PROVIDER RATES: Staff recommends $163.7 million total funds, including $61.5 million General Fund, for an across-the-board increase of 3.0 percent, consistent with the JBC's common policy. The recommendation includes $3.1 million total funds, including $1.5 million General Fund, to apply the increase to non-medical transportation and Group Residential Services and Supports rates in addition to the recommended targeted rate adjustment. The Department had proposed the targeted rate adjustment for these rates in lieu of a common policy adjustment.

R7B TARGETED PROVIDER RATES [INCLUDES LEGISLATION]: Staff recommends a net increase of $124.6 million total funds, including $40.3 million General Fund, for several targeted provider rate adjustments summarized in the table below. In addition, staff recommends that the JBC sponsor legislation to increase nursing home rates and eliminate member copays for pharmacy and outpatient

services. The proposed legislation adds $42.9 million total funds, including $18.9 million General Fund, to the total recommendation.

R7(b) Targeted Rate Adjustments FY 2023-24					
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Rate Review Rebalancing Recommendations					
Physician services	80-100% of benchmark - net 2%	20,160,924	6,045,729	831,971	13,283,224
Eyeglasses and vision	80-100% of benchmark - net 41%	19,170,361	5,748,685	791,094	12,630,582
Laboratory & pathology	80-100% of benchmark - net 4%	2,453,574	531,849	138,476	1,783,249
Dialysis & nephrology	80-100% of benchmark - net 5%	427,077	90,531	26,405	310,141
Injections & miscellaneous J-Codes	80-100% of benchmark - net -9%	(107,757)	(32,313)	(4,448)	(70,996)
Subtotal - Rate Review Rebalance		42,104,179	12,384,481	1,783,498	27,936,200
Other Provider Rate Adjustments					
Minimum wage adjustment for HCBS	$15.75 per hour/$17.29 in Denver	56,953,319	18,850,369	9,056,774	29,046,176
Non-medical transportation - Adult Comp	Align with other waivers - 48.9%	10,050,656	3,299,629	1,625,191	5,125,836
Non-medical transportation - SLS	Align with other waivers - 48.9%	4,299,137	1,411,407	695,170	2,192,560
Group Residential Service and Supports	Align with other services - 18.6%	9,099,372	3,935,213	523,480	4,640,679
Eliminate most non-statutory copays	Retain non-emergent ER copays	2,084,178	408,436	126,731	1,549,011
Subtotal - Other Provider Rate Adjustments		82,486,662	27,905,054	12,027,346	42,554,262
Changes Recommended in Long Bill		**124,590,841**	**40,289,535**	**13,810,844**	**70,490,462**
Proposed Legislation					
Nursing facility rates - Set aside	$18.37/day incr. (on av.)	35,593,248	17,440,692	0	18,152,556
Eliminate statutory copays	Pharmacy and outpatient services	7,345,507	1,439,499	446,651	5,459,357
Subtotal - Proposed Legislation		42,938,755	18,880,191	446,651	23,611,913
TOTAL Recommended Changes		**$167,529,596**	**$59,169,726**	**$14,257,495**	**$94,102,375**
Requests NOT Recommended by JBC Staff					
Rural health provider technology payments	Incentive for connecting to HIE	$4,220,000	$2,067,800	$0	$2,152,200

BA19 ALTERNATIVE PAYMENT MODEL: Staff recommends $2.8 million total funds, including $735,028 General Fund for to annualize a supplemental approved by the General Assembly that reduced the estimated savings associated with the prescriber tool and authorized a revised plan for sharing the savings with providers that gives providers 100 percent of the savings in FY 2023-24, 75 percent in FY 2024-25, and 50 percent thereafter.

ADMINISTRATION AND OTHER

R8 COST AND QUALITY INDICATORS: Staff recommends $7.3 million total funds, including $976,856 General Fund, for collecting and sharing health care data among community partners, and to continue development of cost and quality indicators to determine trends in underlying data.

R10B CHILDREN WITH COMPLEX NEEDS: Staff recommends $648,645 total funds, including $192,129 General Fund, for four new positions (3.7 FTE in the first year) to create a department team for children with complex and co-occurring needs, and for a budget neutral move of $6.1 million total funds, including $3.0 million General Fund, from the Medical Services Premiums line item to the Behavioral Health Capitation Payments line item to reflect an administrative change in how the Department covers behavioral health services for people with autism spectrum disorder

R11 COMPLIANCE: Staff recommends a decrease of $9.6 million total funds, including a decrease of $3.1 million General Fund, and 6.4 FTE to expand and strengthen operational compliance and program oversight and accountability and true up a contract that helps determine and collect third-party liability.

R14 CONVERT CONTRACTS TO FTE: Staff recommends a net decrease of $107,195 total funds, including a decrease of $45,322 General Fund, and an increase of 3.7 FTE to bring work previously done by contractors in-house.

R15 TRANSFERS BETWEEN LINES: Staff recommends 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 reporting analysis contract out of the MMIS line item and into the All-Payer Claims Database line item.

BA6 ELIGIBILITY REDETERMINATIONS: Staff recommends $12.9 million total funds, including $3.2 million General Fund, to annualize funding provided in FY 2022-3 to process eligibility redeterminations when the continuous coverage requirement for Medicaid ends.

BA10 PROVIDER ENROLLMENT FEE & ESTATE RECOVERIES: Staff recommends a net $0 total funds adjustment, including an increase of $85,525 General Fund, to annualize a supplemental that spent down a one-time balance of provider enrollment fees that had accumulated in the Health Care Policy and Financing Cash Fund in order to offset administrative costs of screening providers, such as verifying medical licensing, checking federal databases, and site visits.

BA12 ECONSULT TECHNICAL ADJUSTMENT: Staff does not recommend the requested move of funding associated with clinical and quality reviews for the eConsult program from the Provider Audits and Services, Professional Audit Contracts line item to the Medicaid Management Information System Maintenance and Projects line item, consistent with the JBC's action on the supplemental.

NP PROMOTING EQUITY THROUGH TECHNOLOGY: This is a nonprioritized request to address equity issues through technology.

NP STATEWIDE OPERATING INFLATION: This is a nonprioritized request for an inflationary increase for operating expenses

NP LOCAL AFFAIRS HOUSING VOUCHERS: This is a nonprioritized request adjusting Medical Services Premiums expenditures based on the availability of housing vouchers in the Department of Local Affairs.

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; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor’s Office of Information Technology (OIT); and CORE operations.

HUMAN SERVICES PROGRAMS: This is the request for programs that are financed with Medicaid funds but operated by the Department of Human Services. The amounts will be updated based on the JBC's final action on funding for the Department of Human Services.

Indirect cost recoveries: The staff recommends an increase of $264,914 total funds based on the indirect cost plan approved by the JBC.

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						
Item	Total	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 funding adjustment and contractor conversion	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 children and pregnant people	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 payment models	254,250	254,250	0	0	0	0.0
FY 2023-24 S12 eConsult	250,000	125,000	0	0	125,000	0.0
FY 2022-23 BA9 eConsult program	208,706	71,385	85,789	0	51,532	0.0

Annualize Prior Year Budget Actions						
Item	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
HB 21-1085 Secure trans behavioral health crisis	192,768	88,869	7,515	0	96,384	0.0
SB 22-235 HUM County administration of public assistance programs	80,000	24,060	15,940	0	40,000	0.0
FY 2021-22 R9 Patient access & interoperability rule compliance	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 HUM Prior year salary survey	9,919	4,958	0	0	4,961	0.0
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 interest	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 BA6 PHE county administration resources	0	0	0	0	0	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 2023-24 Safety Net Provider Payments	(18,525,826)	0	(9,262,913)	0	(9,262,913)	0.0
FY 2022-23 R8 County administration oversight and accountability	(16,519,749)	(3,838,321)	(935,408)	0	(11,746,020)	0.1
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
SB 23-138 Payments to Denver Health and Hospital Authority	(5,000,000)	(5,000,000)	0	0	0	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 home workers	(3,071,863)	(1,535,932)	0	0	(1,535,931)	0.0
FY 2023-24 S21 Denver Health one-time payment	(1,423,920)	(1,423,920)	0	0	0	0.0
FY 2023-24 S13 Utilization & quality review disallowance	(1,183,837)	(1,183,837)	0	0	0	0.0
FY 2021-22 R6 Remote supports for HCBS programs	(716,615)	(348,347)	(9,960)	0	(358,308)	0.0
SB 23-117 Supplemental bill	(328,553)	(171,691)	0	0	(156,862)	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 contractor resources to FTE	(274,786)	(117,182)	(2,873)	(13,099)	(141,632)	0.8
FY 2021-22 BA10 PHE end resources	(265,697)	(79,603)	(53,245)	0	(132,849)	0.0
HB 22-1114 Transportation services Medicaid waivers	(146,758)	(52,129)	(2,567)	0	(92,062)	0.0
HB 21-1166 Behavioral health crisis response 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 Organization supplemental payments	(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

Annualize Prior Year Budget Actions						
Item	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
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 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	**($7,674,075)**	**$87,991,062**	**($133,505,086)**	**$11,156,916**	**$26,683,033**	**(12.1)**

TRANSFERS TO OTHER STATE AGENCIES: This reflects requested adjustments to transfers to other state agencies. The amount will be updated to reflect the JBC's final action on funding for the other departments.

TOBACCO FORECAST: Staff recommends an increase of $259,589 total funds, including $3.2 million General Fund, for programs that are financed with Medicaid funds, but operated by the Department of Human Services.

MAJOR DIFFERENCES FROM THE REQUEST

The largest dollar differences between the request and the JBC staff recommendation are due to the JBC staff using the Department's February 2023 forecast of expenditures for Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, the Medicare Modernization Act, and the Office of Community Living rather than the November 2022 forecast that was used for the Governor's request. The table below summarizes the differences between the February 2023 and November 2022 forecasts for all of the forecasted programs.

February 2023 Forecast Higher/(Lower) than November 2022 Forecast					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 22-23					
Medical Services Premiums	$296,800,926	($131,010,469)	$48,221,126	$0	$379,590,269
Behavioral Health	(38,126,686)	(24,012,937)	3,138,239	0	(17,251,988)
Children's Basic Health Plan	(19,338,953)	(8,202,318)	341,509	0	(11,478,144)
Medicare Modernization Act	(1,699,903)	(1,699,903)	0	0	0
Office of Community Living	(28,747,810)	(36,421,057)	(579,040)	0	8,252,287
TOTAL	**$208,887,574**	**($201,346,684)**	**$51,121,834**	**$0**	**$359,112,424**
% Change *from Nov Forecast*	1.6%	-5.5%	3.6%	0.0%	4.4%
FY 23-24					
Medical Services Premiums	304,997,366	11,830,937	18,774,417	(5,414,909)	279,806,921
Behavioral Health	93,865,041	13,286,813	8,052,615	0	72,525,613
Children's Basic Health Plan	(31,322,239)	(12,641,675)	451,871	0	(19,132,435)
Medicare Modernization Act	18,311,834	18,311,834	0	0	0
Office of Community Living	(27,444,405)	(22,501,364)	(199,574)	0	(4,743,467)
TOTAL	**$358,407,597**	**$8,286,545**	**$27,079,329**	**($5,414,909)**	**$328,456,632**
% Change *from Nov Forecast*	2.7%	0.2%	2.0%	-5.4%	4.2%

February 2023 Forecast Higher/(Lower) than November 2022 Forecast					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Cumulative Over Both Years					
Medical Services Premiums	601,798,292	(119,179,532)	66,995,543	(5,414,909)	659,397,190
Behavioral Health	55,738,355	(10,726,124)	11,190,854	0	55,273,625
Children's Basic Health Plan	(50,661,192)	(20,843,993)	793,380	0	(30,610,579)
Medicare Modernization Act	16,611,931	16,611,931	0	0	0
Office of Community Living	(56,192,215)	(58,922,421)	(778,614)	0	3,508,820
TOTAL	**$567,295,171**	**($193,060,139)**	**$78,201,163**	**($5,414,909)**	**$687,569,056**
% Change *from Nov Forecast*	2.1%	-2.5%	2.8%	-2.8%	4.3%

DECISION ITEMS

ENROLLMENT/UTILIZATION TRENDS

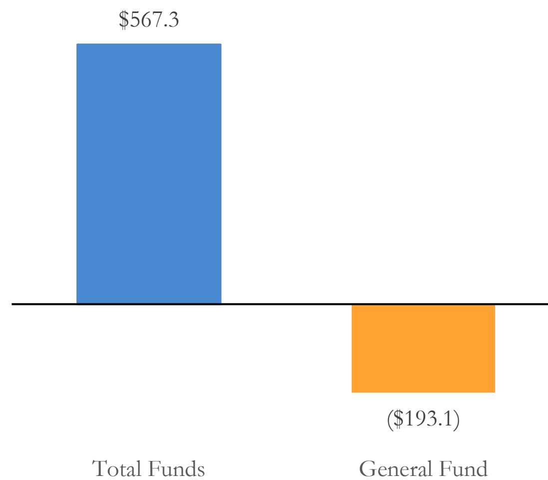
Requests R1 through R5 and BA9 propose changes to both FY 2022-23 and FY 2023-24 based on a new forecast of caseload and expenditures under current law and policy. They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

On February 15, 2023, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2022 forecast used for the Governor's request incorporated data through June 2022. The February 2023 forecast incorporates data through December 2022.

The table below shows the incremental difference between the February 2023 forecast and the November 2022 forecast for all of the forecast requests. This comparison can be useful in understanding how much more or less there is to work with in the overall budget compared to the Governor's request, based on the new information in the February forecast. For this purpose, it is most useful to focus on the cumulative change over both years.

February 2023 Forecast Higher/(Lower) than November 2022 Forecast					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 22-23					
Medical Services Premiums	$296,800,926	($131,010,469)	$48,221,126	$0	$379,590,269
Behavioral Health	(38,126,686)	(24,012,937)	3,138,239	0	(17,251,988)
Children's Basic Health Plan	(19,338,953)	(8,202,318)	341,509	0	(11,478,144)
Medicare Modernization Act	(1,699,903)	(1,699,903)	0	0	0
Office of Community Living	(28,747,810)	(36,421,057)	(579,040)	0	8,252,287
TOTAL	**$208,887,574**	**($201,346,684)**	**$51,121,834**	**$0**	**$359,112,424**
% Change *from Nov Forecast*	1.6%	-5.5%	3.6%	0.0%	4.4%
FY 23-24					
Medical Services Premiums	304,997,366	11,830,937	18,774,417	(5,414,909)	279,806,921
Behavioral Health	93,865,041	13,286,813	8,052,615	0	72,525,613
Children's Basic Health Plan	(31,322,239)	(12,641,675)	451,871	0	(19,132,435)
Medicare Modernization Act	18,311,834	18,311,834	0	0	0
Office of Community Living	(27,444,405)	(22,501,364)	(199,574)	0	(4,743,467)
TOTAL	**$358,407,597**	**$8,286,545**	**$27,079,329**	**($5,414,909)**	**$328,456,632**
% Change *from Nov Forecast*	2.7%	0.2%	2.0%	-5.4%	4.2%
Cumulative Over Both Years					
Medical Services Premiums	601,798,292	(119,179,532)	66,995,543	(5,414,909)	659,397,190

February 2023 Forecast Higher/(Lower) than November 2022 Forecast					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Behavioral Health	55,738,355	(10,726,124)	11,190,854	0	55,273,625
Children's Basic Health Plan	(50,661,192)	(20,843,993)	793,380	0	(30,610,579)
Medicare Modernization Act	16,611,931	16,611,931	0	0	0
Office of Community Living	(56,192,215)	(58,922,421)	(778,614)	0	3,508,820
TOTAL	**$567,295,171**	**($193,060,139)**	**$78,201,163**	**($5,414,909)**	**$687,569,056**
% Change *from Nov Forecast*	2.1%	-2.5%	2.8%	-2.8%	4.3%



Cumulative over the two fiscal years the February forecast is up $567.3 million total funds, but down $193.1 million General Fund. In the Governor's January 3 budget letter, the Governor anticipated a reduction in the forecast of $100.0 million, based on the federal Consolidated Appropriations Act of 2023. The actual forecast is $93.1 million General Fund below what the Governor assumed. It is important to note that the difference is primarily one-time savings due to an over-forecast of FY 22-23. The forecasted General Fund for FY 23-24 is almost unchanged. The JBC should be cautious about allocating the one-time General Fund savings from FY 22-23 for on-going needs.

The overall change in the forecast is largely attributable to the extension, by the federal Consolidated Appropriations Act of 2023, of the enhanced federal match and the continuous coverage requirement. The enhanced federal match now begins phasing down in April 2022 and the continuous coverage requirement ends in April 2022. The extension of the enhanced federal match saves General Fund. The extension of the continuous coverage requirement increases enrollment projections because it increases both the amount of time and the number of people "locked in" to Medicaid during this period when states cannot disenroll people from Medicaid.

The tables below summarize the applicable federal match rates by fiscal quarter.

Standard Medicaid Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	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	55.90	56.20	56.20	56.20	55.00
FY 23-24	51.00	52.50	51.50	50.00	50.00
FY 24-25	*50.00*	50.00	*50.00*	*50.00*	*50.00*

Italicized figures are projections.

ACA "Newly Eligible" Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	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

CHP+ Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	88.00	88.00	88.00	88.00	88.00
FY 19-20	81.55	88.00	76.50	80.84	80.84
FY 20-21	72.22	80.84	69.34	69.34	69.34
FY 21-22	69.34	69.34	69.34	69.34	69.34
FY 22-23	69.13	69.34	69.34	69.34	68.50
FY 23-24	65.70	66.75	66.05	65.00	65.00
FY 24-25	*65.00*	65.00	*65.00*	*65.00*	*65.00*

Italicized figures are projections.

➔ R1 Medical Services Premiums

Request

The Department requests a change to the Medical Services Premiums appropriation for both FY 22-23 and FY 23-24 based on a new forecast of caseload and expenditures under current law and policy. Medical Services Premiums pays for physical health and most long-term services and supports[1] for people eligible for Medicaid.

On February 15, 2023, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2023 forecast is higher than the forecast used for the Governor's request by $296.8 million total funds in FY 22-23 and $305.0 million total funds in FY 23-

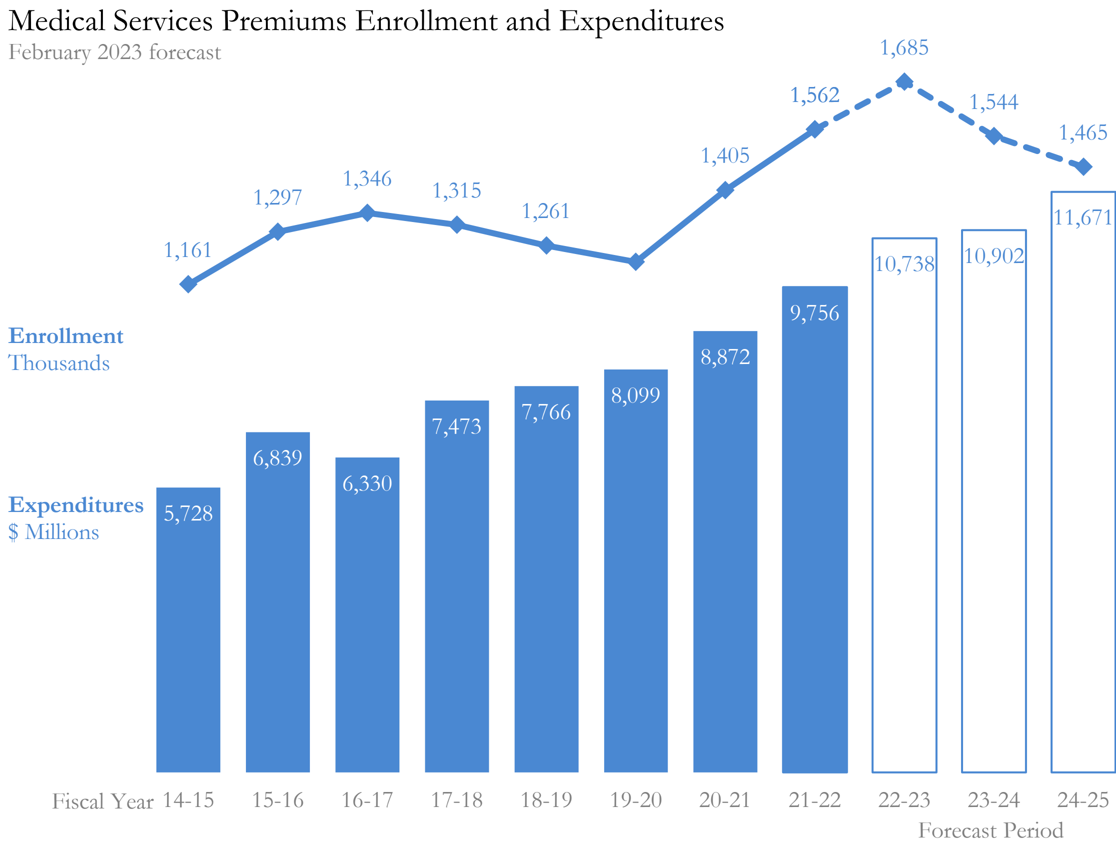
[1] The exception is long-term services and supports for people with intellectual and developmental disabilities, which are funded in the Office of Community Living.

24. However, in General Fund the February 2023 forecast is lower than the Governor's request by $131.0 million in FY 22-23 and $14.4 million in FY 23-24. The cumulative General Fund difference over the two years is $145.4 million lower than the Governor's November request.

RECOMMENDATION

Staff recommends using the Department's February 2023 forecast of enrollment and expenditures to modify both the FY 22-23 and FY 23-24 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



FY 22-23

The table below shows the most significant factors driving the change in the Department's forecast for FY 22-23. Note that this table displays changes from the appropriation and not changes from FY 21-22. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2022-23 Medical Services Premiums Enrollment/Utilization Trends (from FY 2022-23 appropriation)				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2022-23 Appropriation	$10,738,060,133	2,738,702,957	1,338,539,256	6,660,817,920
Acute Care				
Enrollment	386,295,969	122,069,229	12,602,043	251,624,698
Per capita	(177,615,367)	(67,788,215)	4,223,376	(114,050,529)
Subtotal - Acute Care	*208,680,602*	*54,281,014*	*16,825,419*	*137,574,169*
Long-term Services and Supports				
HCBS waivers	30,394,762	13,407,999	2,320,379	14,666,384
Long-Term Home Health/PDN/Hospice	7,521,931	3,760,965	0	3,760,966
Nursing homes	(35,220,315)	(16,499,490)	(31,405)	(18,689,420)
PACE	(4,593,318)	(2,296,659)	0	(2,296,659)
Subtotal - LTSS	*(1,896,940)*	*(1,627,185)*	*2,288,974*	*(2,558,729)*
Medicare & private premiums	8,547,423	4,683,820	0	3,863,603
Service management	16,028,196	4,185,644	1,980,997	9,861,555
Federal match	0	(195,441,856)	30,594,971	164,846,885
Supplemental payments	67,521,878	0	(2,535,141)	70,057,019
Other financing	(2,080,233)	2,908,094	(934,094)	(4,054,233)
TOTAL	**$11,034,861,059**	**$2,607,692,488**	**$1,386,760,382**	**$7,040,408,189**
Increase/(Decrease)	296,800,926	(131,010,469)	48,221,126	379,590,269
Percentage Change	2.8%	-4.8%	3.6%	5.7%

Acute care

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

- Enrollment – The increased forecast is primarily driven by the extension of the continuous eligibility requirement, but it includes a 2 percent increase for the elderly and people with disabilities that is largely driven by the disabled buy-in population.
- Per capita - The Department lowered the forecast of per capita expenses primarily due to those on continuous coverage incurring lower costs. These decreases are somewhat offset by slightly higher than expected costs for the elderly and people with disabilities. The Department anticipates that per capita costs will gradually increase over time with the conclusion of the continuous coverage requirement.

Long-term Services and Supports

The Department increased the forecast for Home- and Community-Based Services (HCBS) by 3 percent based on year-to-date trends in the number of utilizers and services per utilizer. 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 increased the forecast for Long-Term Home Health (LTHH), Private Duty Nursing (PDN), and hospice by 1 percent, primarily due to utilize of LTHH. These increases are largely offset, though, by a 5 percent decrease in projected nursing facility patient days. The utilization of nursing homes has not recovered as quickly as the Department expected from the pandemic. The Department also reduced projected expenditures for the Program for All-

inclusive Care for the Elderly (PACE), primarily due to the temporary moratorium on InnovAge, which has now been lifted.

<u>Other Changes</u>

- Medicare insurance premiums – Actual enrollment of people who are dually eligible for Medicaid and Medicare is running higher than expected.
- Service management – The increase mirrors the projected increase in enrollment as most payments for service management are per member per month.
- Federal match – The forecast includes a decrease of $195.4 million General Fund attributable and corresponding increases in cash funds and federal funds due to the extension of the enhanced federal match. The cash funds are net positive because S.B. 21-213 requires that certain decreases in cash fund obligations due to the enhanced federal match be applied to offset General Fund. Almost all of the increase in cash funds and corresponding decrease in General Fund driven by S.B. 21-213 is attributable to the HAS Fee.
- Supplemental payments – The Department increased the forecast of allowable supplemental payments to hospitals within the federal limits by $67.5 million.

FY 23-24

The next table shows the most significant factors driving the forecasted change in expenditures from FY 22-23 to FY 23-24. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2023-24 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2023-24 Projection	$11,034,861,059	2,607,692,488	1,386,760,382	7,040,408,189
Acute Care				
Enrollment	(603,468,347)	(190,780,850)	(29,944,220)	(382,743,277)
Per capita	561,906,646	206,021,549	16,147,390	339,737,707
Subtotal - Acute Care	*(41,561,701)*	*15,240,699*	*(13,796,830)*	*(43,005,570)*
Long-term Services and Supports				
HCBS waivers	94,162,921	45,344,571	744,014	48,074,336
Long-Term Home Health/PDN/Hospice	62,581,907	31,290,953	0	31,290,954
Nursing homes	44,956,561	23,258,765	0	21,697,796
PACE	46,695,990	22,881,035	0	23,814,955
Subtotal - LTSS	*248,397,379*	*122,775,324*	*744,014*	*124,878,041*
Medicare & private premiums	(12,917,897)	(7,211,478)	0	(5,706,419)
Service management	(28,044,772)	(7,717,641)	(3,663,774)	(16,663,357)
Expiration of ARPA funding	(4,281,208)	36,951,941	(41,233,149)	0
Federal match	0	349,397,618	(49,178,309)	(300,219,309)
Supplemental payments	(4,073,723)	0	43,471,718	(47,545,441)
CUSOM payments	9,786,069	0	4,866,467	4,919,602
Other financing	4,608,959	(3,996,222)	733,095	7,872,086
TOTAL	**$11,206,774,165**	**$3,113,132,729**	**$1,328,703,614**	**$6,764,937,822**
Increase/(Decrease)	171,913,106	505,440,241	(58,056,768)	(275,470,367)
Percentage Change	1.6%	19.4%	-4.2%	-3.9%

Acute Care

- Enrollment – The overall projected decrease in enrollment is driven by the end of the continuous coverage requirement.
- Per capita –The Department forecasts increasing per capita costs in FY 23-24 due to disenrollments of less expensive members.

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 the number of utilizers to increase 2.3 percent and costs per utilizer to increase 6.8 percent.
- Long-term 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 projected increase is primarily driven by an expected 8.9 percent increase in utilization.
- Nursing homes – The Department projects a 3.6 percent increase in patient days and a 3 percent increase in per diem rates pursuant to statute.
- PACE – The Department projects a 3.5 percent increase in cost per enrollee and 12.4 percent increase in enrollment with the end of the temporary enrollment moratorium for InnovAge.

Other

- Medicare insurance premiums - For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. The Department projects a 4.6 percent decrease in enrollment, primarily due to the end of continuous eligibility.
- Service management – The decrease mirrors the projected decrease in enrollment as most payments for service management are per member per month.
- Expiration of ARPA funding – One-time federal funds from the American Rescue Plan Act (ARPA) that were deposited in the HCBS Improvement Fund are no longer available.
- Federal match rate – The forecast includes an increase of $349.4 million General Fund and a corresponding decrease in cash funds and federal funds due to the phase out of the enhanced federal match.
- Supplemental payments – The Department projects a decrease in supplemental payments that are financed with the Healthcare Affordability and Sustainability (HAS) Fee, based on projections of the federal Upper Payment Limit and net patient revenue.
- CUSOM payments – The forecast assumes an increase in University of Colorado School of Medicine (CUSOM) payments. This will be updated based on the JBC's actions during figure setting for the Department of Higher Education.
- Other – The Department forecasts miscellaneous other changes in financing. The net change is primarily driven recoveries.

➔ R3 Child Health Plan plus

Request

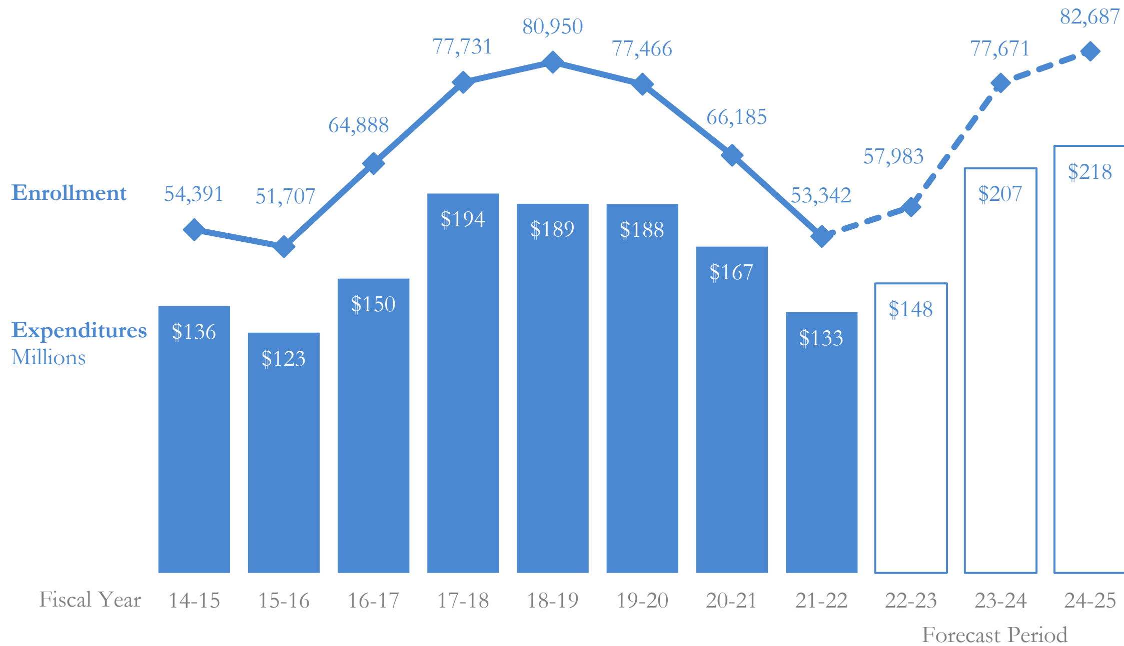
The Department requests a change to the Child Health Plan Plus (CHP+) for both FY 22-23 and FY 23-24 based on a new forecast of caseload and expenditures under current law and policy. The CHP+ pays for physical health services for eligible children and pregnant women and for dental services for children.

On February 15, 2023, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2023 forecast is lower than the forecast used for the Governor's request by $19.3 million total funds, including $7.8 million General Fund, in FY 22-23 and $31.3 million total funds, including $12.7 million General Fund, in FY 23-24. The cumulative General Fund difference over the two years is $20.5 million lower than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2023 forecast of enrollment and expenditures to modify both the FY 22-23 and FY 23-24 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



FY 22-23

The table below shows the most significant factors driving the change in the Department's forecast for FY 22-23. Note that this table displays changes from the appropriation and not changes from FY 21-22. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2022-23 Children's Basic Health Plan Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Appropriation	$182,938,101	$24,514,105	$39,470,009	$118,953,987
Enrollment	(19,069,393)	(5,875,438)	617,569	(13,811,524)
Per capita	(269,560)	(83,054)	(159)	(186,347)
CHP+ Trust balance	0	(2,243,826)	2,243,826	0
Federal match for public health emergency	0	0	(2,595,469)	2,595,469
TOTAL	**$163,599,148**	**$16,311,787**	**$39,735,776**	**$107,551,585**
Increase/(Decrease)	(19,338,953)	(8,202,318)	265,767	(11,402,402)
Percentage Change	-10.6%	-33.5%	0.7%	-9.6%

The Department reduced the enrollment forecast primarily due to the extension of the continuous eligibility requirement. During the continuous eligibility period there are clients churning from CHP+ to Medicaid but no clients churning from Medicaid to CHP+.

The Department made small changes to per capita assumptions and funds available in the CHP+ Trust to offset General Fund.

FY 23-24

The next table shows the most significant factors driving the forecasted change in expenditures from FY 22-23 to FY 23-24. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2023-24 Children's Basic Health Plan Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Projection	$163,599,148	$16,311,787	$39,735,776	$107,551,585
Enrollment	39,121,600	10,375,225	(373,613)	29,119,988
Per capita	7,609,631	1,945,436	0	5,664,195
CHP+ Trust balance	0	2,243,826	(2,243,826)	0
Federal match for public health emergency	0	5,017,165	2,461,885	(7,479,050)
TOTAL	**$210,330,379**	**$35,893,439**	**$39,580,222**	**$134,856,718**
Increase/(Decrease)	46,731,231	19,581,652	(155,554)	27,305,133
Percentage Change	28.6%	120.0%	-0.4%	25.4%

The projected increase in total funds for FY 2023-24 is primarily driven by an expected significant jump in enrollment with the end of the continuous eligibility requirement. For the General Fund

increase, other contributing factors include the phase out of the enhanced federal match and the end of a balance in the CHP+ Trust that has been offsetting the need for General Fund.

➔ R4 Medicare Modernization Act

Request

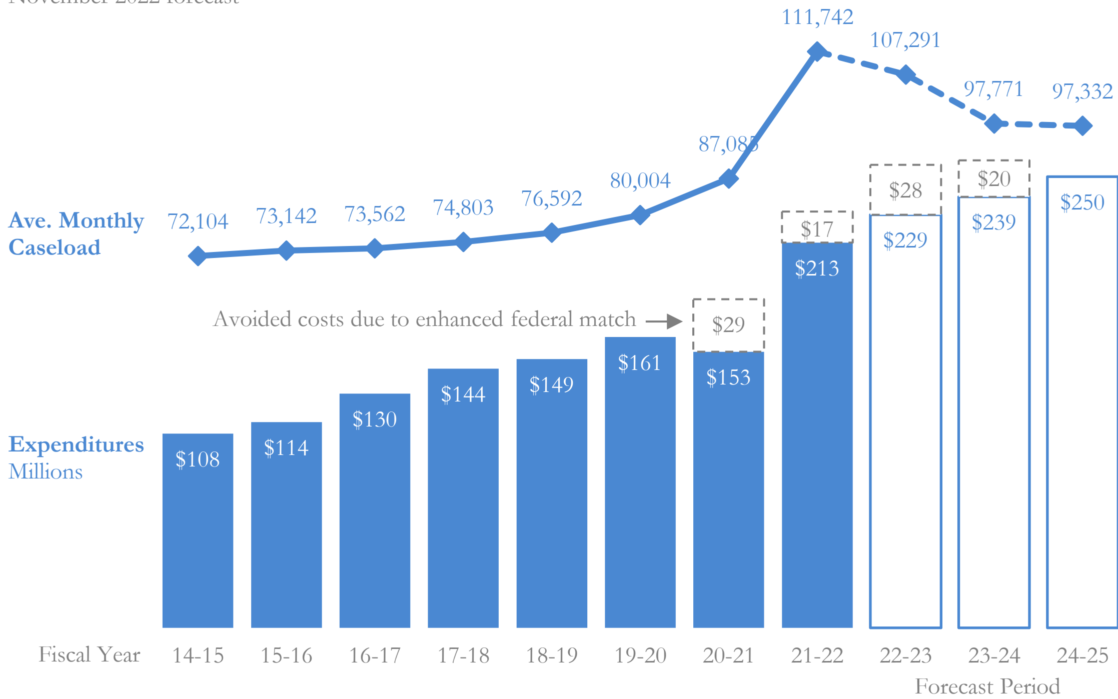
The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible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

On February 15, 2023, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2023 forecast is lower than the forecast used for the Governor's request by $1.7 million General Fund in FY 22-23 and higher than the Governor's request by $18.3 million General Fund in FY 23-24. The cumulative General Fund difference over the two years is $16.6 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2023 forecast of enrollment and expenditures to modify both the FY 22-23 and FY 23-24 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast. The enhanced federal match through the federal Families First Coronavirus Response Act reduces the state obligation under the Medicare Modernization Act. As a result, the Department estimates Colorado is saving $27.6 million General Fund in FY 2022-23 and $20.3 million General Fund in FY 23-24.



FY 22-23

The table below shows the most significant factors driving the change in the Department's forecast for FY 22-23. Note that this table displays changes from the appropriation and not changes from FY 21-22. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2022-23 Medicare Modernization Act	
	General Fund
FY 2022-23 Appropriation	$235,472,292
Enrollment	9,067,693
Per capita	(484,340)
Federal match for public health emergency	(15,197,007)
TOTAL	**$228,858,638**
Increase/(Decrease)	(6,613,654)
Percentage Change	-2.8%

The Department brought up the enrollment forecast based on the extension of the continuous eligibility requirement and reduced the General Fund required due to the extension of the enhanced federal match.

FY 23-24

The next table shows the most significant factors driving the forecasted change in expenditures from FY 22-23 to FY 23-24. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2023-24 Medicare Modernization Act	
	GENERAL FUND
FY 2023-24 Projection	$228,858,638
Enrollment	(8,516,129)
Per capita	3,218,580
Federal match for public health emergency	15,197,007
TOTAL	**$238,758,096**
Increase/(Decrease)	9,899,458
Percentage Change	4.3%

The projection for FY 2023-24 is largely a mirror of the projection for FY 2022-23. The Department brought down the enrollment forecast for the end of the continuous eligibility requirement and increased the estimated required General Fund for the phase out of the enhanced federal match.

➔ BA13 PUBLIC SCHOOL HEALTH SERVICES

REQUEST

The Department requests a net increase of $8.8 million total funds for public school health services based on an updated projection of certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

Through the School Health Services Program school districts and BOCES are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs. Beginning in FY 2020-21 the program expanded, following new federal guidance, to include services outside an IEP or IFSP that are included in other student health plans, such as a 504 disability plan, behavior plan, nursing plan, physician order, or crisis intervention services. Participating school districts and BOCES report their allowable expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds, less administrative expenses, are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services or to expand services for low-income, under or uninsured children and to improve coordination of care between school districts and health providers.

RECOMMENDATION

Staff recommends the request. The expenses for Public School Health Services are driven by an increase in the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The actual amount of certified public expenditures are not in the direct control of the Department. The Department needs the increase in spending authority to distribute the federal funds to the school districts.

BENEFITS/ELIGIBILITY ADJUSTMENTS

➔ R9 PERINATAL SERVICES [INCLUDES LEGISLATION]

REQUEST

The Department requests $1.2 million total funds, including $594,304 General Fund, for the combined cost of a new doula benefit and new donor milk benefit. The cost increases to $1.8 million total funds, including $901,802 General Fund, in the second year.

As part of the original request, the Department included an unrelated change to eliminate the obsolete High Risk Pregnant Women line item and showed this as an offset to the cost of the request of $1.9 million total funds, including $951,546 General Fund. The JBC already approved the elimination of the High Risk Pregnant Women line item in the supplemental.

The Department's request assumes the doula benefit will result in a 6.0 percent reduction in cesarean births for clients who receive the benefit. The Department's request for the doula benefit is for the net cost after estimated savings from improved health outcomes of $120,641 total funds, including $59,342 General Fund, in FY 2023-24 and $263,946 total funds, including $129,831 General Fund in FY 2024-25. The request assumes that for people receiving the doula benefit cesarean births would decrease 6.0 percent and preterm births would drop 1.5 percent. Most of the savings is driven by the decrease in cesarean births.

In Colorado, Medicaid covers just under 25 percent of the population but 42 percent of births. Both new benefits are intended to address documented disparities in health outcomes by race and socioeconomic status.

EVIDENCE LEVEL

The Department indicated that the doula benefit is evidence informed and the donor milk benefit is theory informed, and staff agrees with these designations.

The Department identified a variety of studies, including some using randomized controlled trials, suggesting correlations between doula services and lower cesarean births, lower pre-term births, healthier birth weights, increased breastfeeding, lower post-partum depression, increased adherence to infant safety protocols, and more positive perceptions of the birthing experience. While the studies consistently found positive correlations with improved health outcomes and no negative correlations, there were variations in the magnitude of impact and the specific health outcomes where positive impacts were observed. The Department described the results from state Medicaid programs covering doula services as less definitive, which the Department attributed to provider shortages.

Regarding donor breast milk, the Department says studies suggest access to human donor milk improves infant health outcomes and increases rates of initial breastfeeding and longevity of breastfeeding. The Department says human breastmilk is known to significantly reduce the risk of infants developing necrotizing enterocolitis and that black and Hispanic infants are significantly more likely to receive this diagnosis. The Department cites a recommendation from the American Academy of Pediatrics that donor human milk be used when the birthing person's milk is insufficient in quantity for high-risk infants. The Department speculates that the new benefit would increase utilization of

human milk over formula, that families accessing donor milk would be better informed of the benefits of breastfeeding, and that they would be more likely to form feeding routines centered on breastfeeding instead of formula. According to the Department, studies indicate that the use of donor milk is perceived as a short term solution for preterm and other babies that are challenged to start breastfeeding while formula is viewed as a long term feeding strategy.

RECOMMENDATION

Staff recommends approval of the request, but with modification to

- eliminate the assumed savings from avoided cesarean births
- increase the funding by $450,000 total funds, including $225,000 General Fund, for resource and referral technology
- assume no federal match for the doula scholarships and that the General Fund will cover the cost
- update the match rates for the donor milk benefit and doula services to reflect the phase out of the enhanced federal match rate

Finally, staff recommends that the JBC sponsor legislation to give the Department explicit statutory authority for the proposed doula scholarships

R9 Perinatal Services			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
FY 2023-24			
Donor milk benefit	$203,677	$99,802	$103,875
Doula benefit	-	-	-
Stakeholder engagement	150,000	75,000	75,000
Resource & referral technology	450,000	225,000	225,000
Outreach	30,000	15,000	15,000
Services	837,202	403,571	433,631
Subtotal - Doula benefit	1,467,202	718,571	748,631
Subtotal - Long Bill	**$1,670,879**	**$818,373**	**$852,506**
Proposed Legislation			
Training	100,000	100,000	0
TOTAL - FY 2023-24	**$1,770,879**	**$918,373**	**$852,506**
Not Recommended			
Reduction in caesarean births	(120,641)	(59,342)	(61,299)
FY 2024-25			
Donor milk benefit	$203,677	$101,839	$101,838
Doula benefit	-	-	-
Stakeholder engagement	0	0	0
Resource & referral technology	650,000	325,000	325,000
Outreach	30,000	15,000	15,000
Services	1,758,123	864,794	893,329
Subtotal - Doula benefit	2,438,123	1,204,794	1,233,329
Subtotal - Long Bill	**$2,641,800**	**$1,306,633**	**$1,335,167**
Proposed Legislation			
Training	100,000	100,000	0
TOTAL - FY 2024-25	**$2,741,800**	**$1,406,633**	**$1,335,167**
Not Recommended			

R9 Perinatal Services			
	Total Funds	General Fund	Federal Funds
Reduction in caesarean births	(263,946)	(129,831)	(134,115)
FY 2025-26			
Donor milk benefit	$203,677	$101,839	$101,838
Doula benefit	-	-	-
Stakeholder engagement	0	0	0
Resource & referral technology	35,000	17,500	17,500
Outreach	30,000	15,000	15,000
Services	1,846,030	908,034	937,996
Subtotal - Doula benefit	1,911,030	940,534	970,496
Subtotal - Long Bill	**$2,114,707**	**$1,042,373**	**$1,072,334**
Proposed Legislation			
Training	100,000	100,000	0
TOTAL - FY 2025-26	**$2,214,707**	**$1,142,373**	**$1,072,334**
Not Recommended			
Reduction in caesarean births	(271,002)	(133,302)	(137,700)

Donor Milk Benefit

The Department proposes a new benefit to cover the cost of donor human milk for high-risk infants. Human milk consumption is associated with beneficial health outcomes, including lower rates of sepsis, feeding intolerance, necrotizing enterocolitis, and hospital stays, as well as improved developmental outcomes. The Department speculates that the new benefit would increase utilization of human milk over formula, that families accessing donor milk would be better informed of the benefits of breastfeeding, and that they would be more likely to form feeding routines centered on breastfeeding instead of formula. According to the Department, studies indicate that the use of donor milk is perceived as a short term solution for preterm and other babies that are challenged to start breastfeeding while formula is viewed as a long term feeding strategy.

The Department cites data from the Department of Public Health and Environment indicating that overall 95 percent of Coloradans breastfeed their children for some portion of time, but 17.4 percent of children birthed to low-income families in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) never breastfeed.

A stakeholder engagement process would inform the conditions of medical necessity for the benefit. The request assumes the Department would pay similar to the current out-of-pocket cost of $4.64 per ounce to provide donor milk at no cost to qualifying Medicaid clients.

The supply of human milk is limited by the volume of donations. The Department identified one current supplier in Colorado that meets national quality standards, the Mother's Milk Bank in Arvada. The request assumes Medicaid clients could access the limited supply in proportion to the number of births covered by Medicaid. In other words, the Department assumes that Medicaid clients will take 42 percent of the supply.

Doula benefit

The Department presents a compelling case and relevant research evidence that doula services could benefit Medicaid clients, but it appears to the JBC staff that the Department will largely be building a

supply of providers from scratch. The JBC staff is concerned that the Department might be overestimating how much existing doulas will serve Medicaid clients and not proposing enough of an investment to recruit and support a meaningful pool of new doulas.

While the evidence provides reason to believe that doula services could reduce Medicaid expenditures, the staff recommendation is to not assume any savings until the Department has experience with the actual number of doula providers accepting Medicaid, the actual voluntary utilization by Medicaid clients, and the actual impact on health outcomes. Almost all of the savings assumed by the Department comes from a reduction in cesarean births. While the Department identifies studies suggesting doula services reduce cesarean births, the most recent randomized controlled trial cited by the Department worked with people in low-income areas in Indiana and found that the doula group had no significant reduction in cesarean births, although the study found other positive health outcomes. More concerning is the experiences of Minnesota and Oregon that failed to recruit sufficient providers to serve a meaningful number of Medicaid clients. Minnesota covered doula services for only 804 births in six years and Oregon covered doula services for only 204 births in four years. The Department is proposing rates that would be significantly higher (nearly twice the Minnesota rate and more than four times the Oregon rate) but it remains to be seen if that is sufficient to attract providers. Even if there are sufficient providers, Medicaid clients must also elect to use the service.

The request argues there are cultural and language barriers to patients and medical providers building strong relationships, which lead to fewer doctor visits, avoidance of preventive health services, misdiagnoses, and poor patient satisfaction. The request also cites severe and persistent differences in birth outcomes by race and socioeconomic status, such as maternal mortality rates for black women that are more than twice the average and higher rates for black women of preeclampsia, placental abruption, preterm births, and fetal death. The Colorado Maternal Mortality Review Committee found maternal mortality is four times more likely when Medicaid is the primary insurer. Doula services are described as providing protective emotional, informational, and advocacy supports that the Department implies are missing from current client and medical provider relationships.

To the JBC staff, the existing doula workforce appears both undersized and inexperienced with the Medicaid population to deliver what the Department proposes. The Department estimates there are 94 doulas statewide. According to the Department, most of the people trained do not enter the public market and instead service a relatively small number of people on an ad hoc basis. Despite this, the Department assumes doulas can assist with 48 births in a year[2] and that if Medicaid covers doula services the existing doulas will shift their patient panel to give up private pay clients and include 25 percent from Medicaid.

Doula services are not widely covered by private insurance, so most doulas currently work with clients willing and able to pay out of pocket. A traditional stereotype is that doulas are for people with the luxury to contemplate what music or scented candles they want at the birth of their child and anecdotally the JBC staff found several advertisements for doula services that seemed to play into this stereotype in promoting the doula providers' expertise in areas such as aromatherapy, herbology, and yoga. These might be desirable skills Medicaid clients seek in a doula. However, the JBC staff wonders if doulas that currently primarily work with private pay clients are the ones to bridge the cultural,

[2] https://www.care.com/c/how-much-does-a-doula-make/

language, racial, and socioeconomic divides identified by the Department as barriers to strong patient and provider relationships.

The request acknowledges a need to grow the doula workforce. It notes that Medicaid programs covered doula services for only 804 births in six years in Minnesota and only 204 births in four years in Oregon.

To address the doula workforce, the Department proposes a relatively generous rate for doula services compared to other state Medicaid programs of $1,500 for 6-12 visits spread over pre- and post-partum plus the delivery. The Department says the exact structure of the rates will be designed through a stakeholder process. Staff believes the Department may need to assume that doulas will work part time, based on the feedback from training organizations, and structure the rates accordingly. This might be especially true if the Department is aiming recruiting at Medicaid clients who are new mothers.

In addition to rates, staff believes administrative support, particularly with finding new clients, will be important to recruiting and retaining doulas. There isn't a lot of overhead to become a doula, but steady work presumably requires some investment in building a network for referrals. The Department says other states identified a web-based resource with information on becoming a doula and learning Medicaid provider policies and billing procedures as critical to recruitment. The Department did not request funding for a web-based resource, but provided an estimate at the JBC staff's request. The recommended funding is based on the Department's estimate. The Department suggested an FTE to manage the benefit, including the development of the resource and referral tool, would be helpful, but the staff recommendation assumes the Department can implement it within existing staff. The Department's estimate is heavy on content development and includes language translation, but staff believes that one of the features needs to be focused on connecting doulas and Medicaid clients. Staff suspects that finding clients is the biggest administrative hurdle for new doulas and doulas that want to work part time.

The original request included $100,000 total funds, including $50,000 General Fund, annually to invest in community-based training programs and to help doulas navigate Medicaid reimbursement. On further review, the Department has determined that federal matching funds are not likely available for training. The staff recommendation assumes the $100,000 annual cost will be General Fund. In addition, the JBC staff is concerned that the Department does not have explicit statutory authority to offer a doula scholarship and training program. For this portion of the request, staff recommends that the JBC sponsor legislation.

Staff initially had concerns that the Department had not requested enough money for training. As noted above, staff believes the Department will largely be building a supply of providers from the ground up. However, the Department's proposal is actually quite robust relative to the cost of training. The Department notes that the training to become certified as a doula is minimal. The largest doula certifying organization is DONA International and it offers certification workshops that can be completed in 24 cumulative hours. Posted rates to attend training range from $500 to $750. Colorado does not currently have any doula licensure requirements and the Department proposes to develop minimum criteria for eligibility to receive Medicaid reimbursement as part of the new benefit. The Department hopes to recruit new doulas from among Medicaid clients. The primary benefit of a doula appears to come less from the training than from the experience. The Department says it is considering paying for a trainee's time to attend births before becoming a doula. Experience with a lot of births is

what makes doulas a terrific source of information for families about what is normal and what to expect, without needing a medical degree.

PROVIDER RATES

➔ R6 VALUE-BASED PAYMENTS

REQUEST

The Department requests an increase of $8.7 million total funds, including $2.9 million General Fund, for training and incentives for primary care providers to transition to an Alternative Payment Model (APM). This APM will pay primary care providers a partial capitation payment and allow them to earn incentives for performance in managing the care of members with chronic conditions.

The General Assembly approved funding for the APM in FY 2022-23, but the JBC expressed apprehension about the Department's proposal to make the program mandatory for all Medicaid primary care providers. The Department wanted participation in the APM to be mandatory out of concern that a voluntary program would attract only highly motivated and high performing providers who would implement the practice transformations with or without payment reform. However, based on the JBC's direction, the Department implemented a voluntary program. Now the Department is proposing initiatives intended to increase participation in the voluntary program.

First, the Department proposes spending $1,020,000 total funds, including $510,000 General Fund, ongoing to provide training and technical assistance to Medicaid primary care providers. The proposal is modeled on the Transforming Clinical Practice Initiative (TCPI) developed by the Centers for Medicare and Medicaid Services (CMS). The training will cover sustainable business operations, understanding data, care coordination, and evidence-based care. It will address service delivery challenges when implementing the APM and present successful solutions from other practices. Part of the funding will be used to support a peer-to-peer learning network to coach, mentor, and assist clinicians.

Second, the Department proposes spending $7,659,810 total funds, including $2,343,173 General Fund, for a 16 percent increase in rates for providers who elect to participate in the APM. The amount increases to $8,298,127 total funds, including $2,538,437 General Fund, in FY 2024-25 and beyond. The purpose of the increase is to provide a financial incentive for providers to participate in the APM. It also increases the Medicaid rates for primary care to approximately the level paid by Medicare. This is intended as an incentive for participation in the APM and would be in addition to the common policy community provider rate increase and rate rebalancing adjustments.

EVIDENCE LEVEL

The Department indicated this request is theory informed, and staff agrees with this designation for the portion of the request related to training and technical assistance. For the portion of the request related to increasing rates for providers the Department did not identify any relevant research and the level of evidence is not applicable.

The Department says the training and technical assistance will be based on the Transforming Clinical Practice Initiative (TCPI) developed by the Centers for Medicare and Medicaid Services (CMS). A large study of the TCPI looked at 6,958 participating providers and compared the portion who

subsequently enrolled in a Medicare APM with the portion of 6,958 similarly matched providers who did not participate in the TCPI. In selecting similarly matched providers the study considered factors such as geographic region, size, and patient panel. Perhaps most importantly, the study identified providers with similar histories of participation in practice reform initiatives to reduce potential selection bias of providers more motivated to change. The study found twice as many TCPI participants newly joined a Medicare APM compared to non-TCPI participants.

The study looked at participation in Medicare APMs, which might be different in design from the Department's Medicaid APMs. Also, it is not clear to the JBC staff whether the Department's training and technical assistance will reproduce the TCPI with fidelity. The TCPI isn't a prepackaged curriculum the Department can just plug and play. The study looked at a large number of providers, but it is just one study. While not a perfect match with the Department's initiative, the study does provide a reason to believe the Department's proposed training and technical assistance might be successful at increasing participation in the APM.

RECOMMENDATION

Staff recommends approval of the training and technical assistance portion of the request and an incentive payment for participation in the primary care APM of 6.0 percent, rather than the requested 16.0 percent.

A common problem with voluntary APMs is that the providers who participate are the ones either already performing well or highly motivated to improve. The APM then rewards these providers with larger and/or more flexible payments, but it doesn't change the practices of lower performing or less motivated providers who choose not to participate. The Department's strategies are intended to boost participation in the primary care APM. For the training and technical assistance component, the Department identified a national model with at least one research study suggesting that it is effective in increasing participation in APMs.

For the incentive payments the Department did not present any evidence to suggest whether the provider rate increase would be effective. The Department says it wants the incentive payments to be large enough to be meaningful, but it is not clear how large the payments would need to be in order to be meaningful.

Strangely, the Department's estimate of the cost of the incentive payments did not assume any increase in provider participation in the APMs, even though that is the goal of both the training and technical assistance and incentive payments.

The research on TCPI says that participation by primary care practices in advanced Medicare APMs was 11.6 percentage points higher in the group that participated in TCPI than the group that did not. According to the Department, providers participating in the advanced primary care APM currently serve 4.2 percent of Medicaid clients. If the Medicaid clients served by practices participating in the primary care APM increased by 11.6 percentage points to 15.8 percent, then that would be a 274.2 percent increase in clients serviced by providers participating in the APM. Assuming annual costs increased proportionally, the amount required for a 16.0 percent incentive payment would jump from the Department's request for $8.3 million total funds, including $2.5 million General Fund, to $22.8 million total funds, including $6.8 million General Fund. While a 274.2 percent increase in provider participation in the APM might sound high, it is only the impact from the TCPI that is suggested and

supported by the research and does not include any compounding increase in participation that might occur from the proposed incentive payments.

The JBC staff recommends a more conservative approach than the Department to estimating the cost of the incentive payments that assumes there will be an impact on participation in the APMs from the training and technical assistance program, or TCPI. The JBC staff then recommends reducing the incentive percentage for providers from 16.0 percent to 6.0 percent to keep the total cost similar to the Department's original request. The JBC staff has no basis for assessing how much less effective a 6.0 percent increase might be relative to a 16.0 percent increase, or if either increase would be effective at all in motivating providers to participate in the primary care APM.

Incentive Payments for Primary Care Provider Participation in APM		
	FY 23-24	FY 24-25
Annual expenditure of providers participating in an APM	$51,863,295	$51,863,295
Clients served by providers participating in the advanced APM	4.2%	4.2%
% point increase in APM participation by providers after TCPI	11.6%	11.6%
Clients served by providers participating in APM after TCPI	15.8%	15.8%
% increase in clients served by providers participating in APM	274.2%	274.2%
Annual APM expenditures after 274.2% increase from TCPI	$142,225,584	$142,225,584
Incentive % for providers participating in APM	6.0%	6.0%
Incentive payments	$8,533,535	$8,533,535
Adjustment for timing of payments	92.3%	100.0%
TOTAL	**$7,877,109**	**$8,533,535**
General Fund	2,361,558	2,558,355
Cash Funds	326,112	353,288
Federal Funds	5,189,439	5,621,892

With these adjustments to the percentage for the incentive payments and the methodology for estimating the cost, the full staff recommendation is summarized in the table below.

R6 Value-Based Payments				
	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2022-23				
Training and technical assistance	$1,020,000	$510,000	$0	$510,000
Incentive payments	7,877,109	2,361,558	326,112	5,189,439
Total - FY 2022-23	**$8,897,109**	**$2,871,558**	**$326,112**	**$5,699,439**
FY 2023-24				
Training and technical assistance	$1,020,000	$510,000	$0	$510,000
Incentive payments	8,533,535	2,558,355	353,288	5,621,892
Total - FY 2023-24	**$9,553,535**	**$3,068,355**	**$353,288**	**$6,131,892**

➔ R7(A) PROVIDER RATE COMMON POLICY

REQUEST

The Department requests $24.2 million total funds, including $8.6 million General Fund, for a 0.5 percent across-the-board increase in provider rates. The Governor's FY 2023-24 budget request included a 3.0 percent provider rate increase for community providers funded by other departments. For the Department of Health Care Policy and Financing, the across-the-board increase was decreased to make funding available for the targeted rate adjustments described below under R7(b).

The request excludes certain rates from the common policy that annually receive adjustments based on state or federal policy. For these rates, the annual adjustment is generally cost-based, sometimes within program caps, and is accounted for in the forecast requests (R1 through R5). The rates receiving annual adjustments based on state or federal policy include pharmacy, Rural Health Clinics, Federally Qualified Health Centers, durable medical equipment, managed care, Medicare and private insurance payments, and nursing facilities.

In addition, the request excludes rates set by competitive bid. Notable rates that are paid from Medical Services Premiums and set by competitive bid include a portion of non-medical emergency transportation rendered under a fixed price contract, dental administrative payments, and disease management.

Finally, the request includes a discretionary decision to exclude certain rates where the Department proposed a targeted rate adjustment. Specifically, the request excludes the rates impacted by the rate review recommendations to rebalance to a benchmark, the non-medical transportation, and the Group Residential Support and Services. For these rates, the proposed targeted rate adjustment is in lieu of, rather than in addition to, the common policy adjustment.

The Department proposes that the other targeted rate adjustments be in addition to the common policy, including the minimum wage adjustment for HCBS, rural health provider technology payments, and elimination of member copays. The Department views the targeted adjustment for HCBS as a necessary catchup to the minimum wage and believes an additional across-the-board adjustment is appropriate to ensure sustainable rates looking forward. The rural health provider technology payments are incentives specific to maintaining connections to health information exchanges and not intended to replace a common policy increase on base expenditures. The elimination of member copays is intended to reduce a financial burden on members and eliminate a cost to providers when members don't pay and it is not intended to replace an across-the-board adjustment to the base.

RECOMMENDATION

Staff recommends $160.2 million total funds, including $59.8 million General Fund, for an across-the-board increase of 3.0 percent, consistent with the JBC's common policy, on the same codes the Department requested. In addition, staff recommends $3.1 million total funds, including $1.5 million General Fund, for a 3.0 percent common policy adjustment for non-medical transportation and Group Residential Services and Supports after application of the targeted rate adjustments recommended in *R7(b) Targeted rate adjustments*.

For non-medical transportation and Group Residential Services the targeted rate adjustment is to better align the rates with other waivers and services and if those other waives and services get a common policy adjustment, then non-medical transportation and Group Residential Services will also need a common policy adjustment to keep pace. In addition, the problems the Department identified with the current rates for non-medical transportation and Group Residential Services are large as a percentage of the base, and so the JBC staff wants to provide as much as possible to address the issues with the rates.

The staff recommendation differs from the request due to applying a 3.0 percent increase instead of the requested 0.5 percent increase, applying the increase to non-medical transportation and Group

Residential Support Services that the Department had excluded because they were receiving a targeted rate adjustment, and updating the estimated total costs and fund sources based on the Department's February forecast.

The projected cost increases to $186.6 million total funds, including $71.8 million General Fund, in FY 2024-25.

Common Policy 3.0 Percent Provider Rate Increase				
	Total Funds	General Fund	Cash Funds	Federal Funds
Codes Dept. Included - Updated for February 2023 Forecast				
County Administration	$2,642,777	$316,605	$561,326	$1,764,846
Medical Services Premiums	132,435,413	47,140,172	5,577,432	79,717,809
Behavioral Health Fee-for-service	277,717	61,548	16,743	199,426
Adult Comprehensive Services	17,433,604	8,513,474	28,992	8,891,138
Adult Supported Living Services	2,023,693	853,748	137,862	1,032,083
Children's Extensive Support Services	1,572,836	770,690	0	802,146
Children's Habitation/Rehabilitation Program	375,674	184,080	0	191,594
Case Management	2,791,092	1,362,126	41,965	1,387,001
State Supported Living Services	151,268	151,268	0	0
State Supported Living Services Case Management	147,409	147,409	0	0
Family Support Services	321,811	321,811	0	0
Preventive Dental Hygiene	2,034	2,034	0	0
Subtotal - Codes Dept. Included	$160,175,328	$59,824,965	$6,364,320	$93,986,043
Additional Recommended Codes				
Non-medical transportation - Adult Comprehensive Waiver	899,690	440,848	0	458,842
Non-medical transportation - Supported Living Services Waiver	412,825	202,284	0	210,541
Group Residential Service and Supports	1,742,009	853,584	0	888,425
Subtotal - Additional Recommended Codes	$3,054,524	$1,496,716	$0	$1,557,808
TOTAL - FY 2023-24	**$163,229,852**	**$61,321,681**	**$6,364,320**	**$95,543,851**
TOTAL - FY 2024-25	186,579,962	71,814,160	6,465,515	108,300,287
Codes Dept. Excluded Due to Targeted Rate Adjustment				
Rate Review Rebalance Recommendations	$37,578,653	$11,048,689	$1,592,262	$24,937,702

The estimated cost of the across-the-board adjustment for FY 2023-24 is calculated based on 11 months to account for an average one-month delay between when services are rendered and paid. Appropriations are made for Medicaid based on expected cash expenditures during the fiscal year rather than accrued obligations.

The FY 2024-25 projection includes adding the missing month of expenditures, the change in the federal match rate, and adjustments for forecasted changes in utilization.

The JBC staff considered applying the common policy to the codes the Department had excluded because they were receiving a targeted adjustment as part of the Rate Review Rebalance Recommendations. However, the JBC decided not to recommend the change from the Department's request for several reasons. First, the rates are being rebalanced to benchmarks that are current (generally the 2022 Medicare rates) and that are designed and intended to reflect provider costs.

Second, the benchmarks are external, so the providers are not getting shortchanged relative to other Medicaid providers. Compared to other Medicaid providers, the rebalancing results in a net increase of 3.8 percent versus the common policy 3.0 percent. There are winners and losers with the rebalancing, but these are based on the relationship between current rates and provider costs. Third, the providers impacted by the specific rebalancing the Department is proposing this year are mostly higher skilled and higher paid health care workers offering services where there is capacity to earn revenue from non-Medicaid sources. Assuming limited resources, staff believes the Committee should prioritize rate increases for long-term services and supports that tend to be provided by lower-paid workers where the primary payer (often only payer) is Medicaid.

➔ R7(B) TARGETED RATE ADJUSTMENTS [INCLUDES LEGISLATION]

REQUEST

In addition to the common policy provider rate adjustment, the Department requests $168.7 million total funds, including $61.3 million General Fund, for targeted provider rate adjustments. The FY 2024-25 cost is higher due to timing differences between when services are rendered and paid, projected increases in utilization, the Department's proposal to use federal funds in the HCBS Improvement Fund to offset $11.7 million of the General Fund cost in the first fiscal year, and changes in the federal match rate. The Department's estimated cost of the targeted rate increases in FY 2024-25 is $184.1 million total funds, including $80.0 million General Fund. For the rates impacted by the rate review recommendations to rebalance to a benchmark, the non-medical transportation, and the Group Residential Support and Services, the proposed targeted rate adjustment is in lieu of, rather than in addition to, the across-the-board common policy adjustment.

RECOMMENDATION

The staff recommendation is summarized in the table below. The staff recommendation differs from the request primarily due to updated cost estimates based on the February forecast.

R7(b) Targeted Rate Adjustments FY 2023-24					
Rate	Change	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Rate Review Rebalancing Recommendations					
Physician services	80-100% of benchmark - net 2%	20,160,924	6,045,729	831,971	13,283,224
Eyeglasses and vision	80-100% of benchmark - net 41%	19,170,361	5,748,685	791,094	12,630,582
Laboratory & pathology	80-100% of benchmark - net 4%	2,453,574	531,849	138,476	1,783,249
Dialysis & nephrology	80-100% of benchmark - net 5%	427,077	90,531	26,405	310,141
Injections & miscellaneous J-Codes	80-100% of benchmark - net -9%	(107,757)	(32,313)	(4,448)	(70,996)
Subtotal - Rate Review Rebalance		42,104,179	12,384,481	1,783,498	27,936,200
Other Provider Rate Adjustments					
Minimum wage adjustment for HCBS	$15.75 per hour/$17.29 in Denver	56,953,319	18,850,369	9,056,774	29,046,176
Non-medical transportation - Adult Comp	Align with other waivers - 48.9%	10,050,656	3,299,629	1,625,191	5,125,836
Non-medical transportation - SLS	Align with other waivers - 48.9%	4,299,137	1,411,407	695,170	2,192,560
Group Residential Service and Supports	Align with other services - 18.6%	9,099,372	3,935,213	523,480	4,640,679
Eliminate most non-statutory copays	Retain non-emergent ER copays	2,084,178	408,436	126,731	1,549,011
Subtotal - Other Provider Rate Adjustments		82,486,662	27,905,054	12,027,346	42,554,262
Changes Recommended in Long Bill		**124,590,841**	**40,289,535**	**13,810,844**	**70,490,462**
Proposed Legislation					
Nursing facility rates - Set aside	$18.37/day incr. (on av.)	35,593,248	17,440,692	0	18,152,556
Eliminate statutory copays	Pharmacy and outpatient services	7,345,507	1,439,499	446,651	5,459,357

R7(b) Targeted Rate Adjustments FY 2023-24					
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Subtotal - Proposed Legislation		42,938,755	18,880,191	446,651	23,611,913
TOTAL Recommended Changes		**$167,529,596**	**$59,169,726**	**$14,257,495**	**$94,102,375**
Requests NOT Recommended by JBC Staff					
Rural health provider technology payments	Incentive for connecting to HIE	$4,220,000	$2,067,800	$0	$2,152,200

R7(b) Targeted Rate Adjustments FY 2024-25					
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Rate Review Rebalancing Recommendations					
Physician services	80-100% of benchmark - net 2%	21,993,736	6,727,991	910,490	14,355,255
Eyeglasses and vision	80-100% of benchmark - net 41%	20,913,121	6,397,425	865,756	13,649,940
Laboratory & pathology	80-100% of benchmark - net 4%	2,676,626	591,762	151,214	1,933,650
Dialysis & nephrology	80-100% of benchmark - net 5%	465,902	100,777	28,865	336,260
Injections & miscellaneous J-Codes	80-100% of benchmark - net -9%	(117,552)	(35,959)	(4,868)	(76,725)
Subtotal - Rate Review Rebalance		45,931,832	13,781,995	1,951,457	30,198,380
Other Provider Rate Adjustments					
Minimum wage adjustment for HCBS	$15.75 per hour/$17.29 in Denver	62,130,893	30,873,618	191,837	31,065,438
Non-medical transportation - Adult Comp	Align with other waivers - 48.9%	10,964,352	5,482,176	0	5,482,176
Non-medical transportation - SLS	Align with other waivers - 48.9%	4,689,968	2,344,984	0	2,344,984
Group Residential Service and Supports	Align with other services - 18.6%	9,926,588	4,963,295	0	4,963,293
Eliminate most non-statutory member copays	Retain non-emergent ER copays	2,084,178	408,436	126,731	1,549,011
Subtotal - Other Provider Rate Adjustments		89,795,979	44,072,509	318,568	45,404,902
Changes Recommended in Long Bill		**135,727,811**	**57,854,504**	**2,270,025**	**75,603,282**
Proposed Legislation					
Nursing facility rates - Set aside	$18.37/day incr. (on av.)	40,129,132	20,064,566	0	20,064,566
Eliminate statutory member copays	Pharmacy and outpatient services	7,345,507	1,439,499	446,651	5,459,357
Subtotal - Proposed Legislation		47,474,639	21,504,065	446,651	25,523,923
TOTAL Recommended Changes		**$183,202,450**	**$79,358,569**	**$2,716,676**	**$101,127,205**
Requests NOT Recommended by JBC Staff					
Rural health provider technology payments	Incentive for connecting to HIE	$4,220,000	$2,067,800	$0	$2,152,200

Rate Review Rebalancing Recommendations

The Department attributes a subset of the requested changes directly to the 2022 rate review required by S.B. 15-228.

The JBC sponsored S.B. 15-228 to increase the data available to support rate setting decisions and to establish formal procedures for the Department to review rates at least once every five years and engage with providers regarding rate setting priorities. The JBC sponsored S.B. 22-236 to modify the composition of the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and require that rates be reviewed at least once every three years, beginning July 1, 2023, instead of at least once every five years.

The bills require the Department to submit an analysis report by May 1 each year looking at the access, service, quality, and utilization associated with each rate under review. The analysis report compares each rate to available benchmarks and uses qualitative tools to assess whether payments are sufficient

to allow for provider retention and client access and to support appropriate reimbursement of high-value services. The MPRRAC evaluates the Department's data and analysis, solicits public testimony, and offers feedback to the Department and the legislature. The Department then works with the MPRRAC and stakeholders to develop strategies for responding to the findings, including non-fiscal approaches, rate rebalancing, and policies to address regional capacity issues. Next, the Department works with the Office of State Planning and Budgeting to determine achievable goals and executive branch priorities within the statewide budget. By November 1 each year the Department submits a recommendation report summarizing the Department's proposals and rationale for rate adjustments as well as stakeholder feedback and the Department's response.

The 2022 rate review looked at the following rates:

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

The Department's annual analysis reports and recommendation reports can be found here:
https://hcpf.colorado.gov/rate-review-reports

In the descriptions below, the benchmark is based on comparable Medicare rates when available. Medicare regularly updates rates using a method that attempts to capture average provider costs. To do this, Medicare typically does a deep analysis of actual costs for a sample of providers and then applies regional modifiers to establish rates across the country. The Medicare rates are not immune to criticism. For example, sometimes the sample of providers is not considered representative, or Medicare doesn't recognize and attribute expenses that contribute to the total costs of the provider in delivering a service, or the regional modifiers don't correctly adjust for local conditions. Medicare rates can be different from what is needed to serve Medicaid clients, due to differences in the population demographics, common diagnoses, and treatment approaches at different ages. The Medicare rate is designed to cover provider costs and not intentionally to provide any profit margin for providers. Historically, Medicare rates have tended to be higher than Colorado's Medicaid rates in aggregate, though the results for individual rates might vary. When there was not a comparable Medicare rate, the Department used averages of Medicaid rates paid by other states as the benchmark.

For each of the service areas covered in the 2022 rate review, the Department proposes rebalancing rates to within a range of 80-100 percent of the benchmark. This means that some rates within the service category will be increased and some will be decreased. In most cases the net result is an increase in aggregate compensation to providers. For example, some ophthalmology rates will increase and some will decrease, but overall ophthalmology will see an increase in compensation. However, it is possible that an individual ophthalmology provider could experience a decrease in payments due to the specific subset of services delivered and the applicable rates.

In some cases, a provider will see a net reduction. For example, Radiology is an area with significant expenditures and the Department proposes a net decrease of 3.0 percent. However, the relationship is not always straight forward and intuitive. A radiologist is probably not billing for Ear, Nose, and Throat codes that are getting an increase, but they might be in the same practice, or they might be billing for Primary Care/Evaluation and Management codes that are getting an increase. The

Department doesn't spend as much for Cognitive Capabilities Assessment codes as Radiology codes, but the proposed rebalancing would reduce the rates for Cognitive Capabilities Assessment codes by 24.2 percent. The provider billing for Cognitive Capabilities Assessment codes might be the same provider, or in the same practice with providers, billing for Primary Care/Evaluation and Management, or even Ear, Nose, and Throat, or Women's Health and Family Planning.

The JBC staff recommends both the proposed increases and decreases in rates. When an individual rate gets out of alignment with benchmarks and provider costs it can create an economic incentive for providers to prioritize a particular service or treatment based on reimbursement rates rather than health outcomes. When the Medicaid rates pay more than the benchmark, it implies that the Department is paying more than the provider's cost. While it would be nice for Medicaid to pay a profit margin, there isn't enough money and the rates are typically not intentionally designed to result in a profit, but rather just to cover costs. There are a few exceptions for "high value" preventive services that the Department wants to incentivize due to the impact on reducing overall expenditures. Finally, bringing down rates that are above the benchmark helps offset the cost of bringing up rates that might be woefully below the benchmark.

At the hearing, the Department implied that the JBC has historically been reluctant to reduce rates that exceed the benchmark, but this was not an accurate portrayal of the JBC's past actions. In FY 2019-20 the JBC approved rebalancing primary care, radiology, physical therapy, occupational therapy, laboratory, and pathology rates for a net reduction of $9.3 million total funds, including $3.5 million General Fund. The same year the JBC rejected a proposal to reduce anesthesia rates to 100 percent of the benchmark, but the JBC had previously initiated an increase in anesthesia rates that had not been requested by the Department and was not convinced that the benchmark accurately reflected the need. In FY 2020-21, the JBC rejected a proposal to rebalance durable medical equipment rates that would have resulted in a small net decrease of $49,244 total funds, including $17,432 General Fund. This recently followed a new federal upper payment limit on certain durable medical equipment that had significantly reduced rates and the JBC members expressed reluctance to further reduce rates for a nominal net savings. However, in the same year the JBC approved rebalancing behavioral health fee-for-service rates that resulted in a net increase of $1.6 million total funds, including $875,964 General Fund. In FY 2021-22, the Department did not submit any proposals that would have decreased rates over 100 percent of the benchmark. In FY 2022-23 the JBC again rejected a proposal to rebalance rates for durable medical equipment and only approved the side of the rebalancing that increased rates. In recent years, the JBC has rejected some rebalancing reductions for very specific policy reasons related to the particular rates. The JBC has not rejected all rebalancing reductions out of hand and has actually approved most of the rebalancing proposals brought forward by the Department.

Rate Review Rebalancing Recommendations					
	Current Cost	Increases	Decreases	Net Change	Percent
Physician Services					
Cardiology	16,065,292	636,972	(1,006,479)	(369,507)	-2.3%
Cognitive Capabilities Assessment	7,390,369	7,340	(1,796,179)	(1,788,839)	-24.2%
Ear, Nose, and Throat	19,610,893	1,359,842	(115,822)	1,244,020	6.3%
Gastroenterology	162,160	45,211	(676)	44,535	27.5%
Health Education	687,240	264,708	(36,363)	228,345	33.2%
Ophthalmology	26,152,155	1,952,071	(740,183)	1,211,888	4.6%
Primary Care/Evaluation and Management	361,644,914	13,751,554	(5,329,701)	8,421,853	2.3%
Radiology	58,816,577	4,915,447	(6,664,023)	(1,748,576)	-3.0%
Respiratory	914,336	18,311	(49,593)	(31,282)	-3.4%
Vaccines and Immunizations	14,203,812	28,790	0	28,790	0.2%
Vascular	3,904,163	49,377	(1,027,426)	(978,049)	-25.1%
Women's Health and Family Planning	188,679,084	8,654,925	(3,062,134)	5,592,791	3.0%
Other Physician Services	371,158,303	16,757,214	(6,619,447)	10,137,767	2.7%
Subtotal - Physician Services	1,069,389,298	48,441,762	(26,448,026)	21,993,736	2.1%
Eyeglasses and Vision	51,457,214	21,342,018	(428,897)	20,913,121	40.6%
Laboratory and Pathology	75,238,081	3,824,750	(1,148,124)	2,676,626	3.6%
Dialysis and Nephrology	9,355,158	465,902	0	465,902	5.0%
Injections & Misc. J-Codes	1,250,195	94,078	(211,630)	(117,552)	-9.4%
TOTAL	**$1,206,689,947**	**$74,168,510**	**($28,236,677)**	**$45,931,833**	**3.8%**
General Fund		22,322,349	(8,540,355)	13,781,994	
Cash Funds		3,137,725	(1,186,268)	1,951,457	
Federal Funds		48,708,436	(18,510,054)	30,198,382	

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 with no corresponding decrease to rates above the benchmark. Overall, the Department found vaccine rates were 107.9 percent of the benchmark with individual rates varying form 36.8 percent to 284.7 percent of the benchmark. Of the 45 procedure codes analyzed only 5 used a comparable Medicare rate as the benchmark and the remaining 40 were compared to the average of comparable Medicaid rates in Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon. The Department argues that immunizations are a high-value service with long-term benefits for the individual client and for public health. As a result, the Department views rates above the benchmark as providing appropriate economic incentives to providers, rather than problematic.

Eyeglasses and Vision Services

The Department found the aggregate payment for eyeglasses & vision services was 57.4 percent of the benchmark with individual rates ranging from 14.0 percent to 192.0 percent of the benchmark. The Department 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.

Laboratory and Pathology Services

The Department found the overall payment rate for laboratory and pathology services was 93.7 percent of the benchmark with individual rates varying between 6.9 percent and 178.3 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.

Dialysis and Nephrology Services

The Department found that the average payment rate for dialysis relative to the benchmark was 78.5 for facility-based services and 61.1 percent for professional services with rates for individual codes between 26.9 percent and 104.0 percent of the benchmark. Since none of the individual codes are significantly above 100 percent of the benchmark, the Department just recommends increasing rates to at least 80 percent of the benchmark.

Injections and Miscellaneous J-codes

The Department found the payment rate for injections and miscellaneous J-codes was 95.6 percent of the benchmark with individual rates varying from 5.0 percent to 184.9 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. This results in a slight decrease in payments overall.

OTHER PROVIDER RATE ADJUSTMENTS

Minimum wage adjustment for HCBS

Staff recommends $57.0 million total funds, including $18.9 million General Fund, to increase Home- and Community-Based Services rates based on the Department's estimate of what it is costing providers to increase direct care worker salaries commensurate with the increase in the minimum wage. Statewide the minimum wage is increasing from $15 to $15.75 and in Denver it is increasing from $15.87 to $17.29. The recommendation includes $8.9 million from federal funds deposited in the HCBS Improvement Fund to offset General Fund costs through October 31, 2023. General Fund is required for the state share through the remainder of the fiscal year. The cost increases to $62.1 million total funds, including $30.9 million General Fund, in FY 2024-25.

Home and Community-Based Service (HCBS) provide care in the home or a community setting 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 wages for frontline staff providing direct hands-on care.

There is not much room for discretion on this increase. Salaries for HCBS must remain competitive with the minimum wage to attract workers. The recommended adjustment to keep pace with the minimum wage is in addition to the across-the-board 3.0 percent provider rate common policy. For most of these providers the margins to remain viable and balance revenues and expenses are extremely narrow and Medicaid is the primary or exclusive payer.

Non-Medical Transportation

Staff recommends $14.3 million total funds, including $4.7 million General Fund, to increase rates for non-medical transportation in the Adult Comprehensive Waiver and Supported Living Services Waiver to match the rates paid by other waivers. The recommendation equates to an average 48.9 percent increase. The recommendation includes $2.3 million from federal funds deposited in the HCBS Improvement Fund to offset General Fund costs through October 31, 2023. General Fund is required for the state share through the remainder of the fiscal year. The cost increases to $15.7 million total funds, including $7.8 million General Fund, in FY 2024-25.

The rates for non-medical transportation through these two waivers are desperately low compared to what the Department pays for the same service through different waivers. Not only are the rates across waivers inequitable for no apparent policy reason, but these providers face significant increases in fuel costs on top of the wage pressures that are common to many providers. Non-medical transportation is a critical service that allows these clients to be independent in the community. The Department struggles with long wait times and inconsistent performance statewide and severe regional provider shortages, particularly in rural areas.

Group Residential Services and Supports

Staff recommends $9.1 million total funds, including $3.9 million General Fund, to bring Group Residential Services and Supports rates more in line with Individual Residential Services and Supports. The recommendation is approximately 2.8 times the Department's original request for $3.2 million total funds, including $1.1 million General Fund, and it equates to an average 18.6 percent increase. The recommendation includes $523,480 from federal funds deposited in the HCBS Improvement Fund to offset General Fund costs through October 31, 2023. General Fund is required for the state share through the remainder of the fiscal year. The cost of the staff recommendation increases to $9.9 million total funds, including $5.0 million General Fund, in FY 2024-25.

Group Residential Services and Supports and Individual Residential Services and Supports provide 24/7 residential services for people with intellectual and developmental disabilities and offer training and hands on assistance for self-advocacy, independent living, money management, decision making, and emergency assistance. The primary difference between the two is that Individual Residential Services and Supports includes up to three people living together while Group Residential Services and Supports is for 4-8 people living together. According to the Department, the highest acuity clients tend to end up in Group Residential Services and Supports due to a lack of providers of Individual Residential Services and Supports that can meet their needs. The cost structures are different due to different economies of scale and settings, but the methodology to determine the rates is similar across both services and all HCBS services. Using federally-approved techniques the Department does an analysis and projection of what the Department views as reasonable costs for the providers, using publicly available data such as average wages, leased space, utilities, supplies, etc. The Department then applies a "budget neutrality factor" to bring the calculated rate in line with the appropriated funding. The current average budget neutrality factor for Group Residential Services and Supports rates is a whopping 59.1 percent, compared to an average of 50.0 percent for Individual Residential Services and Supports rates, which is also alarmingly high but relatively better for no apparent policy reason. The statewide average budget neutrality factor for HCBS waiver services is 25 percent.

From January 2018 to September 2022 the Group Residential Services and Supports members served dropped from 802 to 507 (36.8 percent) and the settings dropped from 107 to 84 (21.5 percent). Some of this change might be due to clients selecting different services, including Individual Residential

Services and Supports. However, since the people served in Group Residential Services and Supports are among the highest acuity clients and there are limited alternative appropriate services, the Department is concerned that the decreases in utilization and sites are indicative of inadequate rates.

The JBC staff is not at all confident that the recommendation is sufficient to stem the loss of providers, but it somewhat evens the playing field with Individual Residential Services and Supports. Also, the staff recommendation is already 2.8 times the Department's original request. The Department did not provide a clear explanation or rationale for how it sized the original request. The JBC staff's interpretation is that the size of the Department's request was heavily influenced by the available funds within the statewide budget. The utilization trends for Group Residential Services and Supports and Individual Residential Services and Supports warrant continued monitoring by the Department.

The staff recommendation is to adjust the Group Residential Services and Supports rates and then apply the 3.0 percent common policy adjustment on the revised base. Group Residential Services and Supports providers will also get a bump from the minimum wage adjustment for HCBS.

Eliminate Most Non-Statutory Copays

Staff recommends $2.1 million total funds, including $408,436 General Fund, to eliminate most non-statutory copays. Specifically, the staff recommendation would eliminate copays for physician services, federally qualified health centers, rural health centers, inpatient services, durable medical equipment, and lab and X-ray. Consistent with the request, the recommendation would retain the $8 copay on non-emergent use of an emergency department as a disincentive to utilization of an expensive care setting when there are lower cost alternatives. 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 cited several high quality research studies suggesting that copays for Medicaid clients of as little as $1 can lead to delayed care, pill-splitting, unfilled prescriptions, lower health outcomes, and more expensive utilization. During the pandemic, the General Assembly increased these copays to the federal maximums as a budget saving measure, without regard to the value or desirability of the service for improving health outcomes and reducing costs in the long run.

Copays are often described by providers as a rate reduction. When Medicaid clients can't pay, or it isn't worth the provider's time and expense to pursue payment, the provider eats the cost.

Copays by Medicaid clients do not earn a federal match. By eliminating copays, the state could draw more federal funds to reimburse providers.

Nursing Facility Rates – Set Aside

Staff recommends that the JBC set aside the requested $35.6 million total funds, including $17.4 million General Fund, for a bill to increase nursing home rates above the statutory maximum. The Department is pursuing sponsors and not asking the JBC to carry the bill. Statute describes a detailed formula for calculating nursing home rates that conceptually boils down to the lesser of allowable actual costs or a 3.0 percent increase on the General Fund share of costs. In practice, the allowable costs historically increase more than 3.0 percent. Changes in utilization patterns between facilities with different costs can result in aggregate expenditures that increase by slightly more or less than 3.0 percent, but total nursing home appropriations typically increase by 3.0 percent plus enrollment every year.

The Department is concerned that nursing facilities continue to struggle with the aftermath of the pandemic. There were significant disruptions in client populations and cost that had lasting impacts on the finances of nursing homes. In addition, nursing homes are struggling to recruit and retain workers. The workforce challenges faced by nursing homes are similar to those faced by HCBS providers, but nursing homes are seen as a less desirable place of employment following the pandemic.

To address these issues the Department proposes allowing a one-time increase in FY 2023-24 equal to the increase in actual allowable costs of 5.86 percent. The next year rates would grow by the standard formula off the higher base. The request also mentions ongoing supplemental payments for nursing facilities with high Medicaid utilization rates to improve the sustainability of facilities with few private pay clients. However, the Department's calculation of the cost for the proposed bill does not include any extra money for this purpose, so perhaps the Department intends that the supplemental payments come from within the 5.86 percent increase. The JBC staff assumes the merits, or lack thereof, and financing of any potential supplemental payments would be detailed and debated in the specifics of the bill. The JBC staff cannot speak to the proposed supplemental payments without more information, but the overall requested funding appears reasonable based on the actual allowable costs reported by the nursing homes.

Due to the statutory formula and promise of annual rate adjustments, nursing homes have arguably enjoyed more flexibility to increase expenditures than other similarly situated Medicaid providers that provide 24/7 care to vulnerable populations. However, the Department makes a compelling case that the pandemic has hit nursing homes particularly hard such that a one-time level shift of more than 3.0 percent makes sense to ensure that Medicaid clients continue to have access to this type of service.

Eliminate statutory copays [Requires Legislation]
Staff recommends that the JBC sponsor legislation to eliminate copays for pharmacy and outpatient services at a cost of $7.3 million total funds, including $1.4 million General Fund. The Department is required to charge copays for these particular services by Section 25.5-4-209 (1)(c)(I), C.R.S., so eliminating these copays would require legislation. The recommendation is intended to be consistent with the recommendation on non-statutory copays and the rationale for the recommendation is the same.

Rural Health Provider Technology Payments
Staff does not recommend the Department's request for $4.2 million total funds, including $2.1 million General Fund, to provide ongoing incentive payments to rural health providers who connect electronic health records to the state's health information exchanges.

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). 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. Through federal funds and grants the Governor's Office of Electronic Health Information (OeHI) and the Department can already provide one-time funding to cover a provider's development costs for health information technology. However, there are ongoing fees, licensing, and maintenance costs associated with connecting to the HIEs.

An argument could be made that connecting to the HIEs is the way of the future and a cost that providers will eventually need to incur. New doctors are trained with the technology and might not be excited about job openings where they can't use it. From this perspective, the request could be viewed as a provider rate increase, where the Department is paying for a cost the providers need to incur.

However, it is not currently mandatory for providers to connect to the HIEs and the only way a provider would get this incentive payment is if they decide to incur this optional cost that is roughly equivalent to the size of the incentive. From this perspective, the request sounds like it is more about the Department getting what it wants, which is data to feed the Department's analytics and performance based payments and care coordination efforts. It does not sound to the JBC staff like the rural providers are clamoring for the technology. The state will already essentially design and build the system for the providers for free, but apparently that isn't enough. It seems that the providers don't perceive a sufficient benefit to them to justify the maintenance cost. If that is the case, maybe the Department's problem is less about the money and more about convincing the providers that the investment will improve their lives and the health outcomes of their clients.

There is another argument for this request that it is about equity. If urban Medicaid clients benefit from their providers' access to this technology and all that it makes possible, from predictive analytics that improve care coordination and outreach to performance based payments that help doctors improve their practices, then rural Medicaid clients should enjoy the same benefits. However, the way that the technology impacts health outcomes is not a thick direct line, but a thin meandering line that makes unexpected connections and ties things together that doctors and care coordinators might not otherwise see. Getting those benefits requires that providers and care coordinators adapt to and use the technology. It requires buy in from the users. The state can give away the technology, but if the providers and care coordinators don't change their behavior, it may not accomplish much.

The Department's proposal is not a terrible idea, but there are enough questions about it and the bang for the buck that it will achieve that staff suspects JBC members could find other higher priorities with limited funds for benefits and provider rates.

➔ BA19 ALTERNATIVE PAYMENT MODEL

REQUEST

The Department requests an incremental increase of $2.8 million, including $735,028 General Fund, to annualize a supplemental approved by the General Assembly that reduced the estimated savings associated with the prescriber tool and authorized a revised plan for sharing the savings with providers that gives providers 100 percent of the savings in FY 2023-24, 75 percent in FY 2024-25, and 50 percent thereafter. The prescriber tool provides information to physicians on drug costs, the Department's preferred drug list that reflects current information on the most appropriate and cost-effective drugs, prior authorization requirements, and member-based risk factors based on diagnosis. Prescribers share in the savings if they increase their percentage of prescriptions from the preferred drug list or the lower cost option among multiple drugs on the preferred drug list.

In addition, the Department requests roll forward authority for up to $2,948,850 from FY 2022-23 to FY 2023-24 and up to $2,921,500 from FY 2023-24 to FY 2024-25 for stakeholder engagement and development related to alternative payment models approved in the FY 2022-23 budget, including the

primary care alternative payment model, maternity bundle, and Colorado Providers of Distinction. Based on the JBC's action last year, the Department is going forward with implementation of the primary care alternative payment model. For the maternity bundle and Colorado Providers of Distinction, the Department is doing stakeholder engagement and will presumably present an implementation plan next year. The Department used one procurement for all three initiatives and received an unexpectedly high number of qualifying bids, which required additional time to analyze and negotiate in order to arrive at a vendor. As a result, the Department expects some of the costs originally expected in FY 2022-23 and FY 2023-24 will shift out a year.

RECOMMENDATION

Staff recommends approval of the request. The JBC already approved the lower estimated savings from the prescriber tool and the modified plan for sharing the savings with providers when it approved S19. The requested rollforward authority is to address a longer-than-anticipated procurement process and does not increase the total funding required.

ADMINISTRATION AND OTHER

➔ R8 COST AND QUALITY INDICATORS

REQUEST

The Department requests an increase of $7.3 million total funds, including $1.0 million General Fund, for collecting and sharing health care data among community partners, and to continue development of cost and quality indicators to determine trends in underlying data.

R8 Cost & Quality Indicators				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
FY 2023-24				
Identity Resolution Services	$1,000,000	$155,100	$100,900	$744,000
Clinical Data for Care Management	1,428,040	221,489	144,089	1,062,462
Clinical Data for Core Measure Enhancement	1,247,000	105,096	80,327	1,061,577
Social Determinants of Health (SDoH) Supplemental Data	1,595,500	247,462	160,986	1,187,052
Immunization and Disease Reporting	106,090	16,454	10,705	78,931
Hybrid Data Collection and Reporting	625,000	150,338	135,378	339,284
Hospital Cost and Quality Performance Indicators	1,304,250	80,916	69,073	1,154,261
TOTAL - FY 2023-24	**$7,305,880**	**$976,855**	**$701,458**	**5,627,567**
FY 2024-25				
Identity Resolution Services	$1,000,000	$155,100	$100,900	$744,000
Clinical Data for Care Management	1,428,040	221,489	144,089	1,062,462
Clinical Data for Core Measure Enhancement	1,247,000	105,096	80,327	1,061,577
Social Determinants of Health (SDoH) Supplemental Data	1,595,500	247,462	160,986	1,187,052
Immunization and Disease Reporting	106,090	16,454	10,705	78,931
Hybrid Data Collection and Reporting	625,000	150,338	135,378	339,284
Hospital Cost and Quality Performance Indicators	748,800	116,139	75,554	557,107
TOTAL - FY 2024-25	**$6,750,430**	**$1,012,078**	**$707,939**	**$5,030,413**

IDENTITY RESOLUTION SERVICES

The Department requests $1.0 million total funds, including $155,100 General Fund, for an annual subscription to use identity resolution services. The service is foundational to much of the rest of the request and allows accurate matching of data across systems so that, for example, when the Department pulls in information about social determinates of health, then the data will be matched to the correct clients. Part of the request is to extend the identity resolution services to the All-Payer Claims Database to improve the Department's ability to compare Medicaid claims with other payers.

CLINICAL DATA FOR CARE MANAGEMENT

The Department requests $1.4 million total funds, including $221,489 General Fund, to get hospital admission, discharge, and transfer (ADT) data, laboratory test data, and claims data to Colorado Community Managed Care Network (CCMCN). The CCMCN is the data and analytics vendor for critical access hospitals, rural health centers, and federally qualified health centers. The Department argues that making ADT and lab test data more accessible will improve care coordination. The data is available from the state's two Health Information Exchanges (HIEs), but there are costs for the data and integrating the information into electronic health records that are a barrier for providers and the Department is trying to ensure that key care coordinators get this information.

CLINICAL DATA FOR CORE MEASURE ENHANCEMENT

The Department requests $1.2 million total funds, including $105,096 General Fund, to get clinical data that is stored in the Health Information Exchanges related to the Centers for Medicare and Medicaid Services (CMS) Medicaid Core Measure Sets. The CMS Medicaid Core Measure Sets compare performance across states on behavioral health, primary care access/preventive care, maternal and perinatal health, care of acute and chronic conditions, patient experience, and long-term services and supports. Reporting on the core measures is mostly voluntary but states are required to report on all child core measures and behavioral health measures for adults beginning in 2024. Currently, the Department can only report approximately 60 percent of the core measures due to lack of complete electronic health record data. The electronic health records include clinical data not available from claims data, such as depression screening results, blood pressure readings, and lab results. By purchasing the clinical data related to the CMS Medicaid Core Measure Sets, the Department will be able to report on all the measures and get a better picture of how Colorado performs relative to other states.

SOCIAL DETERMINANTS OF HEALTH (SDOH) SUPPLEMENTAL DATA

The Department requests $1.6 million total funds, including $247,462 General Fund, to purchase two data sets to improve the Department's understanding of member populations and assist in targeting resources to ensure equitable care. The data feeds would fill gaps in the Department's current information to better identify members who might be at higher risk due to social circumstances and help the Department, care coordinators, and providers to develop strategies to improve health outcomes. One data set is PREPARE assessments collected by the Colorado Community Managed Care Network. The PREPARE assessment is a national, research-based tool that is administered by FQHCs when a member presents with certain conditions. The PREPARE assessment covers many areas of interest to the Department, including six prenatal tools, five behavioral health tools, including depression screening and an anxiety assessment, information on social determinants of health, and a Transition of Care High Complexity Questionnaire. The other data set would come from the identity resolution services vendor and include information on basic contact data, income, ethnicity, race, language, religion, education, marital status, occupation, and home ownership. The Department anticipates using this information to develop predictive models that would identify populations that

are most susceptible to health inequities by, for example, identifying people with a high risk for chronic condition indicator, housing insecurity indicator, or transportation insecurity indicator.

IMMUNIZATION AND DISEASE REPORTING

The Department requests $106,090 total funds, including $16,454 General Fund, for a secure weekly data transmission from the Colorado Immunization Information System and a period transmission from the Colorado Electronic Disease Reporting System. The Department currently receives a quarterly manual feed of vaccine data and does not receive disease reporting data. The Department does get disease information when members interact with a provider, but the disease reporting data includes additional information on members who recover at home without seeing a provider. The Department's efforts to respond to COVID highlighted the need for better information sharing to inform the Department's efforts to target vaccine outreach and address racial, ethnic, and demographic disparities.

HYBRID DATA COLLECTION AND REPORTING

The Department requests $625,000 total funds, including $150,338 General Fund, for a federally certified Qualified Improvement Organization to do chart reviews on a sample of members to give a picture of performance on specific metrics in the CMS Medicaid Core Measure Sets. This alternate way of looking at the data serves as a way to validate the accuracy of the Department's reporting, especially when the Department is working with old or incomplete data. As an example, the Department says breast cancer screening claims data might lag by as much as 27 months. The Department requests funding for three years until the feeds from electronic health records can be validated.

HOSPITAL COST AND QUALITY PERFORMANCE INDICATORS

The Department requests $1.3 million total funds, including $80,916 General Fund, to develop a publicly accessible portal for use by members and providers that shows hospital cost and quality performance indicators. The portal would identify the highest performing hospitals on cultural competency, patient experience, outcomes, and cost for different procedures. The Department hopes the tool will steer more care to the highest performing hospitals.

EVIDENCE LEVEL

The Department indicated this request is theory informed, but staff believes that this request should be classified as not applicable. The Department anticipates that collection of this data and targeting interventions based on the data will lead to better health outcomes, but the Department does not cite any relevant research studies exploring whether this administrative step of collecting more data will actually result in better health outcomes.

RECOMMENDATION

Staff recommends approval of the request. The Department anticipates most of these expenditures will qualify for favorable federal match rates for information technology development and maintenance and a proportionate share of state costs can be covered by cash funds (primarily the Health Care Affordability and Sustainability (HAS) Fee) such that the requested General Fund represents only 13.4 percent of the total cost. The request should result in higher quality data that is more complete and accurate to inform care coordination and policy decision making.

Getting the information is one thing and doing something with it is another. The JBC staff suspects that funding this request may lead to additional requests in the future to implement interventions.

The Hospital Cost and Quality Performance Indicators component of the request sounds potentially controversial based on how the Department defines quality. To the extent the request relies on members and providers reviewing the information in the portal to make health care choices, the JBC staff is skeptical that it will have much impact on health outcomes. Patients and providers are overwhelmed by information and make choices about where to get care based on a variety of factors that are not all rational or related to quality or cost. The benefit of such a portal might have more to do with increasing public awareness about high and low performing hospitals and encouraging hospitals to compete on the metrics measured. The JBC staff considered recommending against this portion of the request, but the General Fund share of development costs is only $80,916 and the on-going administrative cost is only $116,139 General Fund. The focus on hospital performance transparency is consistent with other recent initiatives approved by the General Assembly.

➔ R10B CHILDREN WITH COMPLEX NEEDS

REQUEST

The Department requests $400,086 total funds, including $200,043 General Fund, for four new positions (3.7 FTE in the first year) to create a department team for children with complex and co-occurring needs. Also, the Department requests a budget neutral move of $6,070,873 total funds, including $3,035,437 General Fund, from the Medical Services Premiums line item to the Behavioral Health Capitation Payments line item to reflect an administrative change in how the Department covers behavioral health services for people with autism spectrum disorder. A third part of R10 that would add a new skilled and therapeutic respite care benefit for children with intellectual and developmental disabilities will be addressed during figure setting for the Office of Community Living.

DEPARTMENT TEAM FOR CHILDREN WITH COMPLEX AND CO-OCCURRING NEEDS

The Department team for children with complex and co-occurring needs would focus on compliance with federal and state requirements for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The proposed four-person team includes an administrator, two nurses, and a compliance specialist. The team would oversee the approval process for EPSDT exceptions that authorize additional services beyond the state Medicaid plan and provide training, auditing, and technical assistance to ensure that all services and vendors meet EPSDT requirements. In addition, the team would act as liaisons for the members with the providers, agencies, and Regional Accountable Entities in navigating benefits and coordinating the clinical care for children with complex and co-occurring needs that may cross multiple systems and state payment policies. The team would collect data and identify and quantify recurring issues and service gaps for children with complex and co-occurring needs to improve benefit navigation and care coordination.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit covers all medically necessary services for children that are allowable under the federal Medicaid program and needed to correct and ameliorate health conditions, regardless of whether those services are specifically identified in a state's Medicaid plan. Over 40 percent of Colorado's Medicaid population is under the age of 21 and eligible for EPSDT. States are responsible for determining medical necessity on a case-by-case basis following federal guidelines. The EPSDT benefit can result in additional services covered for children that go beyond the state Medicaid plan and beyond the standards in private insurance, particularly for children with special needs. A number of recent national studies have suggested shortcomings in the delivery of the required EPSDT benefit. For example, a Government Accounting

Office review found that nationally only 21 percent of children ages 2 through 5 had a dental visit in the prior year and 19 percent of children ages 1 through 5 were screened for lead exposure. Several lawsuits have been brought against states for insufficient implementation of the EPSDT benefit, including one against Colorado involving Intensive Home- and Community-Based Services that was eventually dismissed. The EPSDT benefit was created in 1967 to address untreated childhood illnesses that came to light through high rejection rates for military draftees. The concern when EPSDT services are not provided properly is that children may experience lifelong health, financial, and wellbeing consequences.

The requested resources are intended to ensure that the Department meets the requirements of EPSDT, especially for these complex and potentially ambiguous cases where children have co-occurring needs, which may require an EPSDT exception for services beyond the standard state Medicaid plan.

BEHAVIORAL HEALTH SERVICES FOR PEOPLE WITH AUTISM SPECTRUM DISORDER

The Department plans to add Autism Spectrum Disorder (ASD) as a covered diagnosis under the capitated behavioral health benefit. The Department says that adding ASD as a covered diagnosis under the capitated behavioral health benefit will improve program delivery.

Currently, when members with ASD seek psychotherapy or other behavioral health services, the payments sometimes initially get denied based on whether ASD is the primary diagnosis. The Department believes the clients get services, because behavioral health treatment for people with ASD is a covered Medicaid benefit even though ASD is not currently a covered diagnosis under the capitated behavioral health benefit. Although the Department thinks the clients get services, the way the benefit is currently designed causes unnecessary confusion, anxiety, debate about the primary diagnosis, administrative intervention to help clients and providers navigate the benefit, and potentially delays in service delivery.

The Department assumes that adding ASD as a covered diagnosis under the capitated behavioral health benefit will not increase expenditures but just move the expenditures from the Medical Services Premiums line item to the Behavioral Health Capitation Payments line item.

In addition to providing more clarity about what Medicaid covers, the Department says that the change would better define the powers and responsibilities of the Regional Accountable Entities (RAEs) in managing the benefit, including developing and contracting for an adequate network of providers.

RECOMMENDATION

Staff recommends approval of the request with modification to apply the JBC's common policies regarding new FTE. The Department's decisions about EPSDT continue to be highly scrutinized and that attention has helped the Department identify ways to improve compliance with EPSDT, especially for children with complex and co-occurring needs. The change to behavioral health services for people with ASD will not alter the benefits people are eligible to receive and it is described as a cost neutral administrative clarification. The JBC staff has concerns the request may not capture potential increases in expenditures that could occur due to people with ASD having quicker and easier access to behavioral health services, but the JBC staff lacks sufficient information to suggest a modification to the projected cost. Even if the request results in a marginal increase in expenditures

for behavioral health services for people with ASD, it is still appropriate in order to ensure that Medicaid clients receive the intended benefits.

R10(b) Children with Complex Needs				
	Total Funds	General Fund	Federal Funds	FTE
FY 2023-24				
Team for Children with Complex Needs				
Administrator IV	$84,328	$42,164	$42,164	0.9
Nurse II	107,801	53,901	53,900	0.9
Nurse II	107,801	53,901	53,900	0.9
Compliance Specialist IV	84,328	42,164	42,164	0.9
Subtotal - Team for Children with Complex Needs	$384,258	$192,130	$192,128	3.6
Behavioral Health Services for People with ASD				
Medical Services Premiums	(6,070,873)	(2,974,728)	(3,096,145)	0.0
Behavioral Health Capitation Payments	6,070,873	2,974,728	3,096,145	0.0
TOTAL - FY 2023-24	**$384,258**	**$192,130**	**$192,128**	**3.6**
FY 2024-25				
Team for Children with Complex Needs				
Administrator IV	$108,584	$54,292	$54,292	1.0
Nurse II	136,522	68,261	68,261	1.0
Nurse II	136,522	68,261	68,261	1.0
Compliance Specialist IV	108,584	54,292	54,292	1.0
Subtotal - Team for Children with Complex Needs	$490,212	$245,106	$245,106	4.0
Behavioral Health Services for People with ASD				
Medical Services Premiums	(6,070,873)	(3,035,437)	(3,035,436)	0.0
Behavioral Health Capitation Payments	6,070,873	3,035,437	3,035,436	0.0
TOTAL - FY 2024-25	**$490,212**	**$245,106**	**$245,106**	**4.0**

➔ R11 Compliance

Request

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

Recommendation

Staff recommends approval of the request with modification to provide one additional staff for fraud, waste, and abuse, rather than the requested two, and to apply the JBC's common policies regarding new FTE. The components of the staff recommendation are summarized in the table below and detailed in the narrative descriptions of each component that follow the table.

R11 Compliance					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2023-24					
S.B. 22-236 Review Medicaid Provider Rates	$263,449	$79,034	$52,690	$131,725	2.8
S.B. 21-131 Protect Personal Identifying Info Kept by State	(9,900)	(2,970)	(1,980)	(4,950)	0.0
Eligibility Interface Contract Manager	103,601	25,900	0	77,701	0.9
Third Party Liability - Contract Adjustment	(8,831,063)	(2,914,251)	(1,501,281)	(4,415,531)	0.0
Third Party Liability - Department Administration	71,971	23,750	12,235	35,986	0.9

R11 Compliance					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Fraud, Waste, and Abuse- Staff	143,942	71,971	0	71,971	1.8
Fraud, Waste, and Abuse- Recoveries	(1,353,363)	(384,933)	(64,658)	(903,773)	0.0
TOTAL - FY 2023-24	**($9,611,363)**	**($3,101,499)**	**($1,502,994)**	**($5,006,871)**	**6.4**
FY 2024-25					
S.B. 22-236 Review Medicaid Provider Rates	$318,197	$95,459	$63,639	$159,099	3.0
S.B. 21-131 Protect Personal Identifying Info Kept by State	0	0	0	0	0.0
Eligibility Interface Contract Manager	124,851	31,212	0	93,639	1.0
Third Party Liability - Contract Adjustment	0				0.0
Third Party Liability - Department Administration	87,207	28,777	14,826	43,604	1.0
Fraud, Waste, and Abuse- Staff	174,414	87,206	0	87,208	2.0
Fraud, Waste, and Abuse- Recoveries	(2,706,725)	(769,865)	(129,315)	(1,807,545)	0.0
TOTAL - FY 2024-25	**($2,002,056)**	**($527,211)**	**($50,850)**	**($1,423,995)**	**7.0**

S.B. 22-236 Review Medicaid Provider Rates

This JBC bill made several changes to the Medicaid rate review process including, most relevant for this request, changing the rate review cycle from five years to three years. The Department argues that the compressed review cycle means that more rates need to be analyzed per year and therefore the Department needs more staff. Going from a five-year cycle to a three-year cycle increases the rates that need to be reviewed per year by 66.7 percent.

The Department currently has 4.0 FTE and $250,000 in contract services specifically appropriated for and devoted to the rate review process. In addition, the Department estimates that the time contributed by the benefit managers for the specific rates being reviewed in a particular year represents another approximately 1.0 - 2.0 FTE.

To handle the additional workload of the compressed review cycle, the Department is requesting three positions.

S.B. 21-131 Protect Personal Identifying Info Kept by State

This bill imposed a number of requirements on state agencies regarding personal identifying information. For the Department, the following requirements drive additional costs:

- The Department must record and report quarterly to the Governor's Office requests for records containing personal identifying information and retain a written record containing the request, the date of the request, whether the request was granted or denied, the name of Department employee who granted or denied the request, the purpose of the request, the identity of the requestor, and a summary of the outcome of the request.
- The Department must collect annual attestations from non-state employees certifying that they will not utilize immigration information in non-public state databases for impermissible purposes. The Department anticipates a need for county and vendor education and outreach and contract amendments to comply with the law.
- The Department must ensure that all non-public department databases (e.g. the Department's Colorado Benefits Management System, Medicaid Management Information System, and Business Intelligence Data Management system) display a "pop-up" window warning individual third-party users when they sign in about the prohibition on misuse of the immigration information contained in the databases.

The Department requests a total of $59,900 spread over two years to implement the bill. This includes $9,900 in FY 2022-23 to implement the required pop-up window and $25,000 in FY 2022-23 plus another $25,000 in FY 2023-24 for county and vendor education and outreach. The General Assembly already approved the FY 2022-23 funding in the supplemental, so the net change from FY 2022-23 to FY 2023-24 for this component of the request is actually a decrease of $9,900 due the end of the one-time funding for the pop-up window.

ELIGIBILITY INTERFACE CONTRACT MANAGER

The Department requests one new position (0.9 FTE in the first year due to the pay date shift) to increase oversight of contracts related to eligibility determinations. The Department has made a number of improvements to the eligibility determination process to increase automation and improve the accuracy and timeliness by connecting with external resources that help the Department verify assets and income. The Department has also added duties to the contracts related to income verification, random moment time sampling, and Systemic Alien Verification for Entitlements (SAVE). These improvements to the eligibility determination process reduce the administrative burden on applicants and county eligibility staff. However, the improvements come with increased complexity of the contracts, increased needs for vendor oversight, additional performance metrics, and training responsibilities. To ensure proper oversight, the Department requests an additional contract manager.

THIRD PARTY LIABILITY

The Department indicates that vendor costs for obtaining information on Medicaid clients' eligibility for third party insurance are significantly lower than anticipated, but internal costs to load the information into the Department's billing system and manage and oversee the contract are higher than expected. The Department requests a net decrease in funding and an increase of two positions (1.8 FTE in the first year due to the pay date shift).

In FY 2020-21, the Department received funding to load commercial insurance eligibility data into the Department's billing system. This allowed the Department to require up front that claims be submitted to the third party before Medicaid paid, rather than Medicaid paying the claim and then using a vendor who earns a contingency fee to recover the payment, resulting in a net savings. By federal law, Medicaid is the payer of last resort when a client has third party insurance.

FRAUD, WASTE, AND ABUSE

The Department requests two new positions including an administrator to review escalated billing tickets and a compliance specialist to coordinate with the Attorney General's Office when the Department is in appeals with providers on program integrity audit findings and litigation. After the Department received resources to increase staff levels for the Member Contact Center, one of the results was that the Department fielded more calls related to illegal billing activity that needed to be escalated to the fraud, waste, and abuse division. In addition, the Department has received multiple funding increases for the fraud, waste, and abuse division, allowing the Department to pursue more cases, resulting in more appeals. The Department argues that hiring specialized staff to handle escalated illegal billing calls and appeals will allow fraud, waste, and abuse staff to pursue more claims, resulting in a net savings.

The JBC staff agrees that the increase in cases referred from the Member Contact Center needs to be investigated from a customer service perspective and as a matter of due diligence. The increase in billing-related concerns is a byproduct of the Department's improvements to the Member Contact

Center such that people are actually getting through to a person to register their complaints. The increase in billing complaints was not anticipated when the General Assembly approved increased funding for the Member Contact Center. The JBC staff is less certain that the quality of the leads from the Member Contact Center will be such that additional staff to investigate these cases will generate the same average net savings as existing investigative staff. However, the JBC staff does not have a defensible basis for modifying the estimated savings beyond gut instinct, so the JBC staff used the Department's estimate that is at least based in past experience, even if that past experience is only mostly equivalent and not entirely equivalent to the new task.

The JBC staff does not agree that an increase in appeals justifies an additional position. If appeals are increasing proportionate to the increase in resources for the fraud, waste, and abuse unit, then that is an expected outcome and not a reason by itself to add more people. If appeals are growing faster than the increase in resources, then that might actually be an indicator that the Department is reaching diminishing returns on additional investigators and bringing cases that are less defensible. The Department didn't provide data in the request on the appeal trends and the JBC staff ran out of time to track down the information, but decided that it wasn't actually necessary for the analysis. Whether the Department needs additional fraud investigators is a more nuanced question than just the number of appeals. The Department needs to look at the types of violations being identified and the appropriate deterrents. Are the cases mostly technical issues or the result of sloppy billing? Maybe the Department needs improved provider training, better billing user interfaces, or automated controls to prevent improper billing up front. Do the cases suggest malicious intent to game the payment system? Maybe the Department needs more severe penalties as a deterrent. These are some of the kinds of issues relevant to a proposal for more investigators that the Department did not address in the request, which mentioned only the increase in appeals.

Every couple years the Department submits a request for more investigative staff, always with the justification that the additional staff will more than pay for themselves with additional recoveries from identified fraud, waste, and abuse. These frequent requests make it appear as if the Department's capacity to identify additional fraud, waste, and abuse is infinite. However, there is a point of diminishing returns and just because the Department might be able to increase recoveries does not mean that focusing on investigations is the best use of the Department's time and energy. Some level of billing error is unavoidable and probably should be acceptable in the interest of not making providers and clients jump through excessive hoops and documentation. If Medicaid were a store, sometimes people count the change wrong, or shoplift small amounts. Not every deterrent is worth changing the atmosphere of the store for the majority of transactions that occur as intended.

By including a request for additional fraud, waste, and abuse staff, and the associated estimated savings from recoveries, with a request for unrelated FTE, the Department can offset the cost of the unrelated new FTE with the savings from additional recoveries. The JBC staff does not know if that was the Department's motivation with this request. The JBC staff believes the Department did not build a sufficient case for why an additional investigator is needed. Other than an increase in appeals, the only other justification in the request is that the state can get more recoveries and therefore, the request implies, the state should. The JBC staff does not agree that the possibility of additional recoveries is sufficient justification by itself for additional investigative staff.

The JBC staff modified the estimated additional fraud, waste, and abuse recoveries to account for the recommendation for fewer staff.

➔ R14 CONVERT CONTRACTS TO FTE

REQUEST

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 contract funding for stakeholder engagement to instead hire FTE for the same purpose. 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 has frequent need to solicit stakeholder feedback to assist in developing policies. The Department generally meets this need in two ways. First, the Department often hires third party contractors to do outreach, organize and facilitate meetings, collect written feedback, and gather and categorize and summarize responses. The Department says contract services are useful and continue to have a place for projects that require high capacity, technical subject matter expertise, or a neutral third party to manage sensitive and political issues or perceived conflicts of interest. However, for more typical projects the Department says it struggles with inconsistent performance and procedures across contractors and, due to switching contractors, a lack of institutional history or an ability to learn and improve from prior experiences with specific Medicaid stakeholder groups, which can be hard to reach and engage. Second, the Department sometimes relies on program administrators to conduct stakeholder engagement. These program administrators are hired because of their technical skills or program knowledge, such as relevant clinical experience, and may lack experience and training to lead high quality, efficient, and effective stakeholder engagement. To address these challenges, the Department proposes developing an internal team focused on stakeholder engagement that would support all programs.

The four-person team would improve and standardize procedures, craft best practice guidelines, update the guidelines as the Department learns from effective and ineffective experiences, manage stakeholder engagement campaigns, and oversee any contracts with third party facilitators.

When the Department contracts for stakeholder services, it often costs more than the Department would pay for state FTE to do the same work. The contractors are trying to earn profit margins and they have administrative overhead costs for things like human resources and accounting that duplicate what the Department already has in place for state FTE. For these reasons, the Department anticipates using state FTE will result in a small net savings compared to contract services.

The Department's proposed reduction in contractor funding is based on the FY 2021-22 actual contract expenditures for stakeholder engagement. Contracts for stakeholder engagement are ad hoc and typically short term, but the Department consistently contracts for several different projects every year. The Department assumes the FY 2021-22 actual expenditures are representative of what the Department typically spends on an annual basis.

EVIDENCE LEVEL

The Department indicated this request is theory informed, but staff believes that this request should be classified as not applicable. The Department indicated other programs have benefited from previously approved budget requests to convert contractor resources to state FTE. This is a highly subjective perspective from the Department. It might be informed by internal metrics but, if so, those metrics were not shared in the request and would not necessarily be relevant to this new and different proposal. There have been no research studies evaluating the outcomes.

RECOMMENDATION

Staff recommends approval of the request with modification to apply the JBC's common policies regarding new FTE. The request results in a modest net savings and the Department presents a reasonable argument for why state FTE might result in better and more consistent processes and performance.

R14 Convert Contracts to FTE					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2023-24					
Stakeholder Engagement Team					
MKTG & Comm Spec IV	$255,387	$84,278	$43,416	$127,693	2.8
MKTG & Comm Spec V	104,623	34,526	17,786	52,311	0.9
Subtotal – Stakeholder Engagement Team	$360,010	$118,804	$61,202	$180,004	3.7
General Professional Services	(467,205)	(164,125)	(69,478)	(233,602)	0.0
TOTAL - FY 2023-24	**($107,195)**	**($45,321)**	**($8,276)**	**($53,598)**	**3.7**
FY 2024-25					
Stakeholder Engagement Team					
MKTG & Comm Spec IV	$109,458	$36,121	$18,608	$54,729	3.0
MKTG & Comm Spec V	109,458	36,121	18,608	54,729	1.0
Subtotal – Stakeholder Engagement Team	$218,916	$72,242	$37,216	$109,458	4.0
General Professional Services	(467,205)	(164,125)	(69,478)	(233,602)	0.0
TOTAL - FY 2023-24	**($248,289)**	**($91,883)**	**($32,262)**	**($124,144)**	**4.0**

➔ R15 TRANSFERS BETWEEN LINES

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 (CIVHIC) reporting analysis contract out of the MMIS line item and into the All-Payer Claims Database line item.

RECOMMENDATION

Staff recommends approval of the request. This is a budget neutral technical change to the structure of the budget that does no harm. The Pharmacy Benefits Prescriber Tool provides information to physicians on drug costs, the Department's preferred drug list, prior authorization requirements, and member-based risk factors based on diagnosis. Prescribers share in the savings if they increase their percentage of prescriptions from the preferred drug list or the lower cost option among multiple drugs on the preferred drug list. The Pharmacy Benefits Prescriber Tool relies on and is closely integrated with the Department's Pharmacy Benefits Management System that is funded from the Medicaid Management Information Systems line item. The CIVHIC reporting analysis contract pays for

comparisons of Medicaid with other payers using data from the All-Payer Claims Database. The information is used for the Access to Care Report, Hospital Price Report, Hospital Discharge Report, and several ad hoc reports each year. CIVHIC is the entity that operates the All-Payer Claims Database. From a budget transparency perspective, both proposed moves make sense.

In addition to improved budget transparency, the Department says the moves will ease the accounting administration with all the funds for each contract in the same line item instead of split between two line items.

The Department has statutory authority, in Section 25.5-4-211, C.R.S., to request rollforward authority from the State Controller for appropriations to the Medicaid Management Information System for up to one year. This does not appear to be a factor in the request. The Department is past the development phase for the Pharmacy Benefits Prescriber Tool and in the more stable maintenance and updates phase. The Department does not anticipate needing any rollforward authority for the Pharmacy Benefits Prescriber Tool.

R15 Transfers Between Lines				
	Total Funds	General Fund	Cash Funds	Federal Funds
Pharmacy Benefits Prescriber Tool				
General Professional Services and Special Projects	($2,996,163)	($988,734)	($509,348)	($1,498,081)
Medicaid Management Information Systems Maintenance & Projects	2,996,163	988,734	509,348	1,498,081
CIVHIC Reporting Analysis Contract				
Medicaid Management Information Systems Maintenance & Projects	(263,000)	(131,500)	0	(131,500)
All- Payers Claims Database	263,000	131,500	0	131,500
TOTAL	**$0**	**$0**	**$0**	**$0**

➔ BA6 Eligibility redeterminations

Request

The Department requested $18.5 million total funds, including $2.6 million General Fund, for administrative resources to process eligibility redeterminations when the continuous coverage requirement for Medicaid ends. However, the request assumed the continuous coverage requirement would end January 31, 2023. Subsequent to the request, the federal government passed the Consolidated Appropriations Act of 2023 revising the timeline for the end of the continuous coverage requirement to March 31, 2023.

The JBC approved a supplemental for FY 2022-23 that took into account the revised timeline. Also, the JBC modified the Department's original request to remove the assumption that a portion of the costs would be covered by county resources and instead provide General Fund. The supplemental was approved by the General Assembly as modified by the JBC. As a result, the original requested amount no longer reflects the Department's need based on more recent action.

The federal Families First Coronavirus Response Act (FFCRA) authorized states to receive an additional 6.2 percentage point federal match for Medicaid during the public health emergency declaration by the federal Secretary of Health and Human Services but, as a condition of receiving the additional match, prohibited states from reducing benefits or disenrolling people from Medicaid due to a change in income or family size beginning in March 2020. The Department was not required to implement continuous eligibility for CHP+ but elected to do so.

When the continuous coverage requirement ends, the Department will need to redetermine eligibility for all the people who have been locked in. The Department estimates it will need to redetermine eligibility for 530,476 people. Under federal guidance, the Department has 12 months to complete the redeterminations. Most of the work will be done by county eligibility offices and the request includes funding for 234 additional county staff to handle the volume.

People with an adverse action have a right to appeal the finding to the county and state. The request includes funding for another 48 county staff to handle the appeals plus Department staff and administrative court hearing officers to manage appeals that are escalated to the Department.

RECOMMENDATION

Staff recommends an increase of $12.9 million total funds, including $3.2 million General Fund in the Department of Health Care Policy and Financing and another $2.0 million reapporpriated funds in the Department of Personnel and Administration to annualize the General Assembly's action on the supplemental. The table below summarizes the actual expenditures in FY 2021-22, the appropriation for FY 2022-23, and the recommended appropriations for FY 2023-24 and FY 2024-25. The increase needed for FY 2023-24 is the incremental difference between the recommendation and the FY 2022-23 appropriation.

BA6 Eligibility redeterminations					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2021-22 Actual expenditures					
HCPF					
County Administration	$3,934,901	$835,321	$262,490	$0	$2,837,090
Department appeals	0	0	0	0	0
Administrative court services	0	0	0	0	0
Subtotal - HCPF	$3,934,901	$835,321	$262,490	$0	$2,837,090
Personnel & Administration					
Office of Administrative Courts	0	0	0	0	0
TOTAL - FY 2021-22 Actual	**$3,934,901**	**$835,321**	**$262,490**	**$0**	**$2,837,090**
FY 2022-23 Appropriation with Approved Supplemental					
HCPF					
County Administration	$10,758,760	$2,342,246	$736,023	$0	$7,680,491
Department appeals	245,833	73,651	49,265	0	122,917
Administrative court services	1,244,952	372,988	249,488	0	622,476
Subtotal - HCPF	$12,249,545	$2,788,885	$1,034,776	$0	$8,425,884
Personnel & Administration					
Office of Administrative Courts	1,244,952	0	0	1,244,952	0
TOTAL - FY 2022-23	**$13,494,497**	**$2,788,885**	**$1,034,776**	**$1,244,952**	**$8,425,884**
FY 2023-24					
HCPF					
County Administration	$21,010,078	$4,728,220	$1,485,787	$0	$14,796,071
Department appeals	879,325	263,445	176,217	0	439,663
Administrative court services	3,251,165	974,049	651,533	0	1,625,583
Subtotal - HCPF	$25,140,568	$5,965,714	$2,313,537	$0	$16,861,317
Personnel & Administration					
Office of Administrative Courts	3,251,165	0	0	3,251,165	0
TOTAL - FY 2023-24	**$28,391,733**	**$5,965,714**	**$2,313,537**	**$3,251,165**	**$16,861,317**
Incremental change needed	$14,897,237	$3,176,829	$1,278,761	$2,006,213	$8,435,434

BA6 Eligibility redeterminations					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
FY 2024-25					
HCPF					
County Administration	$292,080	$111,121	$34,919	$0	$146,040
Department appeals	73,277	21,953	14,685	0	36,639
Administrative court services	270,930	81,170	54,294	0	135,466
Subtotal - HCPF	$636,287	$214,244	$103,898	$0	$318,145
Personnel & Administration					
Office of Administrative Courts	270,930	0	0	270,930	0
TOTAL - FY 2024-25	**$907,217**	**$214,244**	**$103,898**	**$270,930**	**$318,145**
Cumulative Total	$46,728,348	$9,804,164	$3,714,701	$4,767,047	$28,442,436

➔ BA10 PROVIDER ENROLLMENT FEE & ESTATE RECOVERIES

REQUEST

The Department requests annualization of the supplemental *S10 Provider enrollment fee & estate recoveries* that was approved by the General Assembly. Among other provisions, the supplemental included a one-time appropriation of $578,163 in FY 2022-23 from provider enrollment fees that had accumulated in the Health Care Policy and Financing Cash Fund to offset administrative costs of screening providers, such as verifying medical licensing, checking federal databases, and site visits. After spending down the accumulated balance in FY 2022-23, the cash funds are no longer available in FY 2023-24 and must be replaced with $85,525 General Fund and $432,078 federal funds. The total funds do not change.

RECOMMENDATION

Staff recommends approval of the request, consistent with the General Assembly's action on the supplemental.

➔ BA12 ECONSULT DELAYED IMPLEMENTATION

REQUEST

The Department requests moving funding associated with clinical and quality reviews for the eConsult program from the Provider Audits and Services, Professional Audit Contracts line item to the Medicaid Management Information System Maintenance and Projects line item. The eConsult program, which is currently under development, is intended to help primary care providers connect with specialists who accept Medicaid reimbursement. It is intended to increase client access to specialist services and make it easier for specialists to serve Medicaid clients. Part of the funding provided was for development and operation of the system and part to evaluate eConsults for whether primary care providers submitted true clinical questions and whether specialists submitted appropriate responses.

The funding for the quality and clinical reviews was appropriated in the Provider Audits and Services, Professional Audit Contracts line item, as requested. The Department expected to contract for these services for the first two years of the program and then bring the work in-house to a state data and quality specialist FTE that was requested and funded. The Department assumed it would use a separate vendor for the quality and clinical reviews, but subsequently determined it would use the same vendor

for development of the system and the quality and clinical reviews. The Department argues that putting the funding for the quality and clinical reviews in a separate line item from the rest of the vendor contract increases the administrative workload for those who need to account for the funding and reduces budget transparency. Also, the new line item where the Department wants to put the funding for the quality and clinical reviews has roll forward authority that is lacking in the Professional Audit Contracts line item.

STAFF RECOMMENDATION

Staff does not recommend approval of the request, consistent with the JBC's action on the supplemental S12. The JBC denied the supplemental because there was no technical error. The Department subsequently changed its procurement strategy, but that new information doesn't change the purpose of the funding or require a transfer between line items. The Department can make the current structure of the appropriation work, and it only needs to do so for two years until the work is brought in-house.

➔ STAFF-INITIATED – SAFETY NET PROVIDER PAYMENTS

REQUEST

The Department did not submit a formal request, but after the official deadline for supplementals and budget amendments the Department alerted the JBC staff to a shortfall in the appropriation for the Safety Net Provider Payments line item. The line item partially reimburses hospitals for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to adults and emancipated minors with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The source of cash funds is the Healthcare Affordability and Sustainability (HAS) Fee and the federal match rate is at the standard Medicaid rate. Colorado draws the federal funds for Safety Net Provider Payments through a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. The cash funds and federal funds are dependent on annual federal approval of the Department's HAS Fee model. In prior years, delays in federal approval have resulted in large true ups of the supplemental payments in the last quarter of the federal fiscal year, which is the first quarter of the next state fiscal year. This year, the Department anticipates federal approval in the current fiscal year, which would allow true ups in FY 2022-23. Truing up the funding as quickly as possible minimizes potential cash flow issues for hospitals. However, the current appropriation for FY 2022-23 is not sufficient for the Department to make the true up payments in FY 2022-23.

RECOMMENDATION

Staff recommends a supplemental add-on to increase the FY 2022-23 appropriation by $18,525,825 total funds, including $8,169,889 cash funds from the HAS Fee and $10,355,936 federal funds, to align with the expected federal approval of the HAS Fee model. This is a one-time true up of the FY 2022-23 appropriation and does not impact FY 2023-24.

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and

provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Healthcare Affordability and Sustainability Fee.

EXECUTIVE DIRECTOR'S OFFICE						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$499,661,884	$107,058,723	$99,127,872	$4,747,037	$288,728,252	668.2
Other Legislation	25,391,329	7,652,308	755,490	72,826	16,910,705	27.8
TOTAL	**$525,053,213**	**$114,711,031**	**$99,883,362**	**$4,819,863**	**$305,638,957**	**696.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$525,053,213	$114,711,031	$99,883,362	$4,819,863	$305,638,957	696.0
R6 Value-based payments	1,020,000	510,000	0	0	510,000	0.0
R7a Provider rates	2,642,777	316,605	561,326	0	1,764,846	0.0
R8 Cost and quality indicators	7,305,880	976,856	701,458	0	5,627,566	0.0
R9 Perinatal services	630,000	315,000	0	0	315,000	0.0
R10 Children with complex needs	384,258	192,129	0	0	192,129	3.6
R11 Compliance	(8,258,000)	(2,716,566)	(1,438,336)	0	(4,103,098)	6.4
R12 Non Medicaid BH eligibility & claims	2,738,635	2,738,635	0	0	0	8.4
R13 Case management redesign	646,000	168,000	55,000	0	423,000	0.0
R14 Convert contracts to FTE	(107,195)	(45,322)	(8,276)	0	(53,597)	3.7
R15 Transfers between lines	0	0	0	0	0	0.0
BA6 Eligibility redeterminations	12,891,024	3,176,828	1,278,762	0	8,435,434	0.0
BA7 Community based access to services	1,419,125	175,000	517,913	0	726,212	0.0
BA8 ARPA HCBS adjustments	418,951	0	3,588,126	0	(3,169,175)	5.7
BA10 Provider enrollment fee & estate recoveries	0	85,525	(517,603)	0	432,078	0.0
BA11 Behavioral health crisis response	338,400	338,400	0	0	0	0.0
BA12 eConsult technical adjustment	0	0	0	0	0	0.0
BA20 Clinical navigation services	271,904	135,953	0	0	135,951	1.9
NP Promoting equity through technology	3,475,761	487,674	204,431	374,415	2,409,241	4.6
Centrally appropriated items	8,201,915	3,626,608	435,760	(64,564)	4,204,111	5.0
NP Statewide operating inflation	266,722	106,712	24,356	4,649	131,005	0.0
Indirect cost recoveries	264,914	0	(76,093)	118,832	222,175	0.0
Annualize prior year budget actions	39,748,142	15,337,820	(14,466,752)	(20,004)	38,897,078	(9.8)
Transfers to other state agencies	1,063	532	0	0	531	0.0
Technical adjustment	0	0	0	0	0	0.0
TOTAL	**$599,353,489**	**$140,637,420**	**$90,743,434**	**$5,233,191**	**$362,739,444**	**725.5**
INCREASE/(DECREASE)	**$74,300,276**	**$25,926,389**	**($9,139,928)**	**$413,328**	**$57,100,487**	**29.5**
Percentage Change	14.2%	22.6%	(9.2%)	8.6%	18.7%	4.2%
FY 2023-24 EXECUTIVE REQUEST	**$624,758,479**	**$137,487,173**	**$110,159,346**	**$5,233,191**	**$371,878,769**	**746.0**
Request Above/(Below) Recommendation	$25,404,990	($3,150,247)	$19,415,912	$0	$9,139,325	20.5

LINE ITEM DETAIL — EXECUTIVE DIRECTOR'S OFFICE

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, employee-related expenses and benefits, operating expenses, and general contract services. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

STATUTORY AUTHORITY: Section 25.5-1-104 et. seq., C.R.S.

CENTRALLY APPROPRIATED LINE ITEMS SET BY JBC COMMON POLICY

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases the common policy allocates costs to agencies for a centralized service based on prior year actual utilization of that service by the department. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

REQUEST: The Department requests:

- Annualizations of prior year bills and budget actions
- Application of the OSPB common policies
- Benefits associated with new requested FTE
- Non prioritized requests associated with decision items submitted by other departments

RECOMMENDATION: Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below, including the way benefits for new FTE are handled. Note that the JBC's common policy was pending for some of the line items at the time this document was prepared. The amounts included in the numbers pages and department and division summary tables for the pending items are based on the request and will be updated to reflect the JBC's actions.

Centrally appropriated line items
Health, Life, and Dental
Short-term Disability
Amortization Equalization Disbursement
Supplemental AED
PERA Direct Distribution
Salary Survey
Workers' Compensation
Legal Services
Administrative Law Judge Services
Payment to Risk Management and Property
Capitol Complex Leased Space
Payments to OIT
IT Accessibility
CORE Operations
Statewide Training

The base recommendations for legal services and administrative law judge services are for continuation hours.

Personal Services

This line item contains all of the personal services for the Department's employees, including employee salaries and the employer contributions to PERA and Medicare taxes. The line item also includes funding for temporary employees, employee buy-outs, and some contract services. However, most of the Department's professional contract service costs are contained in separate line items.

Request: The Department requests:

- Funding associated with new FTE requested in R10, R11, R12, R14, BA6, and BA8, BA20, and a nonprioritized request for promoting equity through technology
- Annualizations of prior year bills and budget actions

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

Executive Director's Office, General Administration, Personal Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$55,672,434	$20,245,130	$6,314,203	$2,205,581	$26,907,520	665.2
Other Legislation	$2,087,307	$1,320,849	($292,496)	$67,440	$991,514	27.8
TOTAL	**$57,759,741**	**$21,565,979**	**$6,021,707**	**$2,273,021**	**$27,899,034**	**693.0**
FY 2023-24 Recommended Appropriation						
FY 2022-23 Appropriation	$57,759,741	$21,565,979	$6,021,707	$2,273,021	$27,899,034	693.0
BA6 Eligibility redeterminations	2,665,706	798,644	534,208	0	1,332,854	0.0
BA8 ARPA HCBS adjustments	2,021,391	0	1,010,697	0	1,010,694	5.7
Annualize prior year budget actions	1,370,114	1,052,917	(391,837)	49,071	659,963	(9.8)
R12 Non Medicaid BH eligibility & claims	644,882	644,882	0	0	0	8.4
NP Promoting equity through technology	525,833	79,046	40,760	287,069	118,958	4.6
R11 Compliance	480,623	164,397	53,668	0	262,558	6.4
R10 Children with complex needs	325,778	162,889	0	0	162,889	3.6
R14 Convert contracts to FTE	301,530	99,505	51,260	0	150,765	3.7
BA20 Clinical navigation services	207,304	103,652	0	0	103,652	1.9
Indirect cost recoveries	132,457	0	0	132,457	0	0.0
Technical adjustment	0	(2,411)	5,575	(112)	(3,052)	0.0
TOTAL	**$66,435,359**	**$24,669,500**	**$7,326,038**	**$2,741,506**	**$31,698,315**	**717.5**
INCREASE/(DECREASE)	**$8,675,618**	**$3,103,521**	**$1,304,331**	**$468,485**	**$3,799,281**	**24.5**
Percentage Change	15.0%	14.4%	21.7%	20.6%	13.6%	3.5%
FY 2023-24 EXECUTIVE REQUEST	**$66,721,300**	**$24,659,404**	**$7,479,833**	**$2,741,506**	**$31,840,557**	**738.0**
Request Above/(Below) Recommendation	$285,941	($10,096)	$153,795	$0	$142,242	20.5

Operating Expenses

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Request: The Department requests:

- Funding associated with new FTE requested in R10, R11, R12, R14, BA6, and BA8, BA20, and a nonprioritized request for promoting equity through technology
- Annualizations of prior year bills and budget actions
- Non prioritized requests associated with decision items submitted by other departments

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

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$2,963,583	$1,185,688	$270,625	$51,654	$1,455,616	0.0
Other Legislation	$570,487	$213,050	$69,255	$7,550	$280,632	0.0
TOTAL	**$3,534,070**	**$1,398,738**	**$339,880**	**$59,204**	**$1,736,248**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$3,534,070	$1,398,738	$339,880	$59,204	$1,736,248	0.0
NP Statewide operating inflation	266,722	106,712	24,356	4,649	131,005	0.0
BA7 Community based access to services	136,500	0	68,250	0	68,250	0.0
R12 Non Medicaid BH eligibility & claims	70,906	70,906	0	0	0	0.0
BA8 ARPA HCBS adjustments	64,167	0	32,083	0	32,084	0.0
R13 Case management redesign	60,000	0	30,000	0	30,000	0.0
R11 Compliance	56,140	19,890	6,175	0	30,075	0.0
NP Promoting equity through technology	38,675	5,814	2,997	21,115	8,749	0.0
R10 Children with complex needs	32,080	16,040	0	0	16,040	0.0
R14 Convert contracts to FTE	32,080	10,586	5,454	0	16,040	0.0
BA20 Clinical navigation services	15,470	7,735	0	0	7,735	0.0
Annualize prior year budget actions	(426,637)	(149,073)	(29,756)	(40,374)	(207,434)	0.0
BA6 Eligibility redeterminations	(26,000)	(7,790)	(5,210)	0	(13,000)	0.0
TOTAL	**$3,854,173**	**$1,479,558**	**$474,229**	**$44,594**	**$1,855,792**	**0.0**
INCREASE/(DECREASE)	**$320,103**	**$80,820**	**$134,349**	**($14,610)**	**$119,544**	**0.0**
Percentage Change	9.1%	5.8%	39.5%	(24.7%)	6.9%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$3,448,826**	**$1,356,886**	**$394,312**	**$44,594**	**$1,653,034**	**0.0**
Request Above/(Below) Recommendation	($405,347)	($122,672)	($79,917)	$0	($202,758)	0.0

LEASE SPACE

This line item pays for the Department's leased space at 225 E. 16th Street and 303 E. 17th Ave.

REQUEST: The Department requests:

- Funding associated with new FTE requested in R10, R11, R12, R14, BA6, and BA8, BA20, and a nonprioritized request for promoting equity through technology
- Annualizations of prior year bills and budget actions

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

Executive Director's Office, General Administration, Leased Space						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$3,666,036	$1,343,990	$434,705	$31,842	$1,855,499	0.0
Other Legislation	$7,130	$40,860	($36,038)	$0	$2,308	0.0
TOTAL	**$3,673,166**	**$1,384,850**	**$398,667**	**$31,842**	**$1,857,807**	**0.0**
FY 2023-24 Recommended Appropriation						
FY 2022-23 Appropriation	$3,673,166	$1,384,850	$398,667	$31,842	$1,857,807	0.0
BA8 ARPA HCBS adjustments	180,368	0	90,186	0	90,182	0.0
R11 Compliance	46,200	16,368	5,082	0	24,750	0.0
R12 Non Medicaid BH eligibility & claims	42,627	42,627	0	0	0	0.0
R10 Children with complex needs	26,400	13,200	0	0	13,200	0.0
R14 Convert contracts to FTE	26,400	8,712	4,488	0	13,200	0.0
NP Promoting equity through technology	23,250	3,494	1,802	12,694	5,260	0.0
BA20 Clinical navigation services	9,300	4,650	0	0	4,650	0.0
Annualize prior year budget actions	(95,287)	3,300	(50,943)	0	(47,644)	0.0
TOTAL	**$3,932,424**	**$1,477,201**	**$449,282**	**$44,536**	**$1,961,405**	**0.0**
INCREASE/(DECREASE)	**$259,258**	**$92,351**	**$50,615**	**$12,694**	**$103,598**	**0.0**
Percentage Change	7.1%	6.7%	12.7%	39.9%	5.6%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$3,930,638**	**$1,466,686**	**$459,488**	**$44,536**	**$1,959,928**	**0.0**
Request Above/(Below) Recommendation	($1,786)	($10,515)	$10,206	$0	($1,477)	0.0

General Professional Services and Special Projects

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Nursing Home Penalties, and the IDD Services Cash Fund. The federal match rate varies based on the specific contracts.

Request: The Department requests:

- Funding associated with R6, R8, R9, R11, R13, R14, R15, BA7, BA8, and BA11
- Annualizations of prior year bills and budget actions

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

Executive Director's Office, General Administration, General Professional Services And Special Projects						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$68,014,149	$8,321,397	$25,419,903	$81,000	$34,191,849	0.0
Other Legislation	$9,786,501	$322,255	$5,601,520	$0	$3,862,726	0.0
TOTAL	**$77,800,650**	**$8,643,652**	**$31,021,423**	**$81,000**	**$38,054,575**	**0.0**
FY 2023-24 Recommended Appropriation						
FY 2022-23 Appropriation	$77,800,650	$8,643,652	$31,021,423	$81,000	$38,054,575	0.0

Executive Director's Office, General Administration, General Professional Services And Special Projects						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
R8 Cost and quality indicators	1,304,250	80,916	69,073	0	1,154,261	0.0
BA7 Community based access to services	1,241,000	175,000	445,500	0	620,500	0.0
R6 Value-based payments	1,020,000	510,000	0	0	510,000	0.0
R9 Perinatal services	630,000	315,000	0	0	315,000	0.0
BA11 Behavioral health crisis response	338,400	338,400	0	0	0	0.0
R13 Case management redesign	336,000	168,000	0	0	168,000	0.0
Annualize prior year budget actions	(13,970,731)	4,091,708	(13,028,275)	0	(5,034,164)	0.0
BA8 ARPA HCBS adjustments	(3,125,591)	0	(1,773,433)	0	(1,352,158)	0.0
R15 Transfers between lines	(2,996,163)	(988,734)	(509,348)	0	(1,498,081)	0.0
R14 Convert contracts to FTE	(467,205)	(164,125)	(69,478)	0	(233,602)	0.0
R11 Compliance	(9,900)	(2,970)	(1,980)	0	(4,950)	0.0
TOTAL	**$62,100,710**	**$13,166,847**	**$16,153,482**	**$81,000**	**$32,699,381**	**0.0**
INCREASE/(DECREASE)	**($15,699,940)**	**$4,523,195**	**($14,867,941)**	**$0**	**($5,355,194)**	**0.0**
Percentage Change	(20.2%)	52.3%	(47.9%)	0.0%	(14.1%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$95,160,118**	**$12,934,637**	**$34,373,336**	**$81,000**	**$47,771,145**	**0.0**
Request Above/(Below) Recommendation	$33,059,408	($232,210)	$18,219,854	$0	$15,071,764	0.0

(B) TRANSFERS TO OTHER DEPARTMENTS

EDUCATION

PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and Financing and the Department of Education. Pursuant to statute, up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are used to offset appropriations in the Medical Services Premiums line item. In this line item the state match appears as General Fund. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

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

REQUEST: The Department requests a true up to the requested funding by the Department of Education.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Education.

EARLY CHILDHOOD

EARLY INTERVENTION

This line item pays for the portion of Early Intervention services managed by the Department of Early Childhood that are eligible for Medicaid reimbursement.

REQUEST: The Department requests continuation funding, but did not account for the supplemental adjustment to funding.

RECOMMENDATION: Staff recommends funding based on the JBC's decisions regarding funding in the Department of Early Childhood.

HUMAN SERVICES

NURSE HOME VISITOR PROGRAM
This line item pays a portion of the cost for nurses to visit first-time mothers in families with incomes up to 200 percent of the federal poverty guidelines to provide education on nutrition and general child care and to promote the health and development of children. Funding for the program is appropriated to the Department of Human Services and then a portion is transferred to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. Although the Department of Human Services is the lead agency for financing, the program is actually administered by the University of Colorado Health Sciences Center. The federal match rate is at the standard FMAP for Medicaid services.

STATUTORY AUTHORITY: Section 25-31-102, C.R.S.

REQUEST: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding. Based on prior year actual expenditures, this is probably more spending authority than the line item needs, but if fewer Medicaid-eligible clients are served, then the Department of Human Services will transfer less to the Department of Health Care Policy and Financing and use the tobacco settlement monies instead to serve clients who are not eligible for Medicaid.

LOCAL AFFAIRS

HOST HOME REGULATION
This line item pays for housing inspections of host homes.

Request: The Department requests annualization of prior year budget actions.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Local Affairs. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Local Affairs funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

HOME MODIFICATIONS BENEFIT ADMINISTRATION AND HOUSING ASSISTANCE PAYMENTS
This appropriation pays the Department of Local Affairs to administer the existing Medicaid home modifications benefit. In addition, the Department of Local Affairs assists clients of the Colorado Choice Transitions (CCT) program in acquiring housing. The federal match rate is 50 percent for administration.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Local Affairs. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Local Affairs funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

PUBLIC HEALTH AND ENVIRONMENT

FACILITY SURVEY AND CERTIFICATION

This line item pays the Department of Public Health and Environment to monitor a variety of long-term care providers for safety and compliance with Medicaid regulations, including nursing homes, hospices, home health agencies, alternative care facilities, personal care/homemaking agencies, and adult day services. This monitoring is performed as part of the Department of Public Health and Environment's larger function of establishing and enforcing standards of operation for health care facilities. Financing for the Medicaid-related regulation is provided as follows:

Minimum Data Set resident assessment (used to determine nursing home patient acuity, which is a consideration in the nursing home reimbursement formula)	100% General Fund
In-the-field surveys and inspections	75% federal match
Office time preparing reports and administering the program	50% federal match

REQUEST: The Department requests a nonprioritized adjustment to match the requested funds by the Department of Public Health and Environment.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

PRENATAL STATISTICAL INFORMATION

This line item pays the Department of Public Health and Environment to collect and analyze data, through the Vital Statistics office, on the effectiveness of the Enhanced Prenatal Care program, more commonly known as Prenatal Plus. This program provides case management, nutrition, and mental health counseling for women assessed as at-risk for delivering low birth weight infants. The services address lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect pregnancy. Services are paid for in the Medical Services Premiums line item. This appropriation covers only the data collection and evaluation performed by the Department of Public Health and Environment. The federal match rate is 50 percent.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still

pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

REGULATORY AGENCIES

NURSE AIDE CERTIFICATION
This line item pays for the Department of Regulatory Agencies to certify nurse aides working in facilities with Medicaid patients. The Department of Regulatory Agencies also receives payments from Medicare. The reappropriated funds are fees for background checks transferred from the Department of Regulatory Affairs. Only non-certified nurses are required to pay the fees. The federal match rate is 50 percent.

STATUTORY AUTHORITY: Section 12-38.1-101 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding based on the JBC's actions during figure setting for the Department of Regulatory Agencies. The money is transferred to the Division of Registrations in the Department of Regulatory Agencies.

REVIEWS
This line item pays the Department of Regulatory Affairs to conduct sunset reviews of programs administered by the Department of Health Care Policy and Financing. The federal match rate depends on the program being reviewed.

STATUTORY AUTHORITY: Section 24-34-104, et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

This line item pays for maintenance of the Medicaid Management Information System (MMIS) and the Web Portal. MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-

related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives an 88 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

STATUTORY AUTHORITY: Section 25.5-4-204, C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for R8, R12, R15, BA7, BA8, BA10, and BA12.

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

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$46,579,137	$2,832,277	$11,364,076	$12,204	$32,370,580	0.0
Other Legislation	$605,642	($45,900)	($6,747,364)	$0	$7,398,906	0.0
TOTAL	**$47,184,779**	**$2,786,377**	**$4,616,712**	**$12,204**	**$39,769,486**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$47,184,779	$2,786,377	$4,616,712	$12,204	$39,769,486	0.0
Annualize prior year budget actions	56,365,238	11,105,279	1,882,060	0	43,377,899	0.0
R8 Cost and quality indicators	5,376,630	745,601	497,007	0	4,134,022	0.0
R15 Transfers between lines	2,733,163	857,234	509,348	0	1,366,581	0.0
R12 Non Medicaid BH eligibility & claims	1,121,000	1,121,000	0	0	0	0.0
BA8 ARPA HCBS adjustments	872,102	0	4,025,332	0	(3,153,230)	0.0
R13 Case management redesign	250,000	0	25,000	0	225,000	0.0
BA7 Community based access to services	41,625	0	4,163	0	37,462	0.0
BA10 Provider enrollment fee/estate recoveries	0	85,525	(517,603)	0	432,078	0.0
BA12 eConsult technical adjustment	0	0	0	0	0	0.0
TOTAL	**$113,944,537**	**$16,701,016**	**$11,042,019**	**$12,204**	**$86,189,298**	**0.0**
INCREASE/(DECREASE)	**$66,759,758**	**$13,914,639**	**$6,425,307**	**$0**	**$46,419,812**	**0.0**
Percentage Change	141.5%	499.4%	139.2%	0.0%	116.7%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$114,543,037**	**$16,776,016**	**$11,266,269**	**$12,204**	**$86,488,548**	**0.0**
Request Above/(Below) Recommendation	$598,500	$75,000	$224,250	$0	$299,250	0.0

CBMS OPERATING AND CONTRACT EXPENSES

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for R12 and a nonprioritized request for promoting equity through technology.

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

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$49,903,812	$9,821,039	$5,981,077	$1,654	$34,100,042	0.0
Other Legislation	$4,273,536	$841,032	$512,397	$0	$2,920,107	0.0
TOTAL	**$54,177,348**	**$10,662,071**	**$6,493,474**	**$1,654**	**$37,020,149**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$54,177,348	$10,662,071	$6,493,474	$1,654	$37,020,149	0.0
NP Promoting equity through technology	2,577,935	315,840	114,711	4	2,147,380	0.0
R12 Non Medicaid BH eligibility & claims	859,220	859,220	0	0	0	0.0
Annualize prior year budget actions	121,437	71,090	355	0	49,992	0.0
Centrally appropriated items	0	0	0	0	0	0.0
TOTAL	**$57,735,940**	**$11,908,221**	**$6,608,540**	**$1,658**	**$39,217,521**	**0.0**
INCREASE/(DECREASE)	**$3,558,592**	**$1,246,150**	**$115,066**	**$4**	**$2,197,372**	**0.0**
Percentage Change	6.6%	11.7%	1.8%	0.2%	5.9%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$57,735,940**	**$11,908,221**	**$6,608,540**	**$1,658**	**$39,217,521**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

CBMS HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests an adjustment for a nonprioritized request for promoting equity through technology.

RECOMMENDATION: Staff requests permission to update the total based on the JBC's action on the nonprioritized request for promoting equity through technology

OFFICE OF EHEALTH INNOVATIONS OPERATIONS

This line item pays for the operations of the Office of eHealth Innovations.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding.

ALL-PAYER CLAIMS DATABASE

This line item helps subsidize operations of the All-Payer Claims Database. A portion of the line item for Medicaid's share of costs receives a federal match. The line item also includes $500,000 General Fund for a scholarship program to promote access to the All-Payer Claims Database.

STATUTORY AUTHORITY: Section 25.5-1-204 (4)(b), C.R.S.

REQUEST: The Department requests annualizations and an adjustment related to R15.

RECOMMENDATION: The JBC staff recommends the requested funding.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital. The sources of cash funds are the Hospital Provider Fee and Colorado Autism Treatment Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-4-105, 25.5-6-104, 25.5-4-205, and 25.5-4-402.3, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

COUNTY ADMINISTRATION

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds and the federal government has increased the federal match rate. The traditional federal match was 50 percent, but a recent reinterpretation by the Centers for Medicare and Medicaid Services (CMS) expanded the activities eligible for a 75 percent match as maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests annualizations of prior year budget actions and adjustments related to R7a and BA6.

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

EXECUTIVE DIRECTOR'S OFFICE, ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES, COUNTY ADMINISTRATION						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$123,622,889	$20,061,678	$27,113,119	$0	$76,448,092	0.0
Other Legislation	(4,551,363)	92,418	(1,469,646)	0	(3,174,135)	0.0
TOTAL	**$119,071,526**	**$20,154,096**	**$25,643,473**	**$0**	**$73,273,957**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$119,071,526	$20,154,096	$25,643,473	$0	$73,273,957	0.0
BA6 Eligibility redeterminations	10,251,318	2,385,974	749,764	0	7,115,580	0.0
R7a Provider rates	2,642,777	316,605	561,326	0	1,764,846	0.0
Annualize prior year budget actions	244,100	142,863	11,924	0	89,313	0.0
TOTAL	**$132,209,721**	**$22,999,538**	**$26,966,487**	**$0**	**$82,243,696**	**0.0**
INCREASE/(DECREASE)	**$13,138,195**	**$2,845,442**	**$1,323,014**	**$0**	**$8,969,739**	**0.0**
Percentage Change	11.0%	14.1%	5.2%	0.0%	12.2%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$124,044,299**	**$19,596,414**	**$27,826,729**	**$0**	**$76,621,156**	**0.0**
Request Above/(Below) Recommendation	($8,165,422)	($3,403,124)	$860,242	$0	($5,622,540)	0.0

MEDICAL ASSISTANCE SITES

This line item pays Medical Assistance sites for their work in processing applications.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

ADMINISTRATIVE CASE MANAGEMENT

This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CUSTOMER OUTREACH

This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and

regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-5-102 (1) (g) and 25.5-5-406 (1) (a) (II), C.R.S.

REQUEST: The Department requests annualization of prior year actions.

RECOMMENDATION: Staff recommends the requested funding.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). It also includes money for determining Medicaid eligibility for adults without dependent children and the Medicaid buy-in for people with disabilities. The source of cash funds is the Hospital Provider Fee. The federal match rate varies based on the type of work and the population served. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. For populations that are "newly eligible" pursuant to the ACA the match rate is higher.

STATUTORY AUTHORITY: Section 25.5-4-102, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

This line item reimburses Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

REQUEST: The Department requests annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the requested funding.

ELIGIBILITY OVERFLOW PROCESSING CENTER

This line item pays for a contract to handle eligibility determination backlogs.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

RETURNED MAIL PROCESSING

This line item pays for the centralized processing of returned mail.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding.

WORK NUMBER VERIFICATION

This line item pays for a contract to provide electronic verification of income.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the request.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

This line item contains the professional contracts related to reviewing acute care utilization, long-term care utilization, external quality review, drug utilization review, and mental health quality review. These contracts ensure that the benefits and services provided to Medicaid clients are medically necessary and appropriate.

Acute care utilization performs prior authorization review for services such as transplants, out-of-state elective admissions, inpatient mental health services, inpatient substance abuse rehabilitation, durable medical equipment, non-emergent medical transportation, home health service reviews, and physical and occupational therapy. It also includes retrospective reviews of inpatient hospital claims to ensure care was medically necessary, required an acute level of care, and was coded and billed correctly. The federal match rate is 75.0 percent.

Long-term care utilization review includes prior authorization reviews to determine medical necessity, level of care, and target population determinations. It also includes periodic reevaluations of services. The federal match for the majority of services is 75.0 percent.

External quality review handles provider credentialing, including activities such as verifying licensure and certification information, validating Healthcare Effectiveness Data and Information Set (HEDIS) measures, and reviewing provider performance improvement projects. The federal match rate is 75.0 percent.

Mental health external quality review is very similar to the external quality review, but for mental health providers. The federal match rate is 75.0 percent.

Drug utilization review performs prior authorization reviews, retrospective reviews, and provider education to ensure appropriate drug therapy according to explicit predetermined standards.

STATUTORY AUTHORITY: Sections 25.5-5-405, 506, and 411, C.R.S.

REQUEST: The Department requests annualizations of prior year budget actions and R8.

RECOMMENDATION: The staff recommendations are summarized in the table below. See the discussion of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, UTILIZATION AND QUALITY REVIEW CONTRACTS, PROFESSIONAL SERVICE CONTRACTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$26,961,574	$7,236,040	$2,032,069	$0	$17,693,465	0.0
Other Legislation	$1,183,837	$1,183,837	$0	$0	$0	0.0
TOTAL	**$28,145,411**	**$8,419,877**	**$2,032,069**	**$0**	**$17,693,465**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$28,145,411	$8,419,877	$2,032,069	$0	$17,693,465	0.0
R8 Cost and quality indicators	625,000	150,339	135,378	0	339,283	0.0
Annualize prior year budget actions	(1,533,534)	(1,268,461)	(54,460)	0	(210,613)	0.0
TOTAL	**$27,236,877**	**$7,301,755**	**$2,112,987**	**$0**	**$17,822,135**	**0.0**
INCREASE/(DECREASE)	**($908,534)**	**($1,118,122)**	**$80,918**	**$0**	**$128,670**	**0.0**
Percentage Change	(3.2%)	(13.3%)	4.0%	0.0%	0.7%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$27,236,877**	**$7,301,755**	**$2,112,987**	**$0**	**$17,822,135**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.
- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.
- Payment Error Rate Measurement Project -- Each state must estimate the number of Medicaid payments that should not have been made or that were made in an incorrect amount, including underpayments and overpayments, every three years according to a staggered schedule set up by the federal government.
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.
- Primary Care Program – These audits improve performance and ensure sound fiscal management of the Primary Care Program.

The sources of cash funds are the Hospital Provider Fee, Nursing Facility Fee, CHP+ Trust, and Primary Care Fund. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-6-201 and 202, 25.5-4-401 (1) (a), 25.5-4-402, 25.5-5-408 (1) (d), 25.5-6-106, 25.5-6-107, 25.5-4-105, and 25.5-4-402.3 (3) (a), C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and BA12.

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

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$4,655,865	$1,816,102	$582,801	$0	$2,256,962	0.0
Other Legislation	(250,000)	(125,000)	0	0	(125,000)	0.0
TOTAL	**$4,405,865**	**$1,691,102**	**$582,801**	**$0**	**$2,131,962**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$4,405,865	$1,691,102	$582,801	$0	$2,131,962	0.0
BA12 eConsult technical adjustment	0	0	0	0	0	0.0
Annualize prior year budget actions	(124,846)	(45,423)	(17,000)	0	(62,423)	0.0
TOTAL	**$4,281,019**	**$1,645,679**	**$565,801**	**$0**	**$2,069,539**	**0.0**
INCREASE/(DECREASE)	**($124,846)**	**($45,423)**	**($17,000)**	**$0**	**($62,423)**	**0.0**
Percentage Change	(2.8%)	(2.7%)	(2.9%)	0.0%	(2.9%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$4,131,019**	**$1,570,679**	**$565,801**	**$0**	**$1,994,539**	**0.0**
Request Above/(Below) Recommendation	($150,000)	($75,000)	$0	$0	($75,000)	0.0

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

STATUTORY AUTHORITY: Section 25.5-4-301, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

THIRD-PARTY LIABILITY COST AVOIDANCE CONTRACT

This is line item pays for a contract to identify third party eligibility for Medicaid claims.

REQUEST: The Department requests an adjustment related to R11.

RECOMMENDATION: Staff recommends the requested funding.

(H) INDIRECT COSTS

STATEWIDE INDIRECT COST ASSESSMENT

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB).

REQUEST: The Department requests an indirect cost adjustment based on OSPB's common policies.

RECOMMENDATION: Staff recommends the request based on the indirect cost plan approved by the JBC.

(2) MEDICAL SERVICES PREMIUMS

This division provides funding for physical health and most long-term services and supports for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term services and supports for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

MEDICAL SERVICES PREMIUMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$10,476,745,973	$2,896,264,906	$1,252,446,475	$90,013,408	$6,238,021,184	0.0
Other Legislation	246,031,843	(155,285,812)	(11,962,587)	0	413,280,242	0.0
Recommended Long Bill Add-on	296,800,926	(131,010,469)	48,221,126	0	379,590,269	0.0
TOTAL	**$11,019,578,742**	**$2,609,968,625**	**$1,288,705,014**	**$90,013,408**	**$7,030,891,695**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$11,019,578,742	$2,609,968,625	$1,288,705,014	$90,013,408	$7,030,891,695	0.0
R1 Medical Services Premiums	160,173,584	459,048,342	(23,454,035)	(6,310,453)	(269,110,270)	0.0
R6 Value-based payments	7,877,109	2,361,558	326,112	0	5,189,439	0.0
R7a Provider rates	132,435,413	47,140,172	5,577,432	0	79,717,809	0.0
R7b Targeted provider rates	74,210,668	24,396,814	5,017,271	0	44,796,583	0.0
R9 Perinatal services	995,585	487,837	0	0	507,748	0.0
R10 Children with complex needs	(6,070,873)	(2,974,728)	0	0	(3,096,145)	0.0
R11 Compliance	(1,353,364)	(384,933)	(64,658)	0	(903,773)	0.0
BA7 Community based access to services	2,850,886	0	1,420,589	0	1,430,297	0.0
BA8 ARPA HCBS adjustments	20,707,707	0	8,630,461	0	12,077,246	0.0
BA19 Alternative payment model	2,750,667	735,028	157,297	0	1,858,342	0.0
Annualize prior year budget actions	10,315,603	44,967,979	(39,469,200)	11,176,920	(6,360,096)	0.0
Transfers to other state agencies	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
TOTAL	**$11,420,255,839**	**$3,183,638,750**	**$1,246,846,283**	**$94,879,875**	**$6,894,890,931**	**0.0**
INCREASE/(DECREASE)	**$400,677,097**	**$573,670,125**	**($41,858,731)**	**$4,866,467**	**($136,000,764)**	**0.0**
Percentage Change	3.6%	22.0%	(3.2%)	5.4%	(1.9%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$11,051,250,293**	**$3,155,078,012**	**$1,223,312,590**	**$100,294,784**	**$6,572,564,907**	**0.0**
Request Above/(Below) Recommendation	($369,005,546)	($28,560,738)	($23,533,693)	$5,414,909	($322,326,024)	0.0

LINE ITEM DETAIL

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

This line item provides funding for physical health and most long-term care services for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term care services for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. This is the only line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

STATUTORY AUTHORITY: Section 25.5-5-101 et seq., C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for R1, R6, R7a, R7b, R9, R10, R11, BA7, BA8, and BA19.

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

MEDICAL SERVICES PREMIUMS, MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$10,476,745,973	$2,896,264,906	$1,252,446,475	$90,013,408	$6,238,021,184	0.0
Recommended Long Bill Add-on	$296,800,926	($131,010,469)	$48,221,126	$0	$379,590,269	0.0
Other Legislation	$246,031,843	($155,285,812)	($11,962,587)	$0	$413,280,242	0.0
TOTAL	**$11,019,578,742**	**$2,609,968,625**	**$1,288,705,014**	**$90,013,408**	**$7,030,891,695**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$11,019,578,742	$2,609,968,625	$1,288,705,014	$90,013,408	$7,030,891,695	0.0
R1 Medical Services Premiums	160,173,584	459,048,342	(23,454,035)	(6,310,453)	(269,110,270)	0.0
R7a Provider rates	132,435,413	47,140,172	5,577,432	0	79,717,809	0.0
R7b Targeted provider rates	74,210,668	24,396,814	5,017,271	0	44,796,583	0.0
BA8 ARPA HCBS adjustments	20,707,707	0	8,630,461	0	12,077,246	0.0
Annualize prior year budget actions	10,315,603	44,967,979	(39,469,200)	11,176,920	(6,360,096)	0.0
R6 Value-based payments	7,877,109	2,361,558	326,112	0	5,189,439	0.0
BA7 Community based access to services	2,850,886	0	1,420,589	0	1,430,297	0.0
BA19 Alternative payment model	2,750,667	735,028	157,297	0	1,858,342	0.0
R9 Perinatal services	995,585	487,837	0	0	507,748	0.0
R10 Children with complex needs	(6,070,873)	(2,974,728)	0	0	(3,096,145)	0.0
Transfers to other state agencies	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
R11 Compliance	(1,353,364)	(384,933)	(64,658)	0	(903,773)	0.0
TOTAL	**$11,420,255,839**	**$3,183,638,750**	**$1,246,846,283**	**$94,879,875**	**$6,894,890,931**	**0.0**
INCREASE/(DECREASE)	**$400,677,097**	**$573,670,125**	**($41,858,731)**	**$4,866,467**	**($136,000,764)**	**0.0**
Percentage Change	3.6%	22.0%	(3.2%)	5.4%	(1.9%)	0.0%

Medical Services Premiums, Medical And Long-term Care Services For Medicaid Eligible Individuals						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2023-24 EXECUTIVE REQUEST	**$11,051,250,293**	**$3,155,078,012**	**$1,223,312,590**	**$100,294,784**	**$6,572,564,907**	**0.0**
Request Above/(Below) Recommendation	($369,005,546)	($28,560,738)	($23,533,693)	$5,414,909	($322,326,024)	0.0

(5) INDIGENT CARE PROGRAM

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

Indigent Care Program	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2022-23 Appropriation					
H.B. 22-1329 (Long Bill)	$468,729,167	$29,733,317	$178,238,366	$260,757,484	0.0
Other Legislation	(25,902,380)	(16,784,070)	(12,055,310)	2,937,000	0.0
Recommended Long Bill Add-on	132,534	(7,820,520)	9,075,262	(1,122,208)	0.0
TOTAL	**$442,959,321**	**$5,128,727**	**$175,258,318**	**$262,572,276**	**0.0**
FY 2023-24 Recommended Appropriation					
FY 2022-23 Appropriation	$442,959,321	$5,128,727	$175,258,318	$262,572,276	0.0
Tobacco forecast	(53,250)	(26,625)	(26,625)	0	0.0
R3 Child Health Plan Plus	46,988,338	19,576,972	(571,891)	27,983,257	0.0
R9 Perinatal services	45,294	15,536	0	29,758	0.0
Annualize prior year budget actions	(19,728,595)	(341,930)	(9,388,821)	(9,997,844)	0.0
TOTAL	**$470,211,108**	**$24,352,680**	**$165,270,981**	**$280,587,447**	**0.0**
INCREASE/(DECREASE)	**$27,251,787**	**$19,223,953**	**($9,987,337)**	**$18,015,171**	**0.0**
Percentage Change	6.2%	374.8%	(5.7%)	6.9%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$496,358,248**	**$37,618,900**	**$179,371,006**	**$279,368,342**	**0.0**
Request Above/(Below) Recommendation	$26,147,140	$13,266,220	$14,100,025	($1,219,105)	0.0

LINE ITEM DETAIL – INDIGENT CARE PROGRAM

Safety Net Provider Payments

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

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

patients. Federal DSH allotments are required to decrease in aggregate with the implementation of the Affordable Care Act and the expected decrease in the uninsured population.

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

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

REQUEST: The Department requests continuation funding.

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

INDIGENT CARE PROGRAM, SAFETY NET PROVIDER PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$226,610,308	$0	$113,305,154	$0	$113,305,154	0.0
Recommended Long Bill Add-on	$18,525,825	$0	$8,169,889	$0	$10,355,936	0.0
Other Legislation	$0	$0	($13,370,008)	$0	$13,370,008	0.0
TOTAL	**$245,136,133**	**$0**	**$108,105,035**	**$0**	**$137,031,098**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$245,136,133	$0	$108,105,035	$0	$137,031,098	0.0
Annualize prior year budget actions	(18,525,826)	0	(9,262,913)	0	(9,262,913)	0.0
TOTAL	**$226,610,307**	**$0**	**$98,842,122**	**$0**	**$127,768,185**	**0.0**
INCREASE/(DECREASE)	**($18,525,826)**	**$0**	**($9,262,913)**	**$0**	**($9,262,913)**	**0.0**
Percentage Change	(7.6%)	0.0%	(8.6%)	0.0%	(6.8%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$226,610,308**	**$0**	**$113,305,154**	**$0**	**$113,305,154**	**0.0**
Request Above/(Below) Recommendation	$1	$0	$14,463,032	$0	($14,463,031)	0.0

PEDIATRIC SPECIALTY HOSPITAL

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

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

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

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

APPROPRIATION FROM TOBACCO TAX FUND TO GENERAL FUND

Section 24-22-117(1)(c)(I)(A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-117(1)(c)(I)(B.5), C.R.S. requires that 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends a small adjustment consistent with the JBC's actions during figure setting for tobacco supported programs.

PRIMARY CARE FUND

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

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

Awards are based on the percentage of medically indigent clients the provider serves. The Primary Care Fund receives 19 percent of tobacco tax collections annually.

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CHILDREN'S BASIC HEALTH PLAN (CHP+) ADMINISTRATION

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

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

Prior to FY 2016-17 the federal match for this line item was based on a time allocation between Medicaid and CHP+. In order to qualify for CHP+ an applicant must first be determined ineligible for Medicaid. Beginning in FY 2016-17 the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for a new time allocation plan that attributes all of the work of this contractor to the CHP+ match rate.

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

REQUEST: The Department requests R3 to true up the fund sources to the correct federal match.

RECOMMENDATION: The staff recommendation is based on the February forecast.

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$3,864,405	$0	$1,243,319	$0	$2,621,086	0.0
Other Legislation	$0	$0	$25,365	$0	($25,365)	0.0
Recommended Long Bill Add-on	$0	$0	$0	$0	$0	0.0
TOTAL	**$3,864,405**	**$0**	**$1,268,684**	**$0**	**$2,595,721**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$3,864,405	$0	$1,268,684	$0	$2,595,721	0.0
R3 Child Health Plan Plus	0	0	56,807	0	(56,807)	0.0
TOTAL	**$3,864,405**	**$0**	**$1,325,491**	**$0**	**$2,538,914**	**0.0**
INCREASE/(DECREASE)	**$0**	**$0**	**$56,807**	**$0**	**($56,807)**	**0.0**
Percentage Change	0.0%	0.0%	4.5%	0.0%	(2.2%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$3,864,405**	**$0**	**$1,352,542**	**$0**	**$2,511,863**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$27,051	$0	($27,051)	0.0

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

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both

managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

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

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The projected average federal match rate for state FY 2020-21 is 67.88 percent.

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

REQUEST: The Department requests annualizations of prior year funding and R3 and R9.

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

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$179,020,656	$24,351,312	$39,132,095	$0	$115,537,249	0.0
Other Legislation	(31,124,203)	(16,148,994)	1,289,333	0	(16,264,542)	0.0
Recommended Long Bill Add-on	(18,393,291)	(7,820,520)	905,373	0	(11,478,144)	0.0
TOTAL	**$129,503,162**	**$381,798**	**$41,326,801**	**$0**	**$87,794,563**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$129,503,162	$381,798	$41,326,801	$0	$87,794,563	0.0
R3 Child Health Plan Plus	46,988,338	19,576,972	(628,698)	0	28,040,064	0.0
R9 Perinatal services	45,294	15,536	0	0	29,758	0.0
Annualize prior year budget actions	(1,202,769)	(341,930)	(125,908)	0	(734,931)	0.0
Tobacco forecast	(26,625)	(26,625)	0	0	0	0.0
TOTAL	**$175,307,400**	**$19,605,751**	**$40,572,195**	**$0**	**$115,129,454**	**0.0**
INCREASE/(DECREASE)	**$45,804,238**	**$19,223,953**	**($754,606)**	**$0**	**$27,334,891**	**0.0**
Percentage Change	35.4%	5,035.1%	(1.8%)	0.0%	31.1%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$206,649,737**	**$32,236,895**	**$40,155,512**	**$0**	**$134,257,330**	**0.0**
Request Above/(Below) Recommendation	$31,342,337	$12,631,144	($416,683)	$0	$19,127,876	0.0

(6) OTHER MEDICAL SERVICES

This division contains the funding for:

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

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

Other Medical Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$494,749,494	$248,569,377	$152,769,180	$225,000	$93,185,937	4.0
Other Legislation	11,174,119	(2,098,999)	16,826,492	(26,550)	(3,526,824)	2.3
TOTAL	**$505,923,613**	**$246,470,378**	**$169,595,672**	**$198,450**	**$89,659,113**	**6.3**
FY 2023-24 Recommended Appropriation						
FY 2022-23 Appropriation	$505,923,613	$246,470,378	$169,595,672	$198,450	$89,659,113	6.3
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
BA8 ARPA HCBS adjustments	222,586	0	222,586	0	0	0.0
BA9 Public school health servcies	8,828,258	0	9,518,849	0	(690,591)	0.0
Annualize prior year budget actions	(47,320,411)	(5,048,025)	(42,272,386)	0	0	(2.3)
TOTAL	**$470,939,850**	**$244,708,157**	**$137,064,721**	**$198,450**	**$88,968,522**	**4.0**
INCREASE/(DECREASE)	**($34,983,763)**	**($1,762,221)**	**($32,530,951)**	**$0**	**($690,591)**	**(2.3)**
Percentage Change	(6.9%)	(0.7%)	(19.2%)	0.0%	(0.8%)	(36.5%)
FY 2023-24 EXECUTIVE REQUEST	**$477,553,504**	**$251,855,181**	**$137,064,721**	**$225,000**	**$88,408,602**	**0.0**
Request Above/(Below) Recommendation	$6,613,654	$7,147,024	$0	$26,550	($559,920)	(4.0)

LINE ITEM DETAIL – OTHER MEDICAL SERVICES

Old Age Pension State Medical Program

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

With the expansion of Medicaid that was authorized in S.B. 13-200, a large portion of the people eligible for an old age pension are also eligible for Medicaid. All $10.0 million of the constitutional allocation of sales tax is appropriated in this line item to ensure the funds are available to serve eligible people who do not qualify for Medicaid. Any funds left over are reappropriated to the Medical Services Premiums line item to offset the need for General Fund in that line item for people who are dually

eligible for Medicaid and the Old Age Pension Health and Medical Program. For FY 2020-21 the Department is projecting $9.9 million will be available to offset General Fund in the Medical Services Premiums line item. If that forecast is off, the Medical Services Premiums line item has statutory authority to overexpend the appropriation.

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

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

SENIOR DENTAL PROGRAM

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

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

COMMISSION ON FAMILY MEDICINE

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

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

MEDICARE MODERNIZATION ACT

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

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

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

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

RECOMMENDATION: Staff recommends adjusting both the FY 22-23 and FY 23-24 appropriations based on the updated February 2023 forecast. See the recommendation on *R4 Medicare Modernization Act* for more detail.

OTHER MEDICAL SERVICES, MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$235,472,292	$235,472,292	$0	$0	$0	0.0
Other Legislation	(6,613,654)	(6,613,654)	0	0	0	0.0
TOTAL	**$228,858,638**	**$228,858,638**	**$0**	**$0**	**$0**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$228,858,638	$228,858,638	$0	$0	$0	0.0
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
TOTAL	**$232,144,442**	**$232,144,442**	**$0**	**$0**	**$0**	**0.0**
INCREASE/(DECREASE)	**$3,285,804**	**$3,285,804**	**$0**	**$0**	**$0**	**0.0**
Percentage Change	1.4%	1.4%	0.0%	0.0%	0.0%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$238,758,096**	**$238,758,096**	**$0**	**$0**	**$0**	**0.0**
Request Above/(Below) Recommendation	$6,613,654	$6,613,654	$0	$0	$0	0.0

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

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

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for administrative costs appear

in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

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

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

REQUEST: The Department requests BA9 based on an updated forecast of certified public expenditures.

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

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

OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$172,092,626	$0	$84,651,774	$0	$87,440,852	0.0
Other Legislation	(19,537,512)	0	(15,450,768)	0	(4,086,744)	0.0
TOTAL	**$152,555,114**	**$0**	**$69,201,006**	**$0**	**$83,354,108**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$152,555,114	$0	$69,201,006	$0	$83,354,108	0.0
BA9 Public school health services	8,828,258	0	9,518,849	0	(690,591)	0.0
TOTAL	**$161,383,372**	**$0**	**$78,719,855**	**$0**	**$82,663,517**	**0.0**
INCREASE/(DECREASE)	**$8,828,258**	**$0**	**$9,518,849**	**$0**	**($690,591)**	**0.0**
Percentage Change	5.8%	0.0%	13.8%	0.0%	(0.8%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$161,383,372**	**$0**	**$78,719,855**	**$0**	**$82,663,517**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

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

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

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

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

Staff recommends **CONTINUING AND MODIFYING** the following footnotes:

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.

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 long-standing footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is complying with the footnote.

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

Comment: This footnote expresses the General Assembly's intent regarding how the appropriation should be used. The Department is in compliance with the footnote and using the money for the grant program authorized in Section 25.5-5-208, C.R.S.

32 Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding -- The appropriation in this

Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This long-standing footnote provides transfer authority for a limited portion of the appropriations. The Department is complying with the footnote.

33 Department of Health Care Policy and Financing, Grand Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; and Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $800,000 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $78,885,357, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $78,885,357 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

Comment: Staff requests permission to update the dollar amounts in this footnote to reflect the JBC's actions final actions on funding for the Department of Higher Education.

Staff recommends **DISCONTINUING** the following footnotes:

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 footnote provided rollforward spending authority and is no longer relevant.

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 footnote provided rollforward spending authority and is no longer relevant.

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: The footnote provided rollforward spending authority and is no longer relevant.

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.

Comment: The footnote provided rollforward spending authority and is no longer relevant.

21a 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.

Comment: This footnote explained the purpose of the appropriation. The Department is implementing the non-invasive pre-natal testing benefit and the footnote is no longer relevant.

31 Department of Health Care Policy and Financing, Other Medical Services, State-only Payments for Home- and Community-Based Services -- This appropriation remains available for expenditure until the close of the 2023-24 state fiscal year.

Comment: The footnote provided rollforward spending authority and is no longer relevant.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUING AND MODIFYING** the following requests for information:

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

8 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 year.

<u>Comment:</u> The request for information provides some accountability for the significant benefit to the University of Colorado of the agreement between the Departments.

DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

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

<u>Comment:</u> This is a long-standing report that provides useful information on the populations served and expenditures.

3 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by ~~February 15, 2023,~~ November 1, 2023, detailing the progress on all outstanding issues with administration of the Children's Basic Health Plan. The report should include a progress report on completing backlogged issues since the authorized additional FTE and a projection of when each backlogged issue will be completed and program authorities will become current and compliant. Finally, the report should include a recommendation on whether the administrative staffing level for the Children's Basic Health Plan is sufficient to maintain effective operation and performance into the future.

<u>Comment:</u> The Department submitted the report as requested and it shows modest progress on addressing the backlogged issues, but there are still significant outstanding concerns. Due to the timing of the report, there was not much opportunity for the JBC to discuss the findings with the Department. When the request was first sent to the Department, the JBC had concerns that the Department had not asked for enough resources to address the administrative backlog for CHP+. Staff recommends continuing the request for information but asking for the next update by November 1, 2023, so that the JBC can discuss it with the Department at the hearing.

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

under the program. The report should also include information on how many children were served by the program.

Comment: This is a long-standing report that provides useful information on the populations served and expenditures.

Appendix A: Numbers Pages

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
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	57,759,741	66,721,300	66,435,359	*
FTE	573.0	600.5	693.0	738.0	717.5	
General Fund	15,160,759	16,861,340	21,565,979	24,659,404	24,669,500	
Cash Funds	3,931,315	4,699,898	6,021,707	7,479,833	7,326,038	
Reappropriated Funds	1,543,625	1,772,301	2,273,021	2,741,506	2,741,506	
Federal Funds	26,878,118	27,908,896	27,899,034	31,840,557	31,698,315	
Health, Life, and Dental	5,264,801	7,071,991	9,139,400	10,713,875	10,457,767	*
General Fund	1,342,322	2,642,297	3,552,746	4,309,861	4,154,990	
Cash Funds	548,313	660,834	796,123	770,599	753,615	
Reappropriated Funds	138,532	166,554	229,292	221,797	221,797	
Federal Funds	3,235,634	3,602,306	4,561,239	5,411,618	5,327,365	
Short-term Disability	72,366	104,617	93,895	101,494	99,004	*
General Fund	26,778	50,803	35,944	40,367	38,858	
Cash Funds	5,695	10,843	7,760	7,260	7,099	
Reappropriated Funds	1,607	3,300	2,119	1,911	1,911	
Federal Funds	38,286	39,671	48,072	51,956	51,136	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
S.B. 04-257 Amortization Equalization Disbursement	2,188,905	2,428,087	2,935,436	3,381,789	3,303,822	*
General Fund	810,157	924,349	1,123,363	1,346,089	1,298,952	
Cash Funds	172,037	211,103	243,684	242,674	237,506	
Reappropriated Funds	48,635	52,920	66,241	62,817	62,817	
Federal Funds	1,158,076	1,239,715	1,502,148	1,730,209	1,704,547	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	2,188,905	2,428,087	2,935,437	3,381,789	3,303,822	*
General Fund	810,157	924,349	1,123,363	1,346,087	1,298,951	
Cash Funds	172,037	211,103	243,684	242,675	237,506	
Reappropriated Funds	48,635	52,920	66,241	62,817	62,817	
Federal Funds	1,158,076	1,239,715	1,502,149	1,730,210	1,704,548	
Salary Survey	0	1,273,930	1,739,584	3,755,526	3,755,526	
General Fund	0	474,954	701,453	1,442,217	1,442,217	
Cash Funds	0	98,663	117,370	277,946	277,946	
Reappropriated Funds	0	29,439	32,730	53,934	53,934	
Federal Funds	0	670,874	888,031	1,981,429	1,981,429	
PERA Direct Distribution	0	1,077,010	668,598	187,621	187,621	
General Fund	0	430,205	0	73,824	73,824	
Cash Funds	0	83,411	75,591	13,754	13,754	
Reappropriated Funds	0	24,889	21,079	2,869	2,869	
Federal Funds	0	538,505	571,928	97,174	97,174	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Temporary Employees Related to Authorized Leave	0	0	5,978	5,978	5,978
General Fund	0	0	0	2,411	2,411
Cash Funds	0	0	5,978	403	403
Reappropriated Funds	0	0	0	112	112
Federal Funds	0	0	0	3,052	3,052
Worker's Compensation	128,527	160,590	194,996	182,211	182,211
General Fund	53,287	64,817	88,614	67,163	67,163
Cash Funds	10,976	14,502	16,622	19,898	19,898
Reappropriated Funds	0	976	6,497	7,142	7,142
Federal Funds	64,264	80,295	83,263	88,008	88,008
Operating Expenses	1,788,412	2,528,896	3,534,070	3,448,826	3,854,173 *
General Fund	862,725	1,209,995	1,398,738	1,356,886	1,479,558
Cash Funds	221,951	233,675	339,880	394,312	474,229
Reappropriated Funds	13,297	13,297	59,204	44,594	44,594
Federal Funds	690,439	1,071,929	1,736,248	1,653,034	1,855,792
Legal Services	1,251,687	1,172,759	959,008	1,714,709	1,714,709
General Fund	398,303	384,389	372,957	603,063	603,063
Cash Funds	222,539	206,798	95,041	187,075	187,075
Reappropriated Funds	0	0	21,289	67,216	67,216
Federal Funds	630,845	581,572	469,721	857,355	857,355
Administrative Law Judge Services	735,806	807,180	890,065	600,498	600,498
General Fund	305,065	330,731	284,141	221,344	221,344
Cash Funds	62,838	70,687	79,076	65,574	65,574
Reappropriated Funds	0	2,172	117,685	23,540	23,540
Federal Funds	367,903	403,590	409,163	290,040	290,040

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Payment to Risk Management and Property Funds	110,332	173,686	383,339	269,352	269,352	
General Fund	45,744	68,525	137,893	99,283	99,283	
Cash Funds	9,422	16,390	46,044	29,414	29,414	
Reappropriated Funds	0	1,928	20,172	10,559	10,559	
Federal Funds	55,166	86,843	179,230	130,096	130,096	
Leased Space	2,559,590	1,363,822	3,673,166	3,930,638	3,932,424	*
General Fund	1,051,765	443,581	1,384,850	1,466,686	1,477,201	
Cash Funds	228,030	238,330	398,667	459,488	449,282	
Reappropriated Funds	0	0	31,842	44,536	44,536	
Federal Funds	1,279,795	681,911	1,857,807	1,959,928	1,961,405	
Capitol Complex Leased Space	591,064	651,086	624,633	0	0	
General Fund	245,055	266,637	256,287	0	0	
Cash Funds	50,477	57,078	54,157	0	0	
Reappropriated Funds	0	1,828	1,172	0	0	
Federal Funds	295,532	325,543	313,017	0	0	
Payments to OIT	8,298,082	5,765,418	9,045,009	11,746,668	11,746,668	
General Fund	3,218,758	1,971,816	3,531,304	4,643,222	4,643,222	
Cash Funds	930,283	910,893	918,497	1,196,918	1,196,918	
Reappropriated Funds	0	0	16,751	42,477	42,477	
Federal Funds	4,149,041	2,882,709	4,578,457	5,864,051	5,864,051	
IT Accessibility	0	0	0	2,933,182 5.0	2,933,182 5.0	*
General Fund	0	0	0	1,145,158	1,145,158	
Cash Funds	0	0	0	297,857	297,857	
Reappropriated Funds	0	0	0	5,431	5,431	
Federal Funds	0	0	0	1,484,736	1,484,736	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
CORE Operations	184,939	112,780	169,033	137,018	137,018	*
General Fund	81,743	56,303	65,526	50,505	50,505	
Cash Funds	15,794	5,835	15,313	14,962	14,962	
Reappropriated Funds	0	0	6,740	5,371	5,371	
Federal Funds	87,402	50,642	81,454	66,180	66,180	
General Professional Services and Special Projects	8,992,784	15,288,124	77,800,650	95,160,118	62,100,710	*
General Fund	2,368,910	3,837,133	8,643,652	12,934,637	13,166,847	
Cash Funds	1,227,887	2,892,967	31,021,423	34,373,336	16,153,482	
Reappropriated Funds	150,000	69,000	81,000	81,000	81,000	
Federal Funds	5,245,987	8,489,024	38,054,575	47,771,145	32,699,381	
Universal Contract for Behavioral Health Services	0	0	3,000,000	0	0	
Cash Funds	0	0	3,000,000	0	0	
Statewide training	0	0	0	10,086	10,086	*
General Fund	0	0	0	3,719	3,719	
Cash Funds	0	0	0	1,100	1,100	
Reappropriated Funds	0	0	0	395	395	
Federal Funds	0	0	0	4,872	4,872	
Paid Family and Medical Leave Insurance	0	0	0	0	0	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Merit Pay	0	0	0	0	0	
General Fund	0	0	0	0	0	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
SUBTOTAL - (A) General Administration	81,870,017	93,650,498	175,552,038	208,382,678	175,029,930
FTE	573.0	600.5	693.0	743.0	722.5
General Fund	26,781,528	30,942,224	44,266,810	55,811,926	55,936,766
Cash Funds	7,809,594	10,623,010	43,496,617	46,075,078	27,743,658
Reappropriated Funds	1,944,331	2,191,524	3,053,075	3,480,024	3,480,024
Federal Funds	45,334,564	49,893,740	84,735,536	103,015,650	87,869,482
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	120,652	182,668	191,731	192,794	192,794
General Fund	60,326	91,334	95,865	96,397	96,397
Federal Funds	60,326	91,334	95,866	96,397	96,397
Early Intervention, Early Childhood	0	0	8,358,218	8,127,382	8,358,218
General Fund	0	0	3,685,974	4,063,691	3,685,974
Federal Funds	0	0	4,672,244	4,063,691	4,672,244
Nurse Home Visitor Program, Human Services	173,642	193,475	3,010,000	3,010,000	3,010,000
Reappropriated Funds	67,019	73,254	1,505,000	1,505,000	1,505,000
Federal Funds	106,623	120,221	1,505,000	1,505,000	1,505,000
Host Home Regulation, Local Affairs	118,747	89,070	133,882	133,882	133,882
General Fund	59,373	44,535	66,941	66,941	66,941
Federal Funds	59,374	44,535	66,941	66,941	66,941

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	265,698	296,990	306,796	306,796	306,796
General Fund	132,849	148,495	153,398	153,398	153,398
Federal Funds	132,849	148,495	153,398	153,398	153,398
Facility Survey and Certification, Public Health and Environment	6,930,318	7,065,278	8,651,460	8,651,460	8,651,460
General Fund	2,346,574	2,445,321	3,218,674	3,218,674	3,218,674
Federal Funds	4,583,744	4,619,957	5,432,786	5,432,786	5,432,786
Prenatal Statistical Information, Public Health and Environment	5,888	5,888	5,887	5,887	5,887
General Fund	2,944	2,944	2,944	2,944	2,944
Federal Funds	2,944	2,944	2,943	2,943	2,943
Nurse Aide Certification, Regulatory Agencies	324,040	324,041	324,041	324,041	324,041
General Fund	147,369	147,369	147,369	147,369	147,369
Reappropriated Funds	14,651	14,652	14,652	14,652	14,652
Federal Funds	162,020	162,020	162,020	162,020	162,020
Reviews, Regulatory Agencies	0	0	3,750	3,750	3,750
General Fund	0	0	1,875	1,875	1,875
Federal Funds	0	0	1,875	1,875	1,875
Regulation of Medicaid Transportation Providers, Regulatory Agencies	41,540	0	0	0	0
General Fund	20,770	0	0	0	0
Federal Funds	20,770	0	0	0	0

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Local Public Health Agencies, Public Health and Environment	364,052	0	0	0	0
General Fund	364,052	0	0	0	0
SUBTOTAL - (B) Transfers to Other Departments	8,344,577	8,157,410	20,985,765	20,755,992	20,986,828
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	3,134,257	2,879,998	7,373,040	7,751,289	7,373,572
Reappropriated Funds	81,670	87,906	1,519,652	1,519,652	1,519,652
Federal Funds	5,128,650	5,189,506	12,093,073	11,485,051	12,093,604
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	15,864,583	10,393,942	47,184,779	114,543,037	113,944,537 *
General Fund	0	0	2,786,377	16,776,016	16,701,016
Cash Funds	2,098,574	1,135,444	4,616,712	11,266,269	11,042,019
Reappropriated Funds	12,204	0	12,204	12,204	12,204
Federal Funds	13,753,805	9,258,498	39,769,486	86,488,548	86,189,298
Colorado Benefits Management Systems, Operating and Contract Expenses	41,210,186	41,290,899	54,177,348	57,735,940	57,735,940 *
General Fund	4,984,722	5,741,240	10,662,071	11,908,221	11,908,221
Cash Funds	4,562,697	4,784,644	6,493,474	6,608,540	6,608,540
Reappropriated Funds	473	147	1,654	1,658	1,658
Federal Funds	31,662,294	30,764,868	37,020,149	39,217,521	39,217,521

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	1,633,016	1,893,968	2,005,074	2,217,092	2,217,092	*
General Fund	536,552	608,896	634,715	703,457	703,457	
Cash Funds	279,590	328,882	354,194	390,757	390,757	
Reappropriated Funds	20	6	73	73	73	
Federal Funds	816,854	956,184	1,016,092	1,122,805	1,122,805	
Office of eHealth Innovations Operations	6,556,066	4,385,240	6,465,845	6,465,845	6,465,845	
FTE	0.1	0.0	3.0	3.0	3.0	
General Fund	660,675	2,296,332	3,372,367	3,372,367	3,372,367	
Federal Funds	5,895,391	2,088,908	3,093,478	3,093,478	3,093,478	
All-Payer Claims Database	3,938,816	4,733,994	5,160,403	5,562,903	5,562,903	*
General Fund	2,962,231	2,962,231	4,327,136	4,598,136	4,598,136	
Federal Funds	976,585	1,771,763	833,267	964,767	964,767	
Health Information Exchange Maintenance and Projects	8,901,743	0	0	0	0	
General Fund	981,083	0	0	0	0	
Federal Funds	7,920,660	0	0	0	0	
State Innovation Model Operations	0	0	0	0	0	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	0	0	0	
Connect for Health Colorado Systems	0	0	0	0	0	
General Fund	0	0	0	0	0	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
SUBTOTAL - (C) Information Technology Contracts and Projects	78,104,410	62,698,043	114,993,449	186,524,817	185,926,317	
FTE	0.1	0.0	3.0	3.0	3.0	
General Fund	10,125,263	11,608,699	21,782,666	37,358,197	37,283,197	
Cash Funds	6,940,861	6,248,970	11,464,380	18,265,566	18,041,316	
Reappropriated Funds	12,697	153	13,931	13,935	13,935	
Federal Funds	61,025,589	44,840,221	81,732,472	130,887,119	130,587,869	
(D) Eligibility Determinations and Client Services						
Contracts for Special Eligibility Determinations	2,932,388	0	12,039,555	12,039,555	12,039,555	
General Fund	856,390	0	1,129,071	1,129,071	1,129,071	
Cash Funds	232,019	0	4,343,468	4,343,468	4,343,468	
Federal Funds	1,843,979	0	6,567,016	6,567,016	6,567,016	
County Administration	76,847,916	79,214,462	119,071,526	124,044,299	132,209,721	*
General Fund	12,476,154	14,337,301	20,154,096	19,596,414	22,999,538	
Cash Funds	14,975,853	14,734,326	25,643,473	27,826,729	26,966,487	
Federal Funds	49,395,909	50,142,835	73,273,957	76,621,156	82,243,696	
Medical Assistance Sites	843,705	825,542	1,531,968	1,531,968	1,531,968	
Cash Funds	402,384	402,419	402,984	402,984	402,984	
Federal Funds	441,321	423,123	1,128,984	1,128,984	1,128,984	
Administrative Case Management	729,944	1,752,340	869,744	869,744	869,744	
General Fund	364,972	876,170	434,872	434,872	434,872	
Federal Funds	364,972	876,170	434,872	434,872	434,872	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Customer Outreach	2,520,295	2,623,526	3,486,071	3,461,519	3,461,519
General Fund	936,784	992,812	1,406,415	1,394,139	1,394,139
Cash Funds	323,363	318,951	336,621	336,621	336,621
Federal Funds	1,260,148	1,311,763	1,743,035	1,730,759	1,730,759
Centralized Eligibility Vendor Contract Project	4,845,249	6,731,692	6,122,400	6,122,400	6,122,400
Cash Funds	1,541,955	2,347,766	2,279,719	2,279,719	2,279,719
Federal Funds	3,303,294	4,383,926	3,842,681	3,842,681	3,842,681
Connect for Health Colorado Eligibility Determination	15,945,067	10,220,546	10,135,914	10,642,710	10,642,710
Cash Funds	6,762,934	5,343,099	4,530,754	4,757,291	4,757,291
Federal Funds	9,182,133	4,877,447	5,605,160	5,885,419	5,885,419
Eligibility Overflow Processing Center	0	740,475	1,904,677	1,904,677	1,904,677
General Fund	0	110,923	285,320	285,320	285,320
Cash Funds	0	74,196	190,849	190,849	190,849
Federal Funds	0	555,356	1,428,508	1,428,508	1,428,508
Returned Mail Processing	818,170	1,337,726	3,298,808	3,298,808	3,298,808
General Fund	240,653	418,000	985,808	985,808	985,808
Cash Funds	50,124	100,758	244,919	244,919	244,919
Reappropriated Funds	23,329	31,303	111,942	111,942	111,942
Federal Funds	504,064	787,665	1,956,139	1,956,139	1,956,139
Work Number Verification	21,516	1,500,105	3,305,114	3,305,114	3,305,114
General Fund	7,085	502,685	1,089,815	1,089,815	1,089,815
Cash Funds	3,548	247,367	545,013	545,013	545,013
Federal Funds	10,883	750,053	1,670,286	1,670,286	1,670,286

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Medical Identification Cards	218,898	1,650,386	0	0	0	
General Fund	74,470	481,831	0	0	0	
Cash Funds	34,561	343,362	0	0	0	
Federal Funds	109,867	825,193	0	0	0	
SUBTOTAL - (D) Eligibility Determinations and Client Services	105,723,148	106,596,800	161,765,777	167,220,794	175,386,216	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	14,956,508	17,719,722	25,485,397	24,915,439	28,318,563	
Cash Funds	24,326,741	23,912,244	38,517,800	40,927,593	40,067,351	
Reappropriated Funds	23,329	31,303	111,942	111,942	111,942	
Federal Funds	66,416,570	64,933,531	97,650,638	101,265,820	106,888,360	
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	14,826,120	19,970,962	28,145,411	27,236,877	27,236,877	*
General Fund	7,299,182	6,803,020	8,419,877	7,301,755	7,301,755	
Cash Funds	857,869	995,697	2,032,069	2,112,987	2,112,987	
Federal Funds	6,669,069	12,172,245	17,693,465	17,822,135	17,822,135	
SUBTOTAL - (E) Utilization and Quality Review Contracts	14,826,120	19,970,962	28,145,411	27,236,877	27,236,877	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	7,299,182	6,803,020	8,419,877	7,301,755	7,301,755	
Cash Funds	857,869	995,697	2,032,069	2,112,987	2,112,987	
Federal Funds	6,669,069	12,172,245	17,693,465	17,822,135	17,822,135	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
(F) Provider Audits and Services						
Professional Audit Contracts	3,148,703	3,507,957	4,405,865	4,131,019	4,281,019	*
General Fund	1,361,059	1,524,776	1,691,102	1,570,679	1,645,679	
Cash Funds	281,124	346,850	582,801	565,801	565,801	
Federal Funds	1,506,520	1,636,331	2,131,962	1,994,539	2,069,539	
SUBTOTAL - (F) Provider Audits and Services	3,148,703	3,507,957	4,405,865	4,131,019	4,281,019	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,361,059	1,524,776	1,691,102	1,570,679	1,645,679	
Cash Funds	281,124	346,850	582,801	565,801	565,801	
Federal Funds	1,506,520	1,636,331	2,131,962	1,994,539	2,069,539	
(G) Recoveries and Recoupment Contract Costs						
Estate Recovery	843,618	749,055	1,165,841	1,165,841	1,165,841	*
Cash Funds	421,809	374,527	582,920	582,920	582,920	
Federal Funds	421,809	374,528	582,921	582,921	582,921	
Third-Party Liability Cost Avoidance Contract	7,134,460	4,622,500	17,248,905	8,417,842	8,417,842	*
General Fund	2,523,513	1,465,509	5,692,139	2,777,888	2,777,888	
Cash Funds	1,043,717	845,741	2,932,314	1,431,033	1,431,033	
Federal Funds	3,567,230	2,311,250	8,624,452	4,208,921	4,208,921	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	7,978,078	5,371,555	18,414,746	9,583,683	9,583,683	
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	2,777,888	
Cash Funds	1,465,526	1,220,268	3,515,234	2,013,953	2,013,953	
Federal Funds	3,989,039	2,685,778	9,207,373	4,791,842	4,791,842	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
(H) Indirect Cost Assessment					
Indirect Cost Assessment	855,070	1,143,073	790,162	922,619	922,619
Cash Funds	364,495	132,859	274,461	198,368	198,368
Reappropriated Funds	0	106,490	121,263	107,638	107,638
Federal Funds	490,575	903,724	394,438	616,613	616,613
SUBTOTAL - (H) Indirect Cost Assessment	855,070	1,143,073	790,162	922,619	922,619
FTE	0.0	0.0	0.0	0.0	0.0
Cash Funds	364,495	132,859	274,461	198,368	198,368
Reappropriated Funds	0	106,490	121,263	107,638	107,638
Federal Funds	490,575	903,724	394,438	616,613	616,613
TOTAL - (1) Executive Director's Office	300,850,123	301,096,298	525,053,213	624,758,479	599,353,489
FTE	573.1	600.5	696.0	746.0	725.5
General Fund	66,181,310	72,943,948	114,711,031	137,487,173	140,637,420
Cash Funds	42,046,210	43,479,898	99,883,362	110,159,346	90,743,434
Reappropriated Funds	2,062,027	2,417,376	4,819,863	5,233,191	5,233,191
Federal Funds	190,560,576	182,255,076	305,638,957	371,878,769	362,739,444

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
(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	11,019,578,742	11,051,250,293	11,420,255,839	*
General Fund	1,944,486,087	2,179,055,708	1,521,021,086	2,066,130,473	2,094,691,211	
General Fund Exempt	0	0	1,088,947,539	1,088,947,539	1,088,947,539	
Cash Funds	1,282,521,053	1,087,673,430	1,288,705,014	1,223,312,590	1,246,846,283	
Reappropriated Funds	40,766,832	82,610,308	90,013,408	100,294,784	94,879,875	
Federal Funds	5,608,995,402	6,406,953,698	7,030,891,695	6,572,564,907	6,894,890,931	
TOTAL - (2) Medical Services Premiums	8,876,769,374	9,756,293,144	11,019,578,742	11,051,250,293	11,420,255,839	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,944,486,087	2,179,055,708	1,521,021,086	2,066,130,473	2,094,691,211	
General Fund Exempt	0	0	1,088,947,539	1,088,947,539	1,088,947,539	
Cash Funds	1,282,521,053	1,087,673,430	1,288,705,014	1,223,312,590	1,246,846,283	
Reappropriated Funds	40,766,832	82,610,308	90,013,408	100,294,784	94,879,875	
Federal Funds	5,608,995,402	6,406,953,698	7,030,891,695	6,572,564,907	6,894,890,931	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
Healthcare Affordability and Sustainability Cash Fund.						
Behavioral Health Capitation Payments	811,992,425	852,041,516	1,126,538,069	1,113,835,257	1,207,509,714	*
General Fund	173,123,597	0	234,385,546	269,039,402	282,270,782	
Cash Funds	52,718,658	63,158,906	91,796,559	82,325,517	90,368,457	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	586,150,170	788,882,610	800,355,964	762,470,338	834,870,475	
Behavioral Health Fee-for-service Payments	14,851,894	12,592,071	11,595,428	10,572,909	10,973,366	*
General Fund	2,692,858	2,280,953	2,312,817	2,390,732	2,431,933	
Cash Funds	989,215	871,824	755,687	639,585	661,577	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	11,169,821	9,439,294	8,526,924	7,542,592	7,879,856	
TOTAL - (3) Behavioral Health Community Programs	826,844,319	864,633,587	1,138,133,497	1,124,408,166	1,218,483,080	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	175,816,455	2,280,953	236,698,363	271,430,134	284,702,715	
Cash Funds	53,707,873	64,030,730	92,552,246	82,965,102	91,030,034	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	597,319,991	798,321,904	808,882,888	770,012,930	842,750,331	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	3,407,396	3,129,269	3,469,613	3,469,613	3,469,613
FTE	34.7	29.1	39.5	39.5	39.5
General Fund	1,539,405	1,307,493	1,858,480	1,858,480	1,858,480
Cash Funds	255,113	210,643	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,612,878	1,611,133	1,611,133	1,611,133	1,611,133
Operating Expenses	160,560	72,072	281,510	281,510	281,510
General Fund	112,261	36,038	164,636	164,636	164,636
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	48,299	36,034	116,874	116,874	116,874
Community and Contract Management System	61,582	62,840	137,480	137,480	137,480
General Fund	30,791	31,420	89,362	89,362	89,362
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	30,791	31,420	48,118	48,118	48,118
Support Level Administration	49,266	51,404	59,317	58,350	58,350
General Fund	24,633	25,702	29,403	28,920	28,920
Cash Funds	0	0	255	255	255
Reappropriated Funds	0	0	0	0	0
Federal Funds	24,633	25,702	29,659	29,175	29,175

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Cross-System Response Pilot Program Services	0	0	0	0	0	
General Fund	0	0	0	0	0	
SUBTOTAL - (i) Administrative Costs	3,678,804	3,315,585	3,947,920	3,946,953	3,946,953	
FTE	34.7	29.1	39.5	39.5	39.5	
General Fund	1,707,090	1,400,653	2,141,881	2,141,398	2,141,398	
Cash Funds	255,113	210,643	255	255	255	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,716,601	1,704,289	1,805,784	1,805,300	1,805,300	
Medicaid Programs						
Adult Comprehensive Waiver Services	503,845,540	593,246,267 0.0	660,401,744	786,908,887	771,570,563	*
General Fund	208,587,557	188,425,770	271,715,607	384,321,080	368,919,010	
Cash Funds	800,001	31,135,458	19,606,380	9,133,363	9,151,410	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	294,457,982	373,685,039	369,079,757	393,454,444	393,500,143	
Adult Supported Living Waiver Services	65,883,070	68,257,740	73,814,616	91,733,120	93,765,842	*
General Fund	24,941,566	19,279,569	24,387,041	39,114,313	38,926,121	
Cash Funds	4,090,144	5,981,477	8,362,151	6,752,249	7,024,708	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	36,851,360	42,996,694	41,065,424	45,866,558	47,815,013	
Children's Extensive Support Services	32,668,165	37,846,959	49,334,765	48,241,851	62,870,839	*
General Fund	14,105,642	13,413,358	21,642,950	22,483,692	29,190,545	
Cash Funds	0	623,899	0	1,637,236	1,649,152	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	18,562,523	23,809,702	27,691,815	24,120,923	32,031,142	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Children's Habilitation Residential Program	4,229,118	9,153,153	11,741,502	15,105,423	14,689,243	*
General Fund	1,708,771	3,335,090	5,177,697	7,420,518	7,068,174	
Cash Funds	0	5,089	0	132,193	132,200	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,520,347	5,812,974	6,563,805	7,552,712	7,488,869	
Case Management for People with IDD	0	80,740,234	90,089,117	105,712,812	109,336,680	*
General Fund	0	36,766,240	41,964,607	49,435,488	50,893,993	
Cash Funds	0	762,621	1,906,921	4,077,534	4,093,618	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	43,211,373	46,217,589	52,199,790	54,349,069	
Home and Community Based Services for People with Intellectual and Developmental Disabilities	0	0	0	0	0	
General Fund	0	0	0	0	0	
Eligibility Determination and Waiting List Management	1,597,270	0	0	0	0	
General Fund	1,301,521	0	0	0	0	
Federal Funds	295,749	0	0	0	0	
Case Management Services	32,871,410	0	0	0	0	
General Fund	14,019,555	0	0	0	0	
Cash Funds	187,939	0	0	0	0	
Federal Funds	18,663,916	0	0	0	0	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
SUBTOTAL - Medicaid Programs	641,094,573	789,244,353	885,381,744	1,047,702,093	1,052,233,167	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	264,664,612	261,220,027	364,887,902	502,775,091	494,997,843	
Cash Funds	5,078,084	38,508,544	29,875,452	21,732,575	22,051,088	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	371,351,877	489,515,782	490,618,390	523,194,427	535,184,236	
State-only Programs						
Family Support Services Program	8,636,298	9,818,346	10,727,042	10,763,585	11,048,853	*
General Fund	8,636,298	9,373,496	10,727,042	10,763,585	11,048,853	
Cash Funds	0	444,850	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
State Supported Living Services	5,539,938	4,898,139	5,042,256	5,089,811	5,193,524	*
General Fund	5,422,133	4,898,139	5,042,256	5,089,811	5,193,524	
Cash Funds	117,805	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
State Supported Living Services Case Management	3,703,361	4,494,161	4,913,632	4,924,590	5,061,041	*
General Fund	3,430,432	4,494,161	4,913,632	4,924,590	5,061,041	
Cash Funds	272,929	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Preventive Dental Hygiene	64,894	64,894	67,789	68,121	69,823	*
General Fund	64,894	64,894	67,789	68,121	69,823	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Supported Employment Provider and Certification Reimbursement	157,100	148,800	303,158	303,158	303,158	*
General Fund	157,100	148,800	303,158	303,158	303,158	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Supported Employment Pilot Program	153,814	415,969	0	0	0	
General Fund	0	415,969	0	0	0	
Cash Funds	153,814	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Eligibility Determination and Waiting List Management	0	0	0	0	0	
General Fund	0	0	0	0	0	
State-only Programs for People with Intellectual and Developmental Disabilities	0	0	0	0	0	
General Fund	0	0	0	0	0	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
SUBTOTAL - State-only Programs	18,255,405	19,840,309	21,053,877	21,149,265	21,676,399
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	17,710,857	19,395,459	21,053,877	21,149,265	21,676,399
Cash Funds	544,548	444,850	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
TOTAL - (4) Office of Community Living	663,028,782	812,400,247	910,383,541	1,072,798,311	1,077,856,519
FTE	34.7	29.1	39.5	39.5	39.5
General Fund	284,082,559	282,016,139	388,083,660	526,065,754	518,815,640
Cash Funds	5,877,745	39,164,037	29,875,707	21,732,830	22,051,343
Reappropriated Funds	0	0	0	0	0
Federal Funds	373,068,478	491,220,071	492,424,174	524,999,727	536,989,536

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	135,548,026	254,743,330	245,136,133	226,610,308	226,610,307
General Fund	0	0	0	0	0
Cash Funds	67,774,013	110,819,422	108,105,035	113,305,154	98,842,122
Reappropriated Funds	0	0	0	0	0
Federal Funds	67,774,013	143,923,908	137,031,098	113,305,154	127,768,185
Pediatric Specialty Hospital	10,764,010	10,764,010	10,764,010	10,764,010	10,764,010
General Fund	4,714,636	4,714,636	4,746,929	5,382,005	4,746,929
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	6,049,374	6,049,374	6,017,081	5,382,005	6,017,081
Appropriation from Tobacco Tax Fund to the General Fund	390,989	364,131	381,798	381,798	355,173
General Fund	0	0	0	0	0
Cash Funds	390,989	364,131	381,798	381,798	355,173
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Primary Care Fund	24,666,536	51,647,973	53,309,813	48,087,990	53,309,813
General Fund	0	0	0	0	0
Cash Funds	24,666,536	22,755,511	24,176,000	24,176,000	24,176,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	28,892,462	29,133,813	23,911,990	29,133,813

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
Children's Basic Health Plan Administration	1,204,364	2,336,020	3,864,405	3,864,405	3,864,405	*
General Fund	0	0	0	0	0	
Cash Funds	370,894	716,224	1,268,684	1,352,542	1,325,491	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	833,470	1,619,796	2,595,721	2,511,863	2,538,914	
Children's Basic Health Plan Medical and Dental Costs	166,658,064	133,119,234	129,503,162	206,649,737	175,307,400	*
General Fund	2,761,239	11,045,841	0	31,855,097	19,250,578	
General Fund Exempt	390,989	0	381,798	381,798	355,173	
Cash Funds	44,010,133	30,065,351	41,326,801	40,155,512	40,572,195	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	119,495,703	92,008,042	87,794,563	134,257,330	115,129,454	
Clinic Based Indigent Care	6,039,386	0	0	0	0	
General Fund	2,645,251	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,394,135	0	0	0	0	
TOTAL - (4) Indigent Care Program	345,271,375	452,974,698	442,959,321	496,358,248	470,211,108	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	10,121,126	15,760,477	4,746,929	37,237,102	23,997,507	
General Fund Exempt	390,989	0	381,798	381,798	355,173	
Cash Funds	137,212,565	164,720,639	175,258,318	179,371,006	165,270,981	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	197,546,695	272,493,582	262,572,276	279,368,342	280,587,447	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation	
(5) OTHER MEDICAL SERVICES						
Old Age Pension State Medical	23,557	0	10,000,000	10,000,000	10,000,000	
General Fund	0	0	0	0	0	
Cash Funds	23,557	0	10,000,000	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Senior Dental Program	2,987,821	0	3,990,358	3,990,358	3,990,358	
General Fund	2,962,510	0	3,962,510	3,962,510	3,962,510	
Cash Funds	25,311	0	27,848	27,848	27,848	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Commission on Family Medicine Residency Training Programs	7,130,420	0	9,490,170	9,490,170	9,490,170	
General Fund	3,123,124	0	3,986,715	4,520,085	3,986,715	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	198,450	225,000	198,450	
Federal Funds	4,007,296	0	5,305,005	4,745,085	5,305,005	
Medicare Modernization Act State Contribution Payment	151,204,900	213,480,167	228,858,638	238,758,096	232,144,442	*
General Fund	151,204,900	213,480,167	228,858,638	238,758,096	232,144,442	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Public School Health Services Contract Administration	1,035,786	0	2,000,000	2,000,000	2,000,000
General Fund	517,893	0	1,000,000	1,000,000	1,000,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	517,893	0	1,000,000	1,000,000	1,000,000
Public School Health Services	127,813,978	0	152,555,114	161,383,372	161,383,372 *
General Fund	0	0	0	0	0
Cash Funds	57,869,729	0	69,201,006	78,719,855	78,719,855
Reappropriated Funds	0	0	0	0	0
Federal Funds	69,944,249	0	83,354,108	82,663,517	82,663,517
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	500,000	0	1,500,000	1,500,000	1,500,000
General Fund	0	0	0	0	0
Cash Funds	500,000	0	1,500,000	1,500,000	1,500,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Reproductive Health Care for Individuals Not Eligible for Medicaid	0	0	3,614,490	3,614,490	3,614,490
General Fund	0	0	3,614,490	3,614,490	3,614,490
Urban Indian Health Organizations State Only Payments	0	0	48,025	0	0
General Fund	0	0	48,025	0	0

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
ARPA HCBS State-only Funds	0	0	57,116,818 4.0	46,817,018 0.0	46,817,018 4.0 *
General Fund	0	0	0	0	0
Cash Funds	0	0	57,116,818	46,817,018	46,817,018
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Primary Care and Behavioral Health Statewide Integration Grant Program	0	0	31,750,000 2.3	0 0.0	0 0.0
Cash Funds	0	0	31,750,000	0	0
Denver Health and Hospital Authority	0	0	5,000,000	0	0
General Fund	0	0	5,000,000	0	0

TOTAL - (5) Other Medical Services	291,900,669	213,480,167	505,923,613	477,553,504	470,939,850
FTE	0.0	0.0	6.3	0.0	4.0
General Fund	158,138,770	213,480,167	246,470,378	251,855,181	244,708,157
Cash Funds	58,418,597	0	169,595,672	137,064,721	137,064,721
Reappropriated Funds	197,100	0	198,450	225,000	198,450
Federal Funds	75,146,202	0	89,659,113	88,408,602	88,968,522

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

TOTAL - (7) Department of Human Services Medicaid-Funded Programs	111,442,385	106,428,624	119,227,795	123,501,422	123,458,442
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	47,208,775	44,517,842	52,758,009	59,491,093	54,831,221
Cash Funds	1,888,903	1,888,903	1,920,783	1,936,723	1,936,723
Reappropriated Funds	0	0	0	0	0
Federal Funds	62,344,707	60,021,879	64,549,003	62,073,606	66,690,498

TOTAL - Department of Health Care Policy and Financing	11,416,107,027	12,507,306,765	14,661,259,722	14,970,628,423	15,380,558,327
FTE	607.8	629.6	741.8	785.5	769.0
General Fund	2,686,035,082	2,810,055,234	2,564,489,456	3,349,696,910	3,362,383,871
General Fund Exempt	390,989	0	1,089,329,337	1,089,329,337	1,089,302,712
Cash Funds	1,581,672,946	1,400,957,637	1,857,791,102	1,756,542,318	1,754,943,519
Reappropriated Funds	43,025,959	85,027,684	95,031,721	105,752,975	100,311,516
Federal Funds	7,104,982,051	8,211,266,210	9,054,618,106	8,669,306,883	9,073,616,709