JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2024-25

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

CONTENTS

ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2023 legislative sessions that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy23-24apprept.pdf

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

- **Medicaid** that serves people with low income and people needing long-term care
- **Children's Basic Health Plan** that provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** that 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** that serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare

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

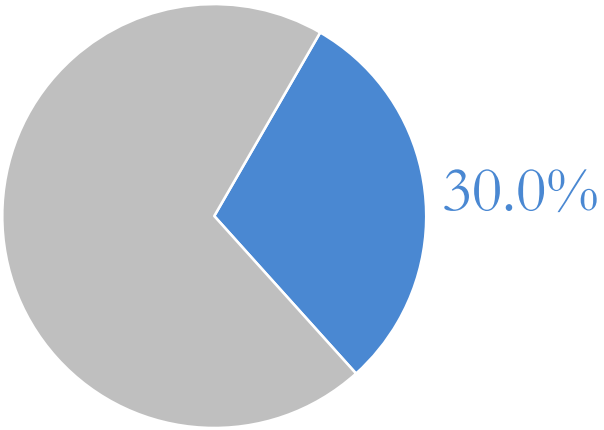
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25 *
General Fund	$3,068,037,679	$3,652,118,890	$4,525,518,658	$4,966,004,584
Cash Funds	1,682,425,600	1,856,769,698	1,769,169,191	1,819,098,761
Reappropriated Funds	87,047,288	95,031,721	105,145,754	121,939,636
Federal Funds	8,637,872,527	9,054,693,848	9,106,914,976	9,480,711,882
TOTAL FUNDS	**$13,475,383,094**	**$14,658,614,157**	**$15,506,748,579**	**$16,387,754,863**
Full Time Equiv. Staff	654.9	745.0	787.9	797.3

*Requested appropriation.

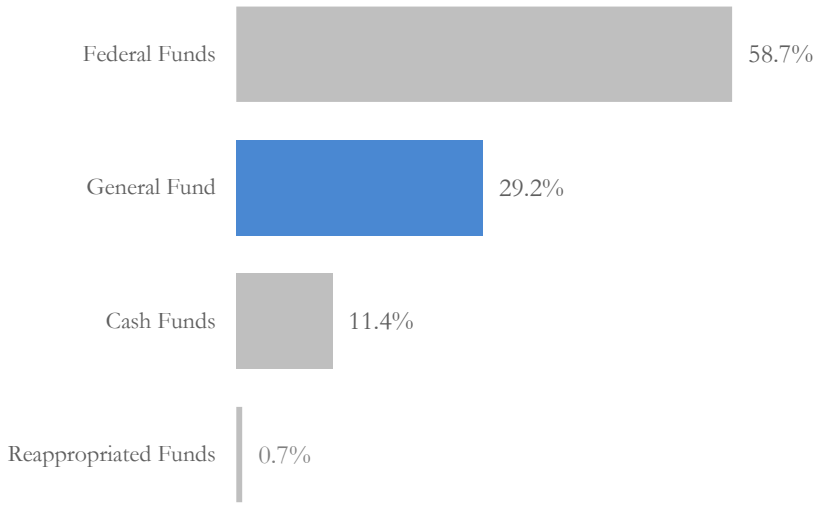
DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund



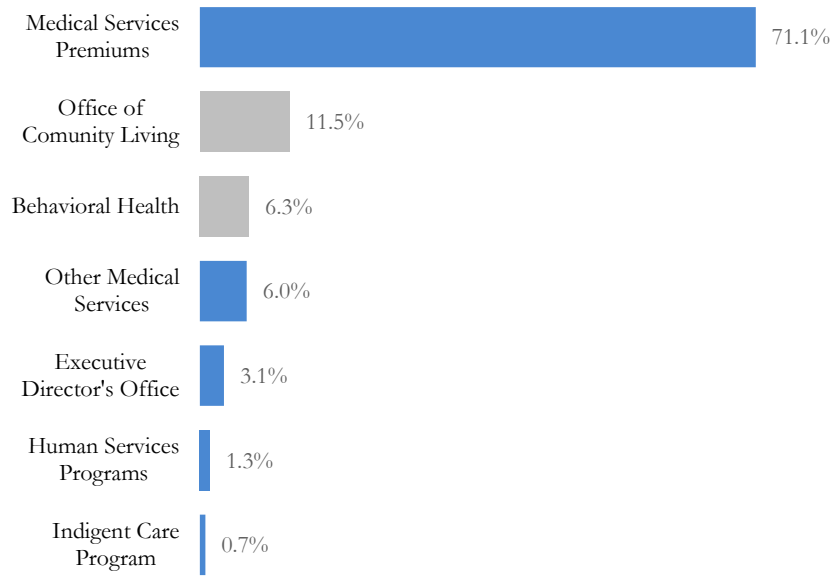
Based on the FY 2023-24 appropriation.

Department Funding Sources



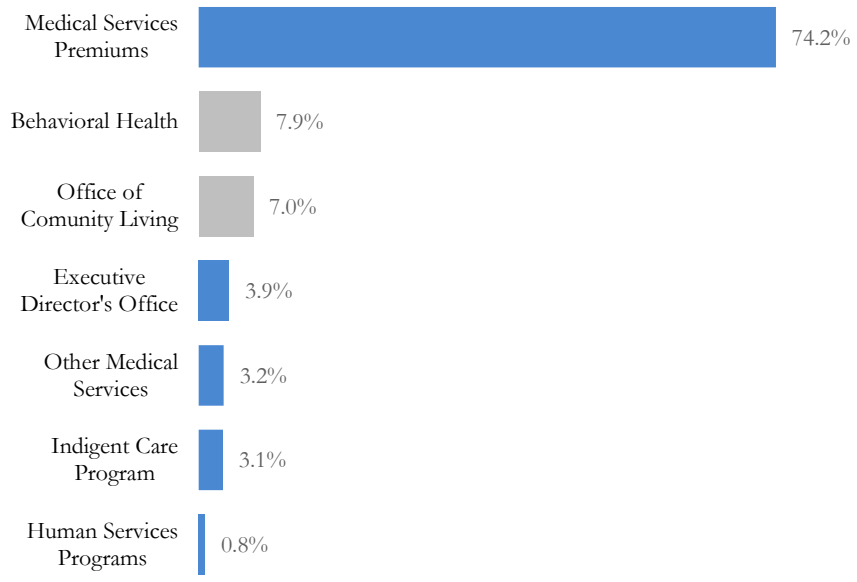
Based on the FY 2023-24 appropriation.

Distribution of General Fund by Division



Based on the FY 2023-24 appropriation.

Distribution of Total Funds by Division



Based on the FY 2023-24 Appropriation

Cash Funds Appropriation Detail				
Fund Name	FY 23-24 Approp		Primary Sources	Primary Uses (in this Department)
Healthcare Affordability and Sustainability (HAS) Fee Cash Fund	$1,251,818,994	[1]	Hospital fees	Supplemental payments to increase hospital reimbursements ($688M); eligibility expansion populations ($497M); General Fund relief ($22M); and admin related to the above ($44M)
Certified public expenditures	143,883,489	[1]	Local government expenditures for Medicaid clients that are certified by the state as eligible for a federal match	Reimbursements to school districts ($79M), emergency medical transport providers ($36M), hospitals, nursing homes, and Connect for Health ($29M)
HCBS Improvement Fund	84,940,692	[1]	Time-limited federal stimulus funds	Improvements to Home- and Community-Based Services that support the elderly and people with disabilities living at home
Tobacco taxes	80,410,147	[2]	Tobacco taxes to: Health Care Expansion Fund ($53M); Primary Care Fund ($26M); Tobacco Tax Cash Fund ($2M); Tobacco Ed Programs ($1M)	Eligibility and benefit expansions and primary care grants
Recoveries and recoupments	67,567,946		Recoveries from overpayments, fraud, 3rd party insurance, and estates	Offset the cost of Medicaid services
Nursing Facility Fee; Service Fee Fund	56,569,625		Fees on nursing for the elderly ($54 M) and people with intellectual and developmental disabilities ($2 M)	Supplemental payments to increase provider reimbursements, similar to the HAS Fee
Adult Dental Fund	31,921,621		Unclaimed Property Trust Fund	Adult dental benefit
Local funds	18,871,933	[1]	County funds	County administration of eligibility determinations for health benefits
Children's Basic Health Plan Trust	16,211,741	[1]	Tobacco settlement; also includes annual premium fees	Children's Basic Health Plan (marketed as the Child Health Plan Plus or CHP+)
Old Age Pension Health and Medical	10,000,000		Constitutional allocation from General Fund	Offsets Medicaid costs for people who qualify for the state old age pension
Autism Treatment Fund	1,799,760	[1]	Tobacco settlement	Early and periodic screening diagnosis and treatment for children
Marijuana Tax Cash Fund	1,500,000	[1]	Marijuana taxes	Screening, Brief Intervention, and Referral to Treatment (SBIRT) training grant program
Medicaid Buy-in	1,102,525		Premiums from people with disabilities who are eligible to "buy-in" to Medicaid	Offsets Medicaid services for people with disabilities
Breast & Cervical Cancer Prev & Treatment Fund	636,356		Specialty license plate surcharge and interest on tobacco settlement	Breast and cervical cancer prevention and treatment
Other	1,934,362		Various	Various
Total	**$1,769,169,191**			

[1] Exempt from TABOR

[2] Some tobacco taxes are subject to TABOR but the revenues for these purposes are exempt.

ADDITIONAL INFORMATION – SELECT FUND SOURCES

HEALTHCARE AFFORDABILITY AND SUSTAINABILITY (HAS) FEE: The HAS Fee is the largest source of cash funds for the Department. Hospitals pay fees into the fund that are then matched with federal funds and returned with the federal funds to the hospitals in the form of supplemental payments. The supplemental payments are in proportion to the indigent care provided, so the fees paid by an individual hospital might be more or less than the supplemental payments received. A portion of the revenue is used to pay for health care services for expansion populations (primarily for adults without dependent children and higher income parents). To the extent hospitals serve the expansion populations, the hospitals receive the payments for expansion populations in the form of Medicaid and CHP+ reimbursements for services. The General Assembly designated the HAS Fee as

part of an enterprise that is exempt from TABOR. The fees are set annually by the board for the enterprise to maximize supplemental payments while not exceeding federal regulatory limits.

AUTISM TREATMENT FUND [POTENTIAL LEGISLATION]: There is a mismatch between the statutory authority for the Autism Treatment Fund and the appropriations from the fund that needs the JBC's attention. Historically, the Autism Treatment Fund has received 2.0 percent of tobacco settlement money annually for autism screening, diagnosis, and treatment for children and for related program evaluations. Prior to FY 2018-19, these services were part of the Home- and Community-Based Services for Children with Autism waiver. The waiver became inactive in FY 2018-19, because new federal guidance required that these services be covered as part of the State Plan. Senate Bill 23-289, sponsored by the JBC, needed to make changes to several waiver statutes to implement Community First Choice and repealing the autism waiver was tacked on to those other waiver statute changes. Repealing the autism waiver was mostly innocuous, since the waiver was inactive, but the bill also repealed the Autism Treatment Fund, without changing appropriations in the FY 2023-24 Long Bill from the now nonexistent Autism Treatment Fund.

The bill did make a conforming change to the tobacco settlement distribution to end transfers to the Autism Treatment Fund, but that conforming change does not take effect until July 1, 2025. So, for FY 2023-24 and FY 2024-25 there is a statutory instruction for the Treasurer to transfer 2.0 percent of the tobacco settlement money to the nonexistent Autism Treatment Fund.

Finally, the Department built the request for FY 2024-25 assuming appropriations from the nonexistent Autism Treatment Fund for services and administrative expenses that would otherwise need to be financed from the General Fund.

One possible solution would be legislation to reauthorize the Autism Treatment Fund. This might be the simplest policy option to explain and it would avoid any potential misperceptions by autism advocates that money is being taken away from autism services. However, staff recommends a slightly more complex solution that will be simpler to administer in the long run and better align the ongoing and increasing costs for autism services with a sustainable fund source.

The are several problems with the way the Autism Treatment Fund worked in the past. The money didn't cover the full cost of autism services. It was merely a partial offset to the General Fund. The revenue source, i.e. tobacco settlement money, is declining, but autism services are an ongoing need with increasing costs. A small amount of the Autism Treatment Fund was allocated to administrative costs, requiring painstaking allocations and tracking by the Department and JBC staff of often tiny amounts of line item totals that are attributable to the Autism Treatment Fund, such as $3 of the Temporary Employees Related to Authorized Leave line item or $67 of the CORE Operations line item.

Staff recommends that the JBC sponsor legislation to eliminate the instruction in Section 24-75-1104.5 (1.7)(k), C.R.S., for the Treasurer to transfer money to the nonexistent Autism Treatment Fund, effective retroactively for FY 2023-24. As part of the supplemental bill for the Department of Health Care Policy and Financing, staff recommends replacing the existing $1.8 million in appropriations from the Autism Treatment Fund with General Fund and continuing that practice into the future. This would leave 2.0 percent of the tobacco settlement money, or approximately $1.8 million, unallocated. The JBC could either find a purpose for the money that is better suited to a declining fund source or, if the JBC wants to make sure that the change is budget neutral, consolidate the $1.8

million into one of the larger existing allocations from the tobacco settlement money that offsets the need for General Fund, such as the allocation to CHP+. The staff recommended solution would simplify appropriations in the Department of Health Care Policy and Financing and better align on-going and increasing costs for autism services with a sustainable fund source.

GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 29.2 percent General Fund, 11.4 percent cash funds, 0.7 percent reappropriated funds, and 58.7 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

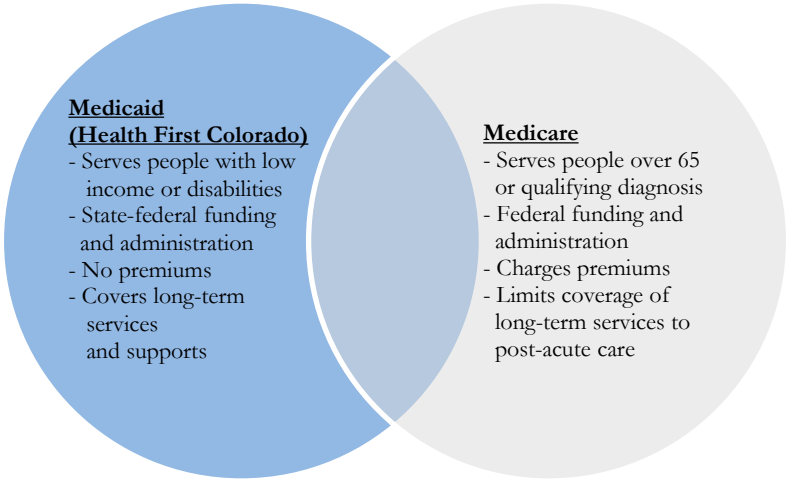
MEDICAID

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

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

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

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



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

For state fiscal year 2023-24 the average FMAP for the majority of Colorado Medicaid expenditures is 51.00 percent as a result of the phase out of a temporary increase in the federal match rate during the pandemic. For state fiscal year 2024-25 the average FMAP will be 50.00 percent.

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.

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

90% Federal Match for "Newly Eligible" pursuant to the Affordable Care Act

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

After accounting for standard income disregards, Medicaid effectively covers people to 138 percent of the federal poverty guidelines, or $20,120 annual income for an individual and $34,307 annual income for a family of three. The Medicaid eligibility limits are slightly higher for children and pregnant women and if these populations earn income above the Medicaid limits they can still qualify for the Children's Basic Health Plan up to effectively 265 percent of the federal poverty guidelines, or $65,879 annual income for a family of three.

STANDARD MEDICAID/CHP+ ELIGIBILITY		
	INDIVIDUAL	FAMILY OF THREE
Adults < 65	$20,120	$34,307
Children or Pregnant Women	$38,637	$65,879

In addition, there are special rules for the elderly, people with disabilities, and some smaller populations that are summarized in the table below.

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

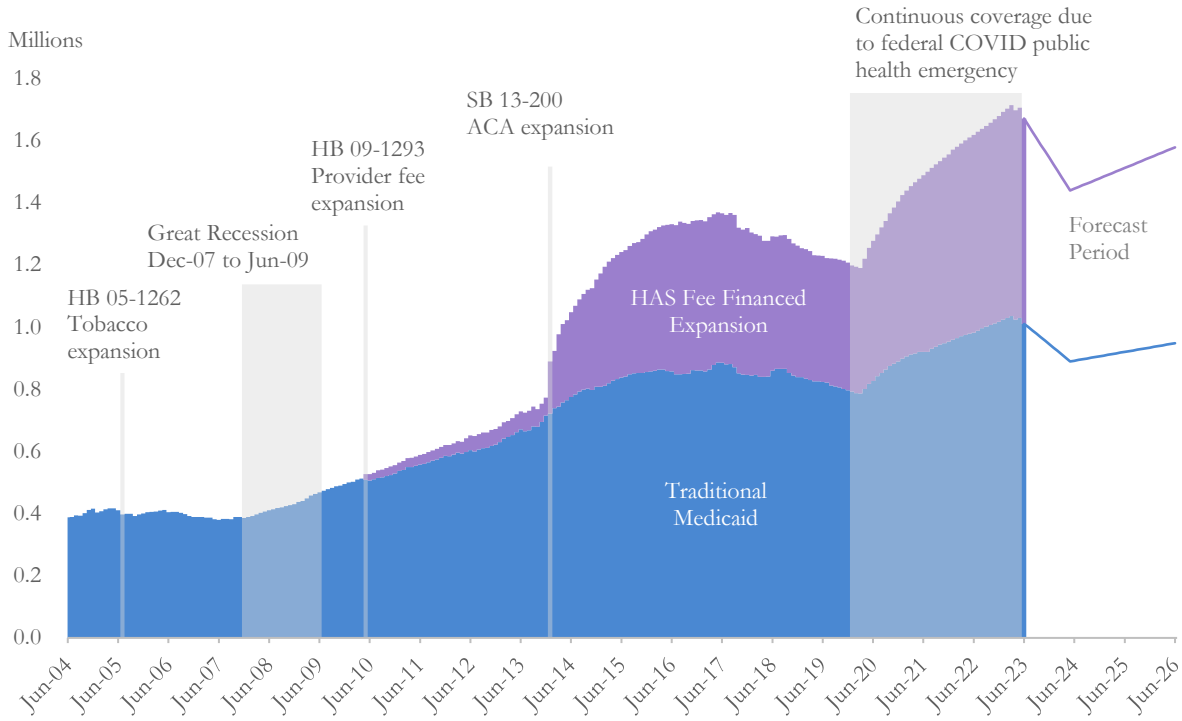
[2] In statute the income limit is 133 percent of the federal poverty guidelines, but with federally mandated standard income disregards, the effective income limit is 138 percent.
[3] See Section 24-75-109 (1)(a), C. R. S.

Family Size	Federal Poverty Guideline – 2020	SSI Annual Income Limit
1	$14,580	$10,968
2	$19,720	$16,452
3	$24,860	
4	$30,000	
More	add $5,140 each	

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

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

Medicaid Enrollment of 1,670,715 as of June 2023
660,803 Healthcare Affordability and Sustainability (HAS) Fee Expansion
1,009,912 Traditional Medicaid (General Fund and non-HAS Fee sources)



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

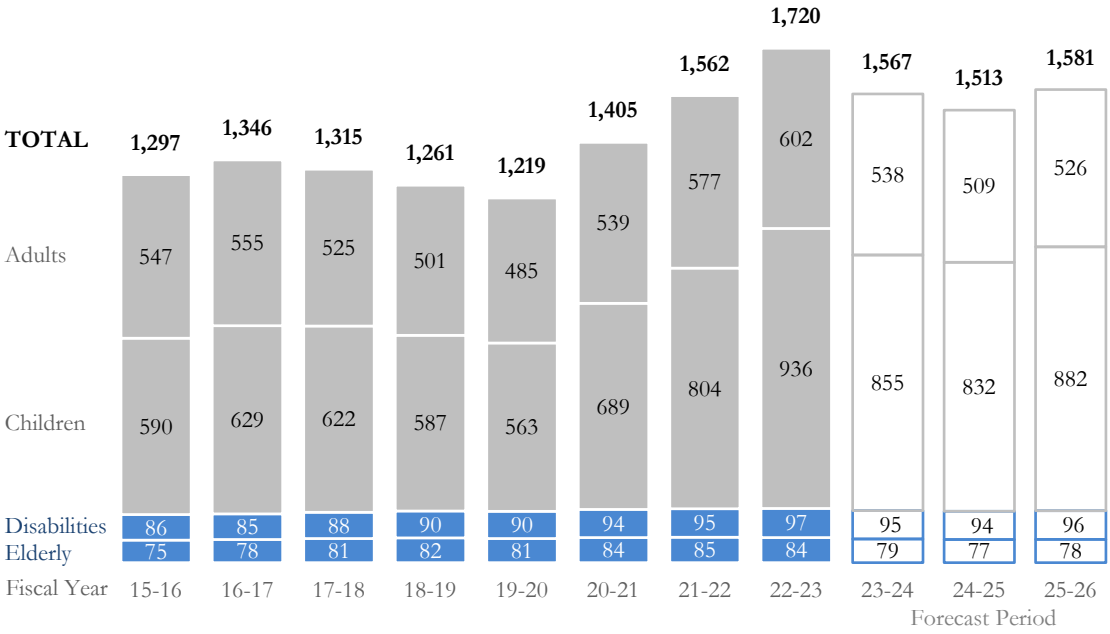
(1) Medical Services Premiums

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

Medicaid serves a large number of low income adults and children but direct expenditures for services are driven by the elderly and people with disabilities.

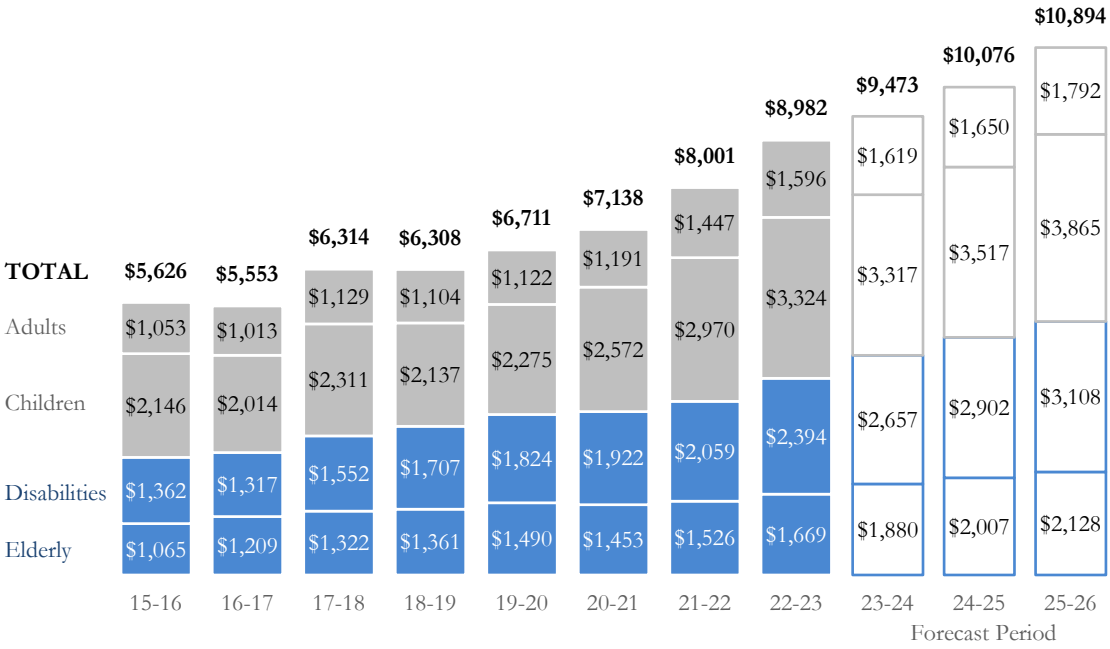
Medicaid Enrollment by Population

November 2023 forecast
(in thousands)

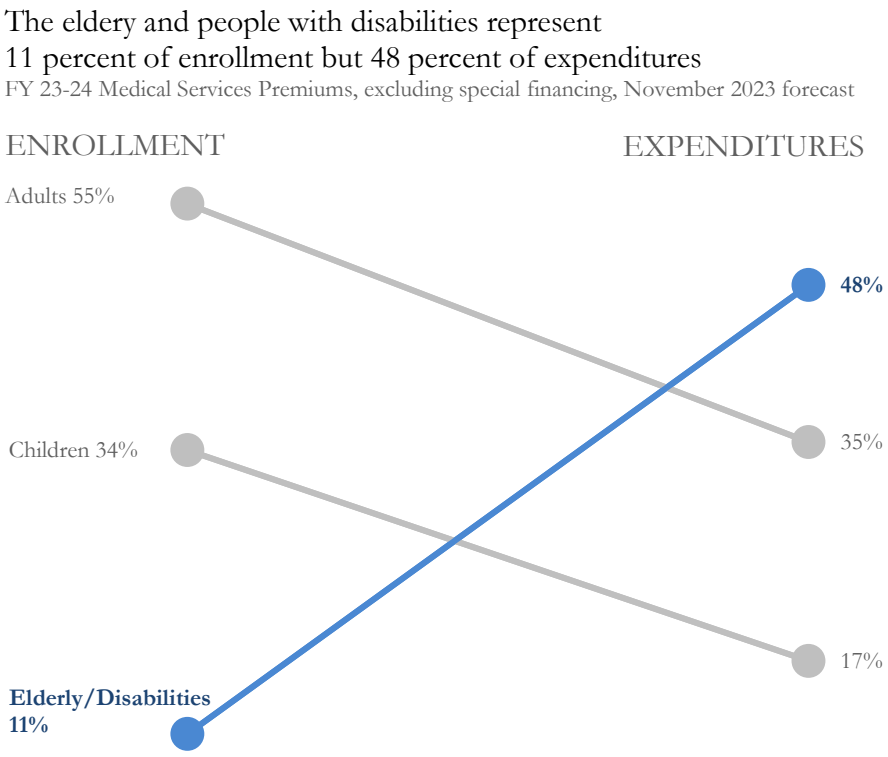


Medical Services Premiums Services Expenditures by Population

November 2023 forecast, excluding special financing
(in millions)



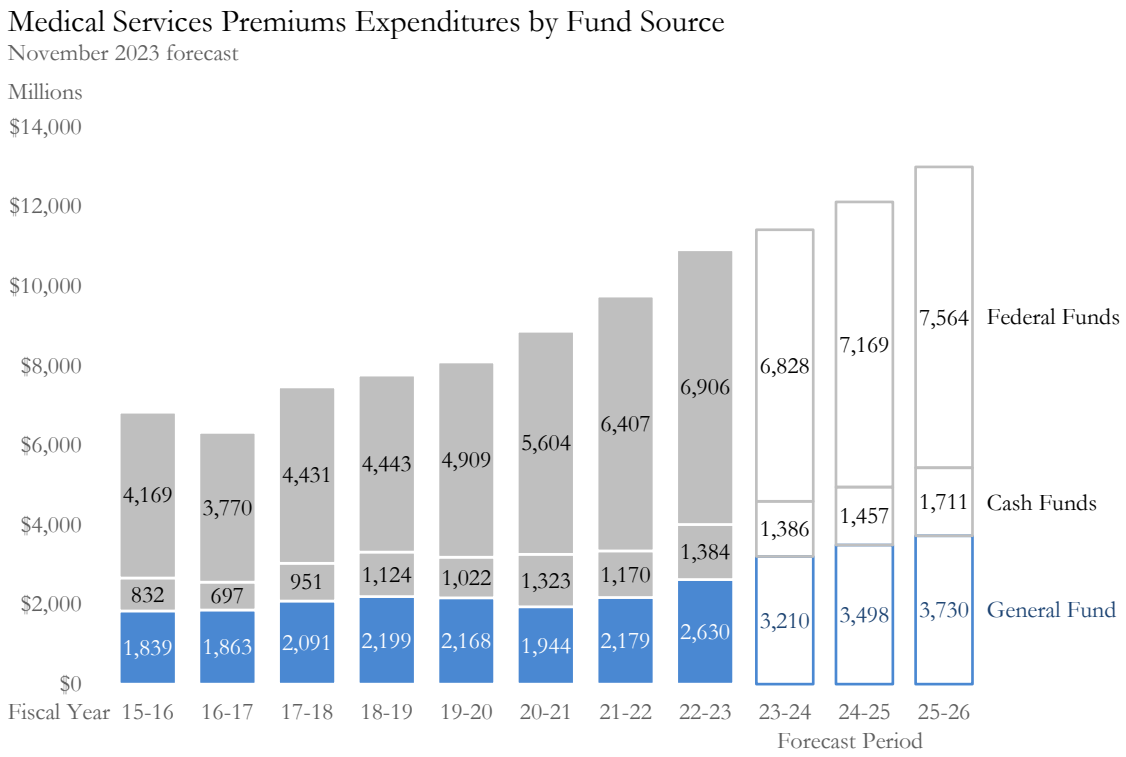
The elderly and people with disabilities represent only 11 percent of the Medicaid enrollment but 48 percent of direct expenditures for services in Medical Services Premiums. This is partly due to higher acuity and medical costs but also to their utilization of long-term services and supports.



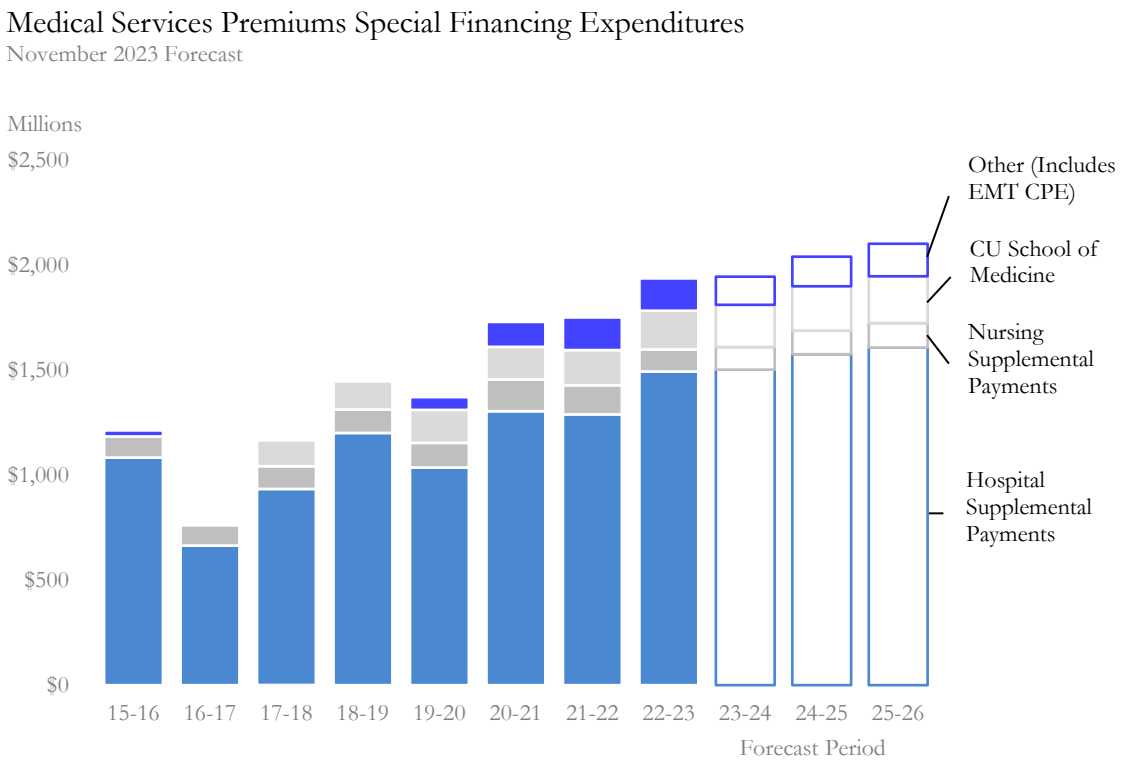
The elderly and people with disabilities are an even more disproportionate share of General Fund expenditures, due to the ways the state and federal government finance different populations and the services they use. For example, for nearly 70 percent of the adult enrollment there is no General Fund cost because they are expansion populations that qualify for an enhanced 90 percent federal match and the state match comes from the HAS Fee. As a result, the elderly and people with disabilities account for 11 percent of Medicaid enrollment but 65 percent of projected direct General Fund expenditures for services in Medical Services Premiums in FY 2023-24.

A big piece of why the elderly and people with disabilities are so expensive is their utilization of long-term care programs. Long-term care programs in this context includes nursing homes, in-home nursing assistance, in-home therapy services, and a wide variety of home and community assistance that helps people with medical needs stay at home rather than in an institution. The last category might include things like assistance with feeding, bathing, and clothing, transportation, adult day centers, respite care, and hospice. Long-term care programs are an estimated 33 percent of total funds and 45 percent of General Fund expenditures for direct services in Medical Services Premiums.

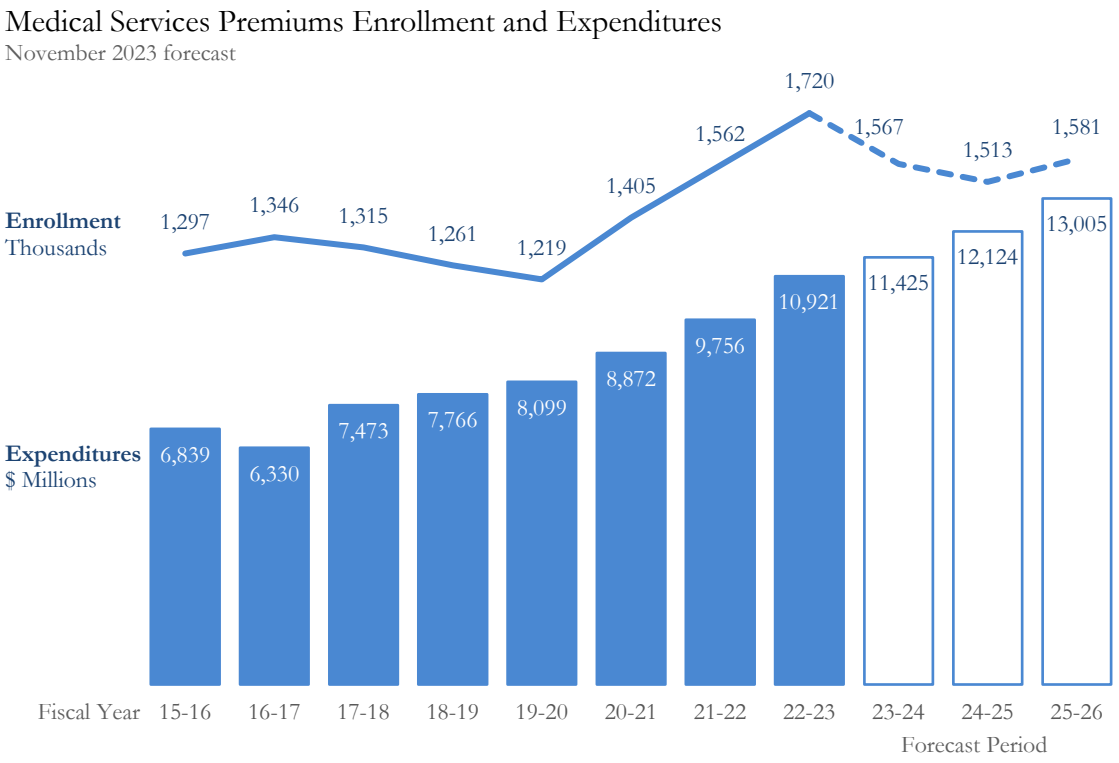
When looking at Medical Services Premiums expenditures by fund source it becomes apparent that the General Fund trend is more commensurate with the enrollment of the elderly and people with disabilities than overall enrollment. The dips in General Fund in FY 2019-20 and FY 2020-21 are primarily attributable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



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



The chart below puts direct expenditures for services together with special financing and enrollment to show the full picture. In FY 2015-16 there was a spike in special financing, noted above, that helps explain why overall expenditures were higher in that year. In FY 2016-17 the Department implemented a new billing system that caused some payment delays and made expenditures shift from FY 2016-17 to FY 2017-18. From FY 2017-18 through FY 2019-20 the enrollment of expensive populations of the elderly and people with disabilities continued to rise even though overall enrollment declined, helping to explain why expenditures increased when overall enrollment was falling. From FY 2020-21 through FY 2022-23 a federal requirement associated with the federal COVID public health emergency prevented the Department from disenrolling anyone from Medicaid due to a change in income or family status. This caused enrollment to swell, but expenditures did not increase as quickly because many of the clients with extended enrollment were low utilizers. Also, this explains why the Department projects expenditures will continue to increase from FY 2023-24 through FY 2025-26 despite a projected correction to the enrollment trend. Projected continued increases in costs for the elderly and people with disabilities overshadow other projected changes in costs due to enrollment trends.



(2) Behavioral Health Community Programs

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

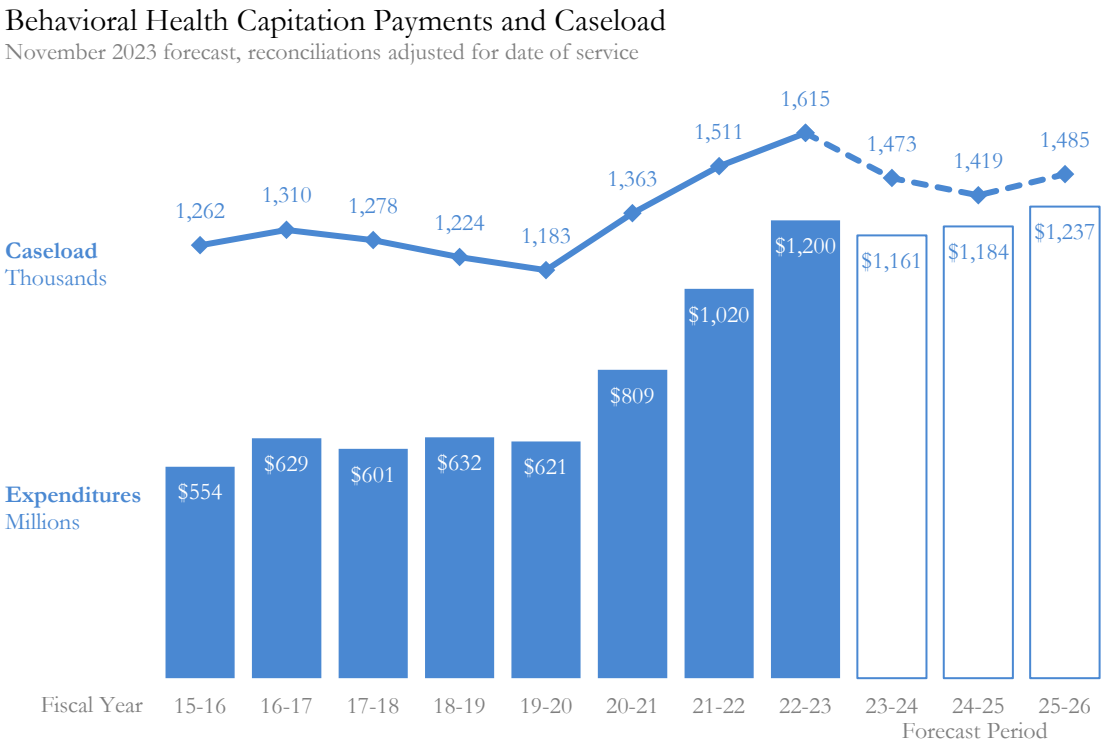
Behavioral health services are primarily supported by the General Fund and federal funds. For adults who are "newly eligible" pursuant to the federal Affordable Care Act (which includes adults without dependent children) the state receives a 90 percent federal match and the state share of costs is financed with the Healthcare Affordability and Sustainability (HAS) Fee. Services for these expansion adults represent a significant portion of total expenditures, but General Fund expenditures are driven more by children (because there are a lot of them) and people with disabilities (because the per capita expenditures are high).

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver programs that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible

within each category. Changes in the federal match rate for various eligibility categories also affect the State's share of expenditures.

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

Regarding more recent trends, in FY 2017-18 rates went down due to a change in federal managed care rules that limited how much Colorado could pay providers. In FY 2018-19 and FY 2019-20 the reductions in overall caseload were primarily in low utilizers of behavioral health services and the remaining members were higher utilizers, resulting in an increase in rates. In FY 2021-22 the rates came in higher than expected, primarily due to a higher percentage of Medicaid clients utilizing behavioral health services and partly due to an increase in substance use disorder treatment capacity. The projected decrease in expenditures and enrollment in FY 2023-24 is related to the expected end of the public health emergency and end of the federal prohibition on disenrolling Medicaid clients.



To better show the relationship between enrollment and expenditures, the chart above moves reconciliation payments to the fiscal year when the cost accrued, rather than the year it was paid. For this reason, the chart above will not exactly match the actual and projected cash expenditures.

With two exceptions, the caseload reported in the graph above is the same as the Medicaid enrollment, since behavioral health is paid per member per month. It is not the same as the number of utilizers of behavioral health services. The first exception is non-citizens, because for this population Medicaid covers emergency health services but not behavioral health. The second exception is elderly adults who qualify for Medicaid assistance with their Medicare premiums but have too much income to

qualify for full Medicaid benefits. For these elderly adults Medicare covers behavioral health under Medicare's policies.

(3) Office of Community Living

Medicaid vs Medicaid Waivers

Medicaid provides health insurance to people with low income and people needing long-term care. Participants generally do not pay annual premiums and copayments at the time of service are either nominal or not required. The federal government and state government share responsibility for financing, administering, and policy setting for the program. Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, if the eligible population and/or the eligible services utilized are greater than expected, then the state and federal government must pay the higher cost, regardless of the initial appropriation.

A Medicaid waiver is a provision in Medicaid law which allows the federal government to waive rules that usually apply to the Medicaid program. The intention is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage, or improving care for certain target groups. There are several different types of Medicaid waivers, all of which serve different purposes.

Section 1115 waivers – Often referred to as research and demonstration waivers, these allow states to temporarily test out new approaches to delivering Medicaid care and financing.

Section 1915(c) waivers – Home and Community-Based Services (HCBS) waivers are designed to allow states to provide home and community-based services to people in need of long-term care. This means they can stay in their own home or a community setting (such as a relative's home or a supported living community) instead of going into a facility.

Section 1915(b) waivers – "Freedom of choice waivers" allow states to provide care via managed care delivery systems. These organizations contract with state Medicaid agencies, and are paid from the state Medicaid fund for providing health care services to the beneficiaries.

HCBS waivers must demonstrate that providing waiver services won't cost more than providing these services in an institution, sometimes known as budget neutrality.

Office of Community Living

Medicaid intellectual and developmental disability (IDD) waiver services are not subject to standard Medicaid State Plan service and duration limits, but rather are provided under a Medicaid waiver program. Colorado has four Medicaid waivers for intellectual and developmental disability services:

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

Four factors determine the overall cost of waiver services, including:

- The number of individuals eligible for services;
- The number of enrollments funded for the DD waiver;
- The number of providers willing and able to provide services; and
- The rates of reimbursement for each type of services.

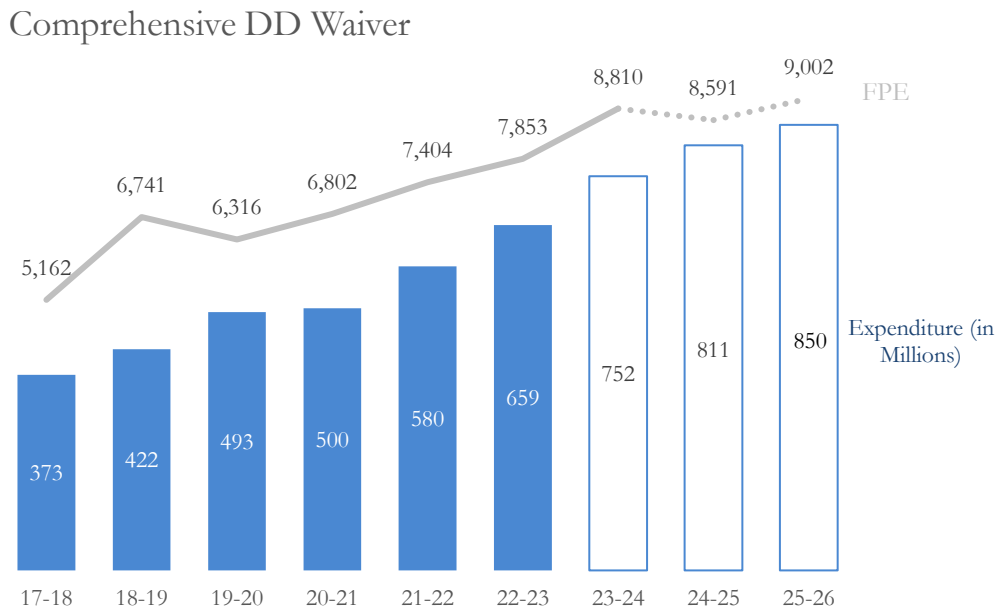
As part of the waivers, Colorado is allowed to limit the number of waiver program participants. Annually, the General Assembly has appropriated sufficient funding to ensure no waiting list for the SLS, CES, and CHRP waivers.

Unlike the SLS, CES, and CHRP waivers, the Comprehensive DD program continues to have a waiting list for enrollments. The Department's annual budget request is based on forecasts of the cost per full-program-equivalent (FPE) in each of the waivers. FPE is calculated as the number of clients with a paid claim in a given month or year. Adjustments to targeted appropriations reflect the current average cost per FPE, are based upon current spending trends, and are intended to maximize the number of individuals that can be served in each program. Because the DD and CHRP waivers provide residential services in addition to daily support services, the average cost of the individuals receiving services through this waiver are significantly higher than those for individuals receiving services through other waivers.

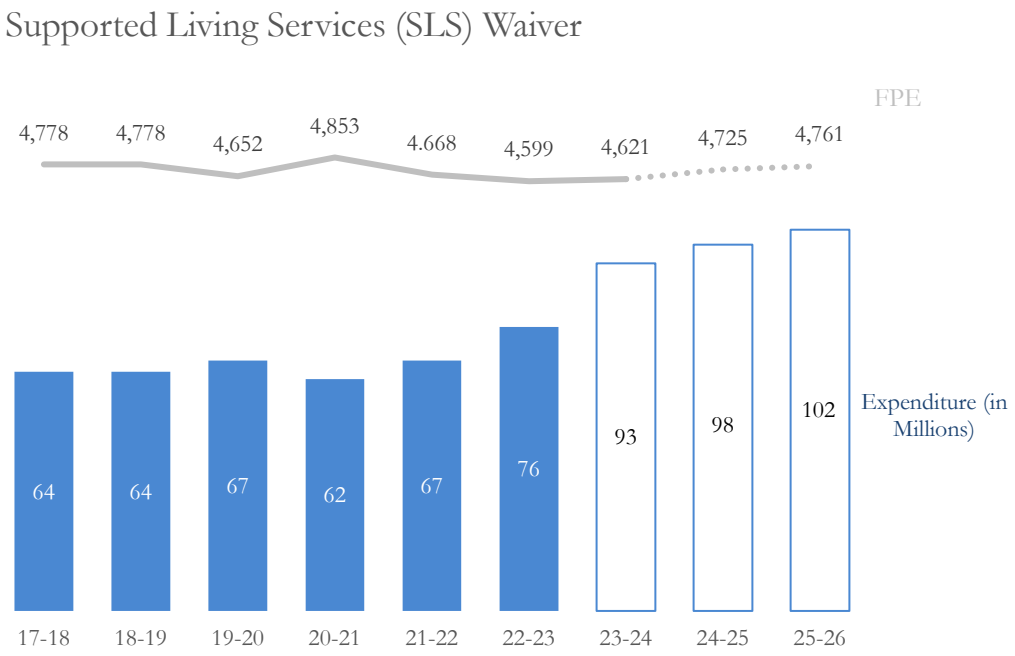
The FY 2022-23 average monthly enrollment on the Comprehensive DD waiver was 7,853, up 5.9 percent from the previous fiscal year. As of November 2023, 3,357 individuals were identified as needing DD services as soon as available. While the majority of these individuals receive services through other programs, including the SLS waiver, some may not be receiving the level of services required to meet their needs. The Department requests that new DD waiver enrollments are funded annually for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and individuals transitioning from institutions.

OCL WAIVER PROGRAMS

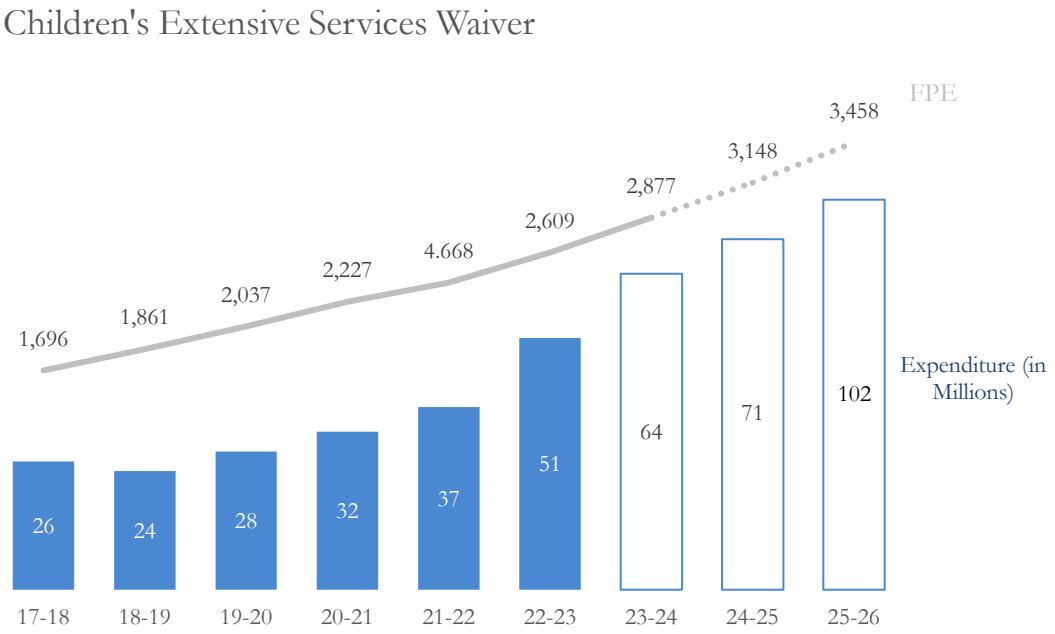
The Comprehensive (DD) waiver provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports.



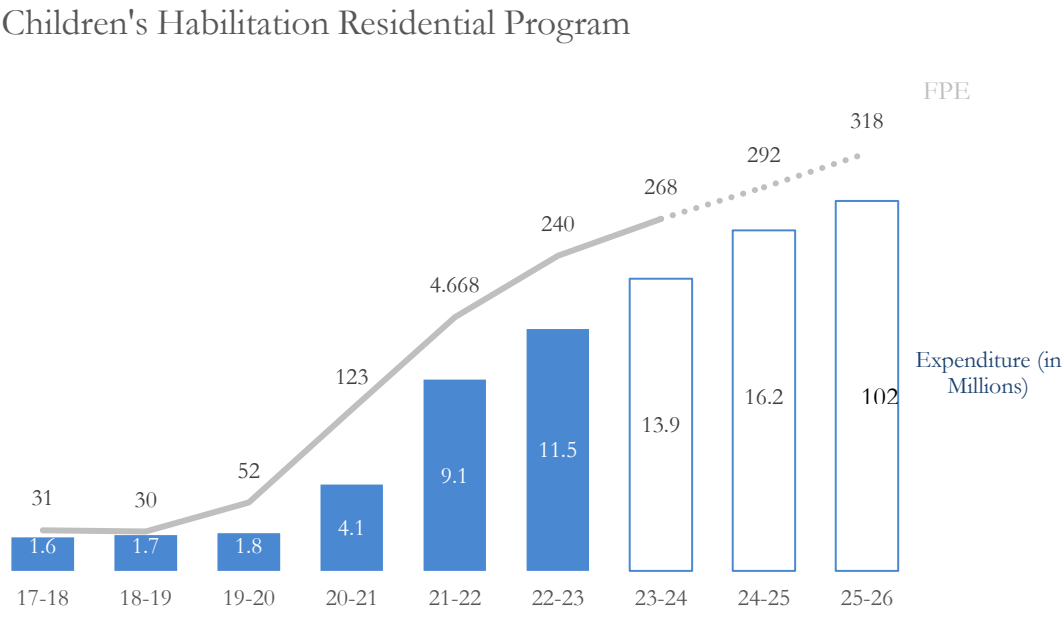
The Supported Living Services (SLS) waiver provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports.



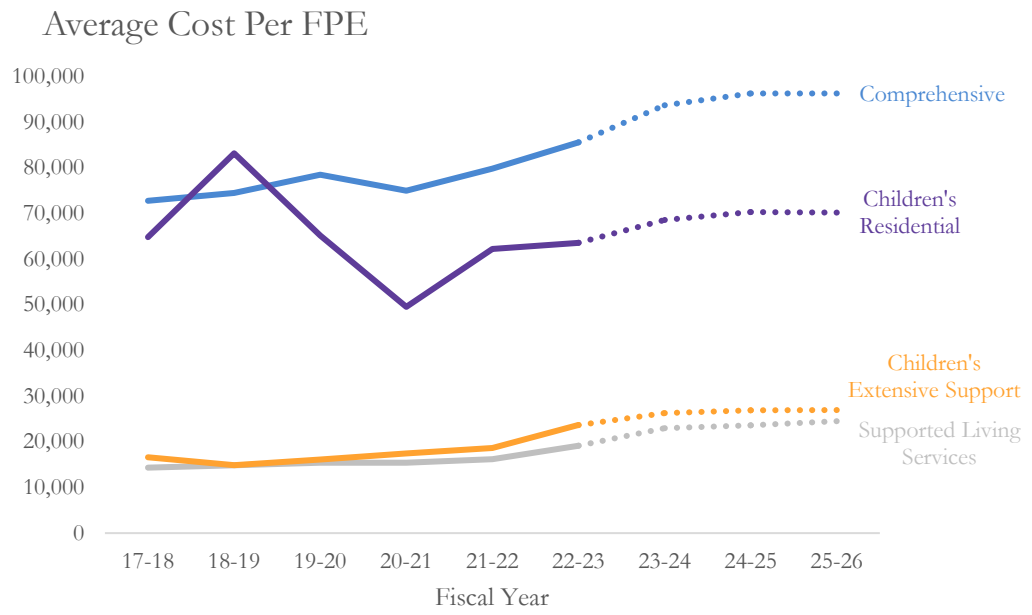
The Children's Extensive Support (CES) waiver provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood.



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



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



(4) Indigent Care Program

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

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

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

Related to the Indigent Care Program there is a primary care grant program financed with tobacco taxes that serves a similar purpose of paying providers who treat patients regardless of insurance using a sliding fee schedule based on income. The primary care grant program has distinct constitutional payment criteria and there are some eligible providers that do not participate in Medicaid. However, S.B. 21-212 (Moreno/McCluskie) instructed the Department to align the primary care grant program more closely with the Indigent Care Program such that almost all of the primary care payments qualified for a Medicaid match. Simultaneously, the General Assembly stopped appropriating General

Fund for clinic based indigent care. In FY 2023-24, the General Assembly added $7.0 million General Fund to the Primary Care Fund.

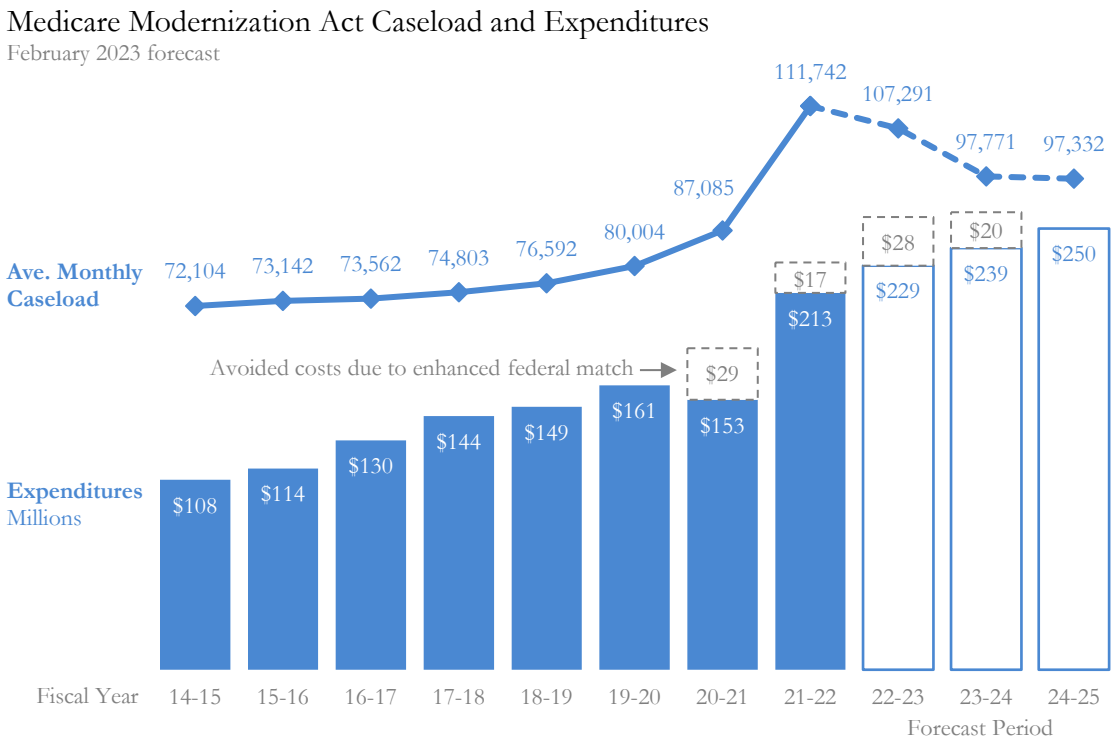
Indigent Care Program					
	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request
Hospital Payments					
Safety Net Provider Payments	$135,548,026	$254,743,329	$259,498,036	$226,610,307	$226,610,308
Pediatric Specialty Hospital	10,764,010	10,764,010	10,764,010	10,764,010	10,764,010
Total Funds	$146,312,036	$265,507,339	$270,262,046	$237,374,317	$237,374,318
General Fund	4,714,636	4,714,636	4,746,928	5,274,365	5,382,005
Cash Funds (HAS Fee)	67,774,013	110,819,422	122,721,974	111,039,051	113,305,154
Federal Funds	73,823,387	149,973,281	142,793,144	121,060,901	118,687,159
Clinic Payments					
Clinic Based Indigent Care	$6,039,386	$0	$0	$0	$0
Primary Care Fund	24,666,536	51,647,974	47,449,654	59,118,641	45,830,960
Total Funds	$30,705,922	$51,647,974	$47,449,654	$59,118,641	$45,830,960
General Fund	2,645,251	0	0	7,000,000	556,902
Cash Funds (tobacco tax)	24,666,536	22,755,512	21,438,852	22,494,290	22,494,290
Federal Funds	3,394,135	28,892,462	26,010,802	29,624,351	22,779,768
TOTAL Indigent Care	**$177,017,958**	**$317,155,313**	**$317,711,700**	**$296,492,958**	**$283,205,278**
General Fund	7,359,887	4,714,636	4,746,928	12,274,365	5,938,907
Cash Funds	92,440,549	133,574,934	144,160,826	133,533,341	135,799,444
Federal Funds	77,217,522	178,865,743	168,803,946	150,685,252	141,466,927

(5) MEDICARE MODERNIZATION ACT

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

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

This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes. The phase out of the temporary 6.2 percent increase in the federal match rate during the pandemic explains a significant portion of recent increases in the MMA obligation. The MMA payment is typically made from the General Fund with rare exceptions when Colorado used alternate fund sources.



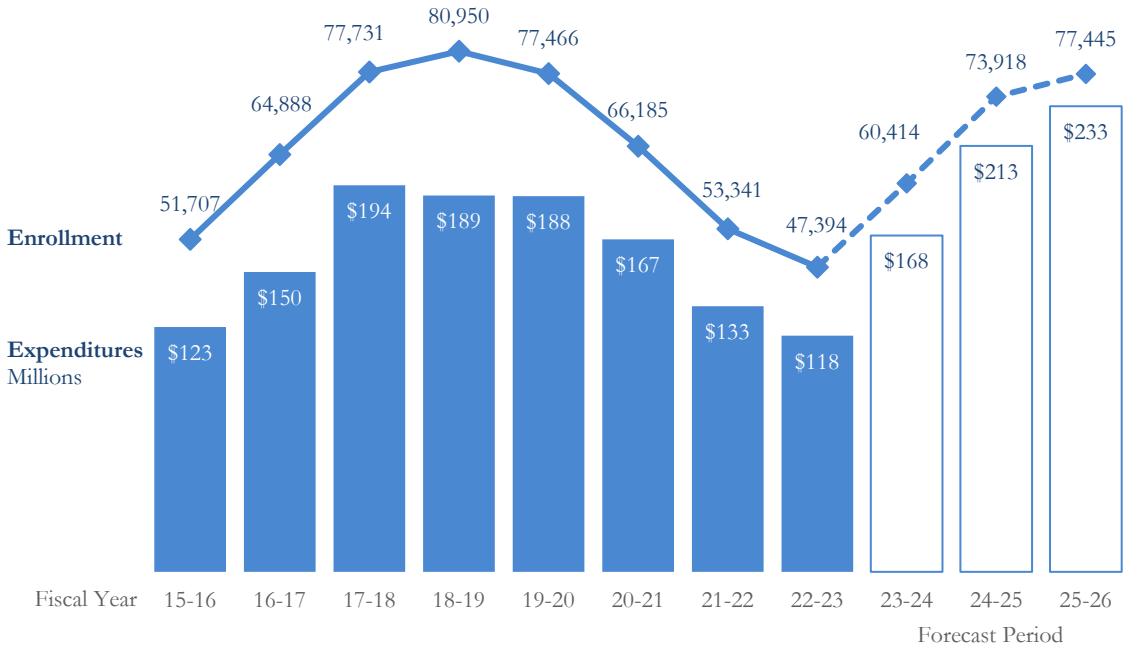
CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with more income than the Medicaid eligibility criteria allow, effectively to 265 percent[4] of the federal poverty guidelines or $65,879 annually for a family of three. Annual membership premiums are $25 for families with one child and $35 for families with two or more children. Coinsurance costs are nominal.

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

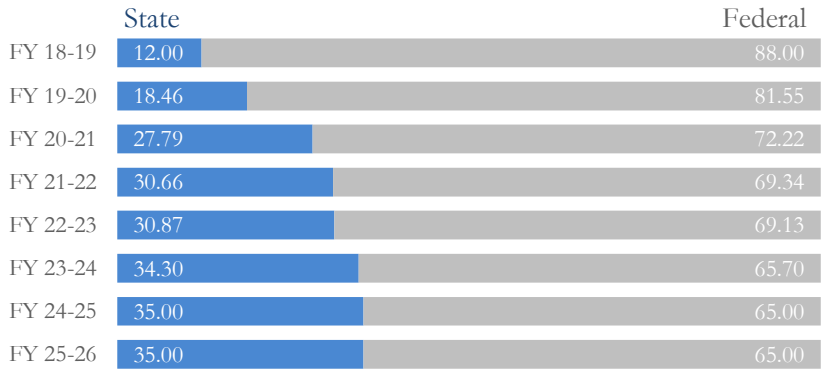
[4] In statute the income limit is 250 percent of the federal poverty guidelines, but with federally mandated standard income disregards, the effective income limit is 265 percent.

Children's Basic Health Plan (CHP+) Enrollment and Expenditures
November 2023 forecast, without reconciliations



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

Children's Basic Health Plan (CHP+)
Average State and Federal Share of Costs by State Fiscal Year



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

SUMMARY: FY 2023-24 APPROPRIATION & FY 2024-25 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2023-24 APPROPRIATION:						
S.B. 23-214 (Long Bill)	15,434,750,224	4,492,248,232	1,768,567,113	105,145,754	9,068,789,125	776.4
Other legislation	71,998,355	33,270,426	602,078	0	38,125,851	11.5
TOTAL	**$15,506,748,579**	**$4,525,518,658**	**$1,769,169,191**	**$105,145,754**	**$9,106,914,976**	**787.9**
FY 2024-25 REQUESTED APPROPRIATION:						
FY 2023-24 Appropriation	$15,506,748,579	4,525,518,658	$1,769,169,191	$105,145,754	$9,106,914,976	787.9
R1 Medical Services Premiums	596,082,486	268,968,078	98,116,763	15,098,477	213,899,168	0.0
R2 Behavioral Health	(22,964,198)	7,229,032	571,519	0	(30,764,749)	0.0
R3 Child Health Plan Plus	37,371,293	17,915,399	(3,581,375)	0	23,037,269	0.0
R4 Medicare Modernization Act	(3,024,782)	(3,024,782)	0	0	0	0.0
R5 Office of Community Living	45,002,004	28,990,641	2,467,507	0	13,543,856	0.0
R6a Provider rates	82,665,975	29,464,829	4,065,580	0	49,135,566	0.0
R6b Targeted provider rates	161,504,431	41,830,985	25,311,222	0	94,362,224	0.0
R7 Behavioral health continuum	4,409,298	945,354	318,817	0	3,145,127	1.4
R8 Eligibility process compliance	8,514,959	799,917	639,862	0	7,075,180	1.8
R9 Access to benefits	14,297,164	3,122,077	1,946,204	0	9,228,883	0.9
R10 Assessments for skilled nursing	1,938,600	484,650	0	0	1,453,950	0.0
R11 Program support	1,106,846	431,818	21,381	0	653,647	4.7
R12 Accessibility & senior dental admin	449,355	216,039	46,140	0	187,176	0.9
R13 Convert contracts to FTE	372,793	(6,606)	(3,951)	394,074	(10,724)	12.6
R14 Contract true up	2,018,390	90,668	473,690	0	1,454,032	0.0
R15 Denver Health	5,000,000	5,000,000	0	0	0	0.0
Centrally appropriated items	10,825,828	4,898,681	795,227	23,179	5,108,741	0.0
Payments to OIT	8,150,957	1,697,254	709,460	1,120,975	4,623,268	0.0
Human Services	3,757,293	2,730,433	(47,820)	0	1,074,680	0.0
Transfers to other departments	341,150	170,575	0	0	170,575	0.0
Indirect costs	266,194	0	75,450	156,732	34,012	0.0
Annualize prior year funding	(77,079,752)	28,530,884	(81,996,106)	445	(23,614,975)	(12.9)
TOTAL	**$16,387,754,863**	**$4,966,004,584**	**$1,819,098,761**	**$121,939,636**	**$9,480,711,882**	**797.3**
INCREASE/(DECREASE)	$881,006,284	$440,485,926	$49,929,570	$16,793,882	$373,796,906	9.4
Percentage Change	5.7%	9.7%	2.8%	16.0%	4.1%	1.2%

DESCRIPTION OF INCREMENTAL CHANGES

R1 MEDICAL SERVICES PREMIUMS [POTENTIAL LEGISLATION]: The Department requests a net decrease of $596.1 million total funds, including an increase of $269.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. The JBC staff recommends that the JBC carry legislation to implement a federal regulation requiring Medicaid coverage for DACA recipients. *See the issue brief "Forecast Trends" for more information.*

R2 BEHAVIORAL HEALTH PROGRAMS: The Department requests a net decrease of $23.0 million total funds, including an increase of $7.2 million General Fund, for projected changes in caseload, per

capita expenditures, and fund sources for behavioral health services. *See the 12/7/23 briefing for Behavioral Health for more information.*

R3 CHILD HEALTH PLAN PLUS: The Department requests an increase of $37.4 million total funds, including $17.9 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. *See the issue brief "Forecast Trends" for more information.*

R4 MEDICARE MODERNIZATION ACT: The Department requests a decrease of $3.0 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. *See the issue brief "Forecast Trends" for more information.*

R5 OFFICE OF COMMUNITY LIVING: The Department requests a net increase of $45.0 million total funds, including an increase of $29.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the 12/11/23 briefing for the Office of Community Living for more information.*

R6A PROVIDER RATES: The Department requests an increase of $82.7 million total funds, including $29.5 million General Fund, for a 1.0 percent across-the-board community provider rate increase for eligible providers. The Department indicates that funding is for the implementation of an evidence-informed practice.

R6B TARGETED PROVIDER RATES [POTENTIAL LEGISLATION]: The Department requests an increase of $161.5 million total funds, including $41.8 million General Fund, for targeted provider rate increases. The largest dollar increases are for dental services and for the wage component of Home- and Community-Based Services. The Department indicates that funding is for the implementation of an evidence-informed practice. As part of the proposed increase for the Primary Care Fund, the Department requests that the JBC sponsor legislation to sunset the Colorado Indigent Care Program and move some of the existing requirements to the Primary Care Fund and Healthcare Affordability and Sustainability (HAS) Fee statutes.

R6b Targeted Provider Rates

Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Adjustments based on the MPRRAC Rate Review					
Dental	15 preventative codes to 100% 13 diagnostic codes to 70%	$78,485,021	$14,331,366	$11,851,238	$52,302,417
Pediatric behavioral therapies	100% of benchmark without NE	11,934,437	5,967,219	0	5,967,218
Maternity	14 preventive rates to 100% 12 other rates to 80%	7,786,537	3,893,269	0	3,893,268
Surgeries	70-100% most surgeries 100% preventive digestive & integumentary 70-125% cardiovascular to non-facility	6,773,293	1,982,002	280,956	4,510,335
Ambulatory surgery centers	Increase rates below 70% to 70%	4,002,748	1,171,284	166,034	2,665,430
Co-surgeries	Expand billable codes	1,613,031	472,005	66,908	1,074,118
Autism spectrum screening	Restore 2 codes to previous levels	1,507,144	753,572	0	753,572
Abortion	100% of benchmark	298	149	0	149
Anesthesia	100% of benchmark	(9,073,136)	(2,654,982)	(376,353)	(6,041,801)
Subtotal - MPRRAC		$103,029,373	$25,915,884	$11,988,783	$65,124,706
Other targeted rate adjustments					
Wages for HCBS	Minimum wage increase	$53,856,751	$13,605,949	$13,322,439	$26,928,363

R6b Targeted Provider Rates					
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Single Assessment Tool	Implementation cost	2,556,493	1,278,246	0	1,278,247
Primary Care Fund	Serve clients 201-250% of FPL	1,113,806	556,902	0	556,904
Regional Center transitions	1-year enhanced rate for transitions	948,008	474,004	0	474,004
Subtotal - Other		$58,475,058	$15,915,101	$13,322,439	$29,237,518
TOTAL		**$161,504,431**	**$41,830,985**	**$25,311,222**	**$94,362,224**

R7 BEHAVIORAL HEALTH CONTINUUM: The Department requests $4.4 million total funds, including $945,354 General Fund, and 1.4 FTE in FY 2024-25 and $4.5 million total funds and 2.0 FTE in FY 2025-26 and ongoing for multiple behavioral health programs described in the table below. The Department indicates that funding for the Permanent Supportive Housing is for an evidence-informed practice and the rest of the request as for theory-informed practices.

R7 Behavioral Health Continuum Summary					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Institutions of Mental Disease stays	$2,450,304	$582,769	$162,017	$1,705,518	0.0
Partial Hospitalization Program	1,025,500	243,900	67,807	713,793	0.0
Permanent Supportive Housing pilot	717,836	22,522	77,327	617,987	0.5
Value Based Payment Methodology	465,658	221,163	11,666	232,829	0.9
SUD Administrative savings	(250,000)	(125,000)	0	(125,000)	0.0
TOTAL	**$4,409,298**	**$945,354**	**$318,817**	**$3,145,127**	**1.4**

See the 12/7/23 briefing for Behavioral Health for more information.

R8 ELIGIBILITY PROCESS COMPLIANCE: The Department requests $8.5 million total funds, including $799,917 General Fund, and 1.8 FTE for (1) federal database charges to automatically verify applicant income, (2) an increase in the federal match for credit bureau income verifications, (3) monitoring county administration of eligibility, and (4) managing eligibility appeals. The Department indicates that funding is for the implementation of a theory-informed practice.

R8 Eligibility Process Compliance					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Federal charges for income verifications	$8,036,599	$1,245,673	$763,477	$6,027,449	0.0
Federal match for credit bureau income verifications	0	(594,048)	(214,502)	808,550	0.0
Monitoring county administration of eligibility	352,070	109,142	66,893	176,035	0.9
Managing eligibility appeals	126,290	39,150	23,994	63,146	0.9
TOTAL	**$8,514,959**	**$799,917**	**$639,862**	**$7,075,180**	**1.8**

R9 ACCESS TO BENEFITS [POTENTIAL LEGISLATION]: The Department requests an increase of $14.3 million total funds, including $3.1 million General Fund, primarily to add autism spectrum disorder treatments as covered services under the Children's Basic Health Plan (marketed as the Child Health Plan Plus or CHP+). The Department requests that the JBC sponsor legislation to remove a statutory prohibition[5] on covering these treatments in CHP+.

[5] Section 25.5-8-107 (1)(a)(IV), C.R.S.

In addition, the request includes money to: (1) continue a federal stimulus-funded program that provides training and peer-to-peer consults for primary care providers regarding client pain management; (2) continue a federal stimulus-funded FTE that provides guidance for the pain management benefit and coordinates referrals for services; and (3) research the efficacy of a nurse navigator program to improve the diagnosis, treatment, and monitoring of members in need of organ transplants.

The Department indicates that funding for Autism spectrum disorder treatment in CHP+ is for a proven practice and the rest of the request is for the implementation of theory-informed practices.

R9 Access to Benefits					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Autism spectrum disorder treatment in CHP+	$13,868,700	$2,922,751	$1,931,294	$9,014,655	0.0
Pain management provider training & consults	250,000	125,000	0	125,000	0.0
Pain management referral coordinator	78,464	24,326	14,910	39,228	0.9
Plan for transplant nurse navigator program	100,000	50,000	0	50,000	0.0
TOTAL	**$14,297,164**	**$3,122,077**	**$1,946,204**	**$9,228,883**	**0.9**

See the 12/11/23 briefing for the Office of Community Living for more information.

R10 ASSESSMENTS FOR SKILLED NURSING: The Department requests $1.9 million total funds, including $484,650 General Fund, for needs assessments of clients for the appropriate level of skilled nursing services provided in the home or a community setting. The projected costs increase to $10.3 million total funds, including $2.6 million General Fund, in FY 2025-26 and on-going. The assessments would use a validated acuity tool to determine the level of care and hours of services for Private Duty Nursing, Long-Term Home Health, and Health Maintenance Activities. The Department indicates that funding is for the implementation of a theory-informed practice.

Prior Authorization Request requirements that determine the medical necessity of services were temporarily suspended in 2022 by the Department for both Private Duty Nursing and Pediatric Long Term Home Health due to stakeholder concerns. The PARs for Private Duty Nursing were reinstated 4/3/2023 but the PARs for Pediatric Long Term Home Health will not be reinstated before 1/31/2025, due to maintenance of effort requirements of the American Rescue Plan Act. During the pauses, home health agencies took responsible for determining the level of care. The stakeholder concerns that led to the pauses in PAR requirements appear to inform the Department's request for a better assessment tool. The Department mentions member confusion over whether Private Duty Nursing or Long Term Home Health is the most appropriate and member and provider questions about why one service would be authorized but not the other.

In addition, the request is intended to address duplicate efforts when PAR reviews are performed for each individual nursing service and respond to a perceived lack of benefit navigation guidance from the PAR process. The PAR vendor communicates only with the case manager and providers and not directly with the member or family. The proposed assessment would be performed by a nurse that would talk to the member and provide information on the range of available services.

The Department is currently spending an estimated $2.2 million federal funds from the HCBS Improvement Fund to develop the assessment and this request would pay for nurses to administer the assessment.

R11 PROGRAM SUPPORT: The Department requests $1.1 million total funds, including $431,818 General Fund, and 4.7 FTE for four initiatives previously funded with federal stimulus money:

- HCBS System support – On-going maintenance for information technology systems related to Home- and Community-Based Services, including increased standardization and reporting of care and utilization data, implementation of Community First Choice that makes available to all Medicaid members certain services that were previously limited to specific waivers, and improved on-line referral services to help members find providers.
- Direct Care Workforce Unit – The unit delivers training for direct care HCBS workers, provides a resource and jobs hub, outlines career pathways, and conducts surveys to inform policy making.
- Preventive care outreach analyst – The position would conduct research and develop strategies to increase preventative care utilization. The original federally funded position focused on vaccines, but the Department proposes expanding the scope to include broader Early and Periodic Screening, Diagnostic and Treatment (EPSDT) deliverables.
- Person-Centered Budget Algorithm – The contract services would provide for on-going maintenance of the Person-Centered Budget Algorithm that determines the service budget for clients based on the Single Assessment Tool. It includes money to manage the exceptions process and provide on-going maintenance.

R11 Program Support					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
HCBS Systems support	$400,896	$100,224	$0	$300,672	2.8
Direct Care Workforce Unit	472,218	236,109	0	236,109	1.0
Preventative Care Outreach Analyst	133,632	45,435	21,381	66,816	0.9
Person-Centered Budget Algorithm	100,100	50,050	0	50,050	0.0
TOTAL	**$1,106,846**	**$431,818**	**$21,381**	**$653,647**	**4.7**

The Department indicates that funding for the Preventative Care Outreach Analyst is for a proven practice, funding for the Person-Centered Budget Algorithm and Direct Care Workforce Unit is for evidence-informed practices, and the HCBS Systems support is for a theory-informed practice.

R12 ACCESSIBILITY & SENIOR DENTAL ADMIN: The Department requests $449,355 total funds, including $216,039 General Fund, and 0.9 FTE for administrative support. Of the total, $374,355 total funds, including $141,039 General Fund, and 0.9 FTE is for on-going costs associated with ensuring department communications are accessible to people with disabilities and compliant with H.B. 21-1110. The remaining $75,000 General Fund (increasing to $150,000 General Fund in out years) is for contract services to assist with invoicing, reporting, and eligibility verifications for the senior dental program that provides roughly $4.0 million per year for around 3,000 seniors at or below 250 percent of the federal poverty guidelines who do not qualify for Medicaid. Currently, eligibility is determined by grantees, invoices are tracked manually, and there are no controls to prevent overutilization of care across multiple providers. The Department believes the contract would reduce the administrative burden on providers, thereby attracting more providers, and allow more seniors to be served.

R13 CONVERT CONTRACTS TO FTE: The Department requests a net increase of $372,793 total funds, including a decrease of $6,606 General Fund, to convert some appropriations for contract services to state FTE. The Department argues that using state FTE will reduce turnover and knowledge drain when work is transitioned between vendors and reduce administrative burdens

associated with overseeing contracts, processing invoices and payments, drafting contract documents, and initiating corrective actions. For two of the contracts, related to payment reform and the Substance Use Disorder (SUD) benefit, the Department estimates the cost of state employees would be cheaper than contract services. For the third contract, related to the Call Center, the Department believes that gains in the customer experience and continuity of knowledge would justify the net increase in cost. The Department indicates that funding is for the implementation of a theory-informed practice.

R13 Convert Contracts to FTE						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Payment Reform						
FTE Costs	$220,389	$68,320	$41,872	$0	$110,197	1.8
Contractor Cost Reductions	(250,000)	(77,500)	(47,500)	0	(125,000)	0.0
Subtotal - Payment Reform	($29,611)	($9,180)	($5,628)	$0	($14,803)	1.8
SUD Benefit						
FTE Costs	195,235	60,522	37,093	0	97,620	1.8
Contractor Cost Reductions	(250,000)	(77,500)	(47,500)	0	(125,000)	0.0
Subtotal - SUD Benefit	($54,765)	($16,978)	($10,407)	$0	($27,380)	1.8
Call Center						
FTE Costs	724,829	102,494	63,350	394,074	164,911	9.0
Contractor Cost Reductions	(267,660)	(82,942)	(51,266)	0	(133,452)	0.0
Subtotal - Call Center	$457,169	$19,552	$12,084	$394,074	$31,459	9.0
TOTAL - HCPF	**$372,793**	**($6,606)**	**($3,951)**	**$394,074**	**($10,724)**	**12.6**
Other dept costs for Call Center						
Human Services	$68,551	$32,163	$3	$0	$36,385	0.0
Public Health & Environment	1,609	0	0	0	1,609	0.0
Early Childhood	5,014	5,014	0	0	0	0.0
Office of the Governor (OIT)	(586,560)	0	0	(586,560)	0	0.0
Total - Other depts Call Center	**($511,386)**	**$37,177**	**$3**	**($586,560)**	**$37,994**	**0.0**
TOTAL - All Departments	**($138,593)**	**$30,571**	**($3,948)**	**($192,486)**	**$27,270**	**12.6**

R14 Contract increases: The Department requests $2.0 million total funds, including $90,668 General Fund, for inflation and population-related increases for two contracts. The contract for the centralized eligibility vendor pays for eligibility determinations and case maintenance for the buy-in program for people with disabilities, managing appeals, CHP+ enrollment and disenrollment, and a customer service center that processes over-the-phone requests including applications and renewals, address and income changes, and enrollment fee payments. The contract is based on a federal formula that takes into account actual allowable costs and a random moment time study of activities eligible for different federal reimbursement rates. The current vendor is Denver Health. The contract for host home inspections pays for biannual visits to ensure residential placements for people with developmental disabilities meet health and safety requirements. The original funding for the contract assumed 1,700 host homes and a cost per inspection of $75. The Department projects 2,300 host homes and an inspection rate of $120. The Department indicates that funding is for the implementation of a theory-informed practice.

R15 DENVER HEALTH [REQUIRES LEGISLATION]: The Department requests that the JBC sponsor legislation authorizing a one-time payment of $5.0 million General Fund to Denver Health for uncompensated care costs.

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

PAYMENTS TO OIT: The Department has a relatively large increase in payments to the Office of Information Technology in the Governor's Office that includes both the Department's share of statewide information technology services and the share for the Colorado Benefits Management System that provides eligibility determination and case management services for safety net programs across multiple agencies.

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

TRANSFERS TO OTHER DEPARTMENTS: The Department requests an increase of $341,150 total funds, including $170,575 General Fund, for transfers to programs administered by other departments.

INDIRECT COSTS: The Department requests an increase of $266,194 for statewide indirect cost assessments.

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 increases are for:

- *FY 23-24 R7 Rate adjustment* that included mid-year rate increases and an annualizaiton to account for services billed in FY 2023-24 that are not paid until FY 2024-25;
- *FY 23-24 R13 Case management redesign* for case management rate increases that were phased in over the course of FY 2023-24; and
- *FY 23-24 BA7 Community-based access to services* that attempted to shore up services for people with disabilities, including implementing Community First Choice, in response to a Department of Justice finding.

The largest decreases are for annualizations of the following:

- *FY 22-23 BA10 HCBS ARPA* for the expiration of some of the spending authority related to one-time federal HCBS Improvement funds;

- *FY 23-24 BA6 PHE Funding* for the expiration of one-time funds provided for eligibility redeterminations associated with the end of Medicaid continuous eligibility; and
- *FY 23-24 Primary Care Fund* for the expiration of a one-time appropriation, initiated by the JBC, for the primary care grant program that provides money to federally qualified health centers and other primary care providers where at least 50.0 percent of the patients served are uninsured or medically indigent. The Department proposes $1.1 million on-going for the Primary Care Fund as part of the targeted provider rate increases in R6b described above.

Annualize Prior Year Budget Actions						
Issue	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
FY 23-24 R7 rate adjustment	$34,488,064	$28,039,035	($11,520,984)	$0	$17,970,013	0.0
FY 23-24 R13 Case management redesign	16,304,243	11,348,498	(3,504,028)	0	8,459,773	0.0
FY 23-24 BA7 Community-based access to services	10,722,858	7,835,809	(2,974,232)	0	5,861,281	13.0
HB 23-1228 Nursing rate setting	6,686,107	3,965,695	0	0	2,720,412	0.0
HB 22-1302 Health practice transformation	2,474,468	1,222,224	0	0	1,252,244	(7.0)
HB 23-1300 Continous eligibility	1,920,576	326,681	0	0	1,593,895	4.1
FY 23-24 R9 Advancing birthing equity	970,921	488,260	0	0	482,661	0.0
FY 23-24 R6 Primary care value based payments	638,317	242,127	26,425	0	369,765	0.0
FY 22-23 BA13 Medicaid for Connect 4 Health	532,136	0	237,865	0	294,271	0.0
SB 21-038 Expansion Complementary & Alt Medicine	491,635	128,063	117,754	0	245,818	(1.0)
SB 23-002 Medicaid reimbursement for cmty health service	459,773	69,887	0	0	389,886	0.6
FY 23-24 Remove adult dental cap	419,096	0	132,184	0	286,912	0.0
HB 22-1114 Trans services for medicaid waiver	319,084	323,718	(19,833)	0	15,199	0.0
SB 21-039 Elimination of subminimum wage employment	259,725	129,862	0	0	129,863	0.0
FY 23-24 Early Intervention services	141,498	84,050	0	0	57,448	0.0
FY 23-24 R12 BH Eligibility and claims processing	130,666	130,666	0	0	0	2.0
HB 22-1068 Therapy using equines	123,220	61,610	0	0	61,610	0.0
HB 22-1290 Wheelchair repairs	40,482	20,242	0	0	20,240	0.0
HB 23-1130 Drug coverage for serious mental illness	26,427	13,213	0	0	13,214	0.2
SB 23-261 Direct care workforce stabilization board	22,272	11,136	0	0	11,136	0.4
HB 23-1226 Hospital transparency and reporting	14,005	0	7,002	0	7,003	0.3
SB 23-172 Protecting opportunities and workers rights	10,331	10,331	0	0	0	0.0
HB 23-1136 Prosthetic devices	9,092	1,687	1,496	0	5,909	0.0
FY 22-23 R13 Compliance FTE	4,900	2,450	0	0	2,450	0.0
FY 23-24 BA20 Clinical navigation services	4,655	2,327	0	0	2,328	0.2
SB 23-298 Allow public hospital collab agreements	4,153	0	2,076	0	2,077	0.2
FY 23-24 R10 Youth complex and co-occurring needs	1,678	885,554	(884,715)	0	839	0.4
FY23-24 R14 Convert contracts to FTE	732	242	124	0	366	0.3
FY 23-24 Speech therapy funding	0	6,695	0	0	(6,695)	0.0
FY 22-23 BA10 HCBS ARPA	(78,056,447)	0	(62,061,809)	0	(15,994,638)	(32.9)
FY 23-24 BA6 PHE Funding	(24,190,723)	(5,657,528)	(2,146,802)	0	(16,386,393)	0.0
FY 23-24 Primary Care Fund	(14,030,868)	(7,000,000)	0	0	(7,030,868)	0.0
FY 23-24 NP1 Housing vouchers	(9,001,786)	(4,549,261)	0	0	(4,452,525)	0.0
FY 23-24 BA8 ARPA HCBS adjustments	(6,700,098)	0	(830,612)	0	(5,869,486)	11.3
FY 23-24 R6 Value based payments	(4,829,661)	(978,233)	(27,305)	0	(3,824,123)	0.0
FY23-24 NPBA1 IT Accessibility	(2,933,182)	(1,145,158)	(297,857)	(5,431)	(1,484,736)	0.0
FY 22-23 NPBA4 Nursing facility transfers	(2,888,664)	(1,444,332)	0	0	(1,444,332)	0.0
HB 22-1289 Child and pregnant health benefits	(2,880,514)	(1,940,258)	7,519	0	(947,775)	1.3
FY 23-24 Denver Health payments	(1,000,000)	(1,000,000)	0	0	0	0.0
FY 23-24 Rural provider access	(1,000,000)	(1,000,000)	0	0	0	0.0
FY 23-24 R11 Compliance	(940,988)	(249,523)	6,021	0	(697,486)	0.6
SB 21-286 Distribution FF HCBS	(758,098)	0	(379,049)	0	(379,049)	(5.0)
FY 22-23 R9 OCL prog enhancements	(677,650)	(338,825)	0	0	(338,825)	0.0
FY 23-24 R8 Cost and quality indicators	(555,450)	35,223	6,481	0	(597,154)	0.0
FY 22-23 R14 MMIS Funding adj	(554,109)	55,461	16,936	0	(626,506)	0.0
SB 21-025 Family Planning Srvc 4 Eligible Individuals	(551,269)	(227,925)	635	0	(323,979)	0.0

Annualize Prior Year Budget Actions						
Issue	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
HB 23-1215 Limits on hospital facility fees	(516,950)	(535,613)	0	0	18,663	0.0
FY 23-24 Federal match trueup	(370,618)	279,314	2,266,103	4,500	(2,920,535)	0.0
FY 23-24 BA19 Alternative payment method	(361,492)	(96,598)	(20,672)	0	(244,222)	0.0
SB 18-145 Employment first recommendations	(331,200)	(331,200)	0	0	0	(0.5)
FY 22-23 BA9 eConsult program	(265,154)	(93,687)	(168,922)	0	(2,545)	0.0
FY 23-24 BA11 BH Crisis response funding	(203,040)	(203,040)	0	0	0	0.0
SB 22-196 Health for people in criminal justice	(129,422)	(64,711)	0	0	(64,711)	(1.0)
HB 22-1325 Primary care alternative payment	(127,125)	(127,125)	0	0	0	0.0
SB 23-288 Coverage for doula services	(100,000)	(100,000)	0	0	0	0.0
FY 22-23 R7 Utilization management	(97,300)	(27,924)	(5,966)	0	(63,410)	0.0
SB 22-106 Conflict interest behavioral health	(86,184)	(43,092)	0	0	(43,092)	(1.0)
HB 23-1197 Stakeholder process oversight host home	(75,000)	(37,500)	0	0	(37,500)	0.0
FY 19-20 R9 LTHH/PDN Clinical assessment tool	(50,000)	(25,000)	0	0	(25,000)	0.0
FY 23-24 Salary survey	(28,035)	(10,789)	(2,062)	(413)	(14,771)	0.0
FY 23-24 NPBA2 Promoting equity thru tech	(9,582)	38,275	20,121	1,789	(69,767)	0.5
HB 23-1295 Audits of HCPF pymts to providers	(257)	(129)	0	0	(128)	0.1
Total	**($77,079,752)**	**$28,530,884**	**($81,996,106)**	**$445**	**($23,614,975)**	**(12.9)**

SUPPLEMENTALS

SET ASIDE FOR SUPPLEMENTALS: The Governor's budget letter includes a set aside in FY 2023-24 of $29.2 million General Fund for potential supplementals. The letter does not detail how the Governor arrived at this net amount. Although the Governor's official supplemental request is not due until January 2024, the budget request for the Department includes projected FY 2022-23 impacts associated with the following requests.

FY 2023-24 Supplementals					
	Total Funds	General Funds	Cash Funds	Reappropriated Funds	Federal Funds
R1 Medical Services Premiums	($81,594,992)	($5,745,819)	$38,058,450	$1	(113,907,624)
R2 Behavioral Health	(53,162,938)	(6,608,720)	(1,370,302)	0	(45,183,916)
R3 Child Health Plan Plus	(6,859,998)	4,717,761	(6,307,621)	0	(5,270,138)
R4 Medicare Modernization Act	(5,315,525)	(5,315,525)	0	0	0
R5 Office of Community Living	(19,448,163)	(8,937,575)	2,400,269	0	(12,910,857)
R14 Contract increases	1,974,480	0	521,534	0	1,452,946
TOTAL	**($164,407,136)**	**($21,889,878)**	**$33,302,330**	**$1**	**(175,819,589)**

TRANSPORTATION PROVIDER CREDENTIALING AND REVIEWS: After the November 1 budget request, the Department submitted an interim supplemental request for $1,313,618 total funds, including $394,085 General Fund, and 0.6 FTE related to non-emergent medical transportation (NEMT). It is not clear if the request is from the $29.2 million General Fund the Governor set aside statewide for supplemental adjustments, or if it is in addition to that amount. The requested funding would increase benefit oversight in response to a suspected fraud scheme, including hiring a vendor for a statewide credentialing process, contracting with a vendor for pre- and post-payment claims reviews and analysis of how to mitigate vulnerabilities, and employing temporary staff to help providers navigate new screening requirements, manage the high volume of payment reviews to minimize backlogs, and coordinate with law enforcement investigating the alleged fraud.

The Department has seen dramatic increases in NEMT providers and utilization and received troubling reports. An example includes a report of a provider bribing Medicaid members at a homeless

shelter to enter a vehicle in excess of the vehicle's capacity limits and to provide their Medicaid identification number. Allegedly, this provider then drove the clients from Pueblo to Denver to a methadone clinic. The clients were active Medicaid members and transportation to a methadone clinic is an eligible service covered by Medicaid, but the described number of people transported and the distance traveled when there were closer options would not be legal. Some of the alleged bribes were paid in the form of drugs, according to this report. The Department is concerned that clients are at risk as well as payments.

At the same time the Department is implementing rigorous new oversight measures, there are clients that need access to services and legitimate providers that need to get paid in a timely manner. The requested additional administrative resources are intended to keep disruptions to clients and legitimate providers at a minimum.

The staff recommendation on the interim supplemental will be presented December 20, 2023.

ISSUE: FORECAST TRENDS (R1–R5)

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined they drive a $652.5 million increase in total funds, including a $320.1 million increase in General Fund, in FY 2024-25. Of the new funds proposed for FY 2024-25, the forecast requests represent 74.1 percent of the total funds increase and 72.7 percent of the General Fund increase. These requests explain what drives the budget, but they are non-discretionary, as they represent the expected obligations under current law and policy. It would take a change to current law or policy to change the trends.

SUMMARY

- Medical Services Premiums
    - For FY 2023-24 the projection is down a net $81.6 million total funds, including a decrease of $5.7 million General Fund.
        - This is primarily due to lower enrollment of people with disabilities, which is a population with high utilization.
        - The enrollment decrease is offset by higher than expected utilization of Long-Term Home Health and specifically the home health basic and extended services.
    - The forecast includes increases in both FY 2023-24 and FY 2024-25 for a new federal regulation extending Medicaid coverage to income qualifying DACA recipients that will require implementing legislation.
    - For FY 2024-25 the Department projects expenditures will increase a net $699.5 million total funds, including an increase of $287.2 million General Fund.
        - Projected increases for acute per capita costs, the federal match, and all other services more than offset the decline in enrollment that is projected due to the end of the continuous eligibility requirement during the federal COVID public health emergency.
        - The General Fund projection includes an increase of $79.0 million General Fund for the final phase out of the enhanced federal match that was available during the federal COVID public health emergency.
- Child Health Plan Plus
    - For FY 2023-24 the Department projects a net decrease of $6.9 million total funds, including an increase of $4.7 million General Fund.
        - The Department slightly lowered the enrollment projection overall, but increased the projection for the lowest income populations where the state match comes from the General Fund.
        - Although the Department lowered the enrollment forecast, the Department is still projecting enrollment will increase from the FY 2022-23 level by 42.4 percent as Medicaid continuous coverage ends and members who were locked in on Medicaid with a CHP+ income level transition to CHP+.
    - For FY 2024-25 the Department forecasts an increase of $44.9 million total funds, including an increase of $13.4 million General Fund
        - The forecast is almost entirely due to an assumption that members who are locked in on Medicaid with a CHP+ income level will enroll in CHP+.
- Medicare Modernization Act

- For FY 2023-24 and FY 2024-25 combined the Department projects a net decrease of $3.0 million General Fund.
    - The Department projects increase in pharmaceutical inflation and the end of the enhanced federal match will increase expenditures $9.9 million.
    - These increases are offset by the projected decrease in enrollment with the end of the continuous eligibility requirement.

DISCUSSION

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. In FY 2024-25, the combined forecast requests account for 72.7 percent of the General Fund adjustments proposed by the Department. It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy. The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2023. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2023. The mid-February forecasts come after deadlines for the Governor to submit supplemental budget requests and budget amendments. Typically, governors do not submit official revised requests based on the mid-February forecasts, neither do they submit official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the mid-February forecast for the budget, because it is the most recent data available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2023-24 expenditures. The requests for changes in FY 2023-24 will be officially submitted in January and until then the Governor's budget includes a placeholder for the FY 2023-24 fiscal impact of the forecasts. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2023-24 is the change from the appropriation and not the change from FY 2022-23.

FY 2023-24					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Appropriation					
Medical Services Premiums	$11,506,136,779	$3,216,123,250	$1,248,504,293	$99,768,813	$6,941,740,423
Behavioral Health	1,218,483,080	284,702,715	91,030,034	0	842,750,331
Children's Basic Health Plan	175,334,025	19,597,188	40,607,383	0	115,129,454
Medicare Modernization Act	257,069,930	257,069,930	0	0	0
Office of Community Living	1,080,475,927	517,986,549	24,021,961	0	538,467,417
TOTAL	**$14,237,499,741**	**$4,295,479,632**	**$1,404,163,671**	**$99,768,813**	**$8,438,087,625**

FY 2023-24					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 23-24 Projection (Nov)					
Medical Services Premiums	11,424,541,787	3,210,377,431	1,286,562,743	99,768,814	6,827,832,799
Behavioral Health	1,165,320,142	278,093,995	89,659,732	0	797,566,415
Children's Basic Health Plan	168,474,027	24,314,949	34,299,762	0	109,859,316
Medicare Modernization Act	251,754,405	251,754,405	0	0	0
Office of Community Living	1,061,027,764	509,048,974	26,422,230	0	525,556,560
TOTAL	**$14,071,118,125**	**$4,273,589,754**	**$1,436,944,467**	**$99,768,814**	**$8,260,815,090**
Difference Proj. to Approp.					
Medical Services Premiums	(81,594,992)	(5,745,819)	38,058,450	1	(113,907,624)
Behavioral Health	(53,162,938)	(6,608,720)	(1,370,302)	0	(45,183,916)
Children's Basic Health Plan	(6,859,998)	4,717,761	(6,307,621)	0	(5,270,138)
Medicare Modernization Act	(5,315,525)	(5,315,525)	0	0	0
Office of Community Living	(19,448,163)	(8,937,575)	2,400,269	0	(12,910,857)
TOTAL	**($166,381,616)**	**($21,889,878)**	**$32,780,796**	**$1**	**($177,272,535)**
Percent Change					
Medical Services Premiums	-0.7%	-0.2%	3.0%	0.0%	-1.6%
Behavioral Health	-4.4%	-2.3%	-1.5%	n/a	-5.4%
Children's Basic Health Plan	-3.9%	24.1%	-15.5%	n/a	-4.6%
Medicare Modernization Act	-2.1%	-2.1%	n/a	n/a	n/a
Office of Community Living	-1.8%	-1.7%	10.0%	n/a	-2.4%
TOTAL	**-1.2%**	**-0.5%**	**2.3%**	**0.0%**	**-2.1%**

FY 2024-25					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 23-24 Projection (Nov)					
Medical Services Premiums	$11,424,541,787	$3,210,377,431	$1,286,562,743	$99,768,814	$6,827,832,799
Behavioral Health	1,165,320,142	278,093,995	89,659,732	0	797,566,415
Children's Basic Health Plan	168,474,027	24,314,949	34,299,762	0	109,859,316
Medicare Modernization Act	251,754,405	251,754,405	0	0	0
Office of Community Living	1,061,027,764	509,048,974	26,422,230	0	525,556,560
TOTAL	**$14,071,118,125**	**$4,273,589,754**	**$1,436,944,467**	**$99,768,814**	**$8,260,815,090**
FY 24-25 Projection (Nov)					
Medical Services Premiums	12,124,014,043	3,497,626,622	1,342,039,752	114,867,290	7,169,480,379
Behavioral Health	1,195,530,466	291,996,332	91,602,303	0	811,931,831
Children's Basic Health Plan	213,406,251	37,756,735	37,000,453	0	138,649,063
Medicare Modernization Act	254,045,148	254,045,148	0	0	0
Office of Community Living	1,152,316,773	575,487,108	12,008,835	0	564,820,830
TOTAL	**$14,939,312,681**	**$4,656,911,945**	**$1,482,651,343**	**$114,867,290**	**$8,684,882,103**
Difference FY 23-24 to FY 24-25					
Medical Services Premiums	699,472,256	287,249,191	55,477,009	15,098,476	341,647,580
Behavioral Health	30,210,324	13,902,337	1,942,571	0	14,365,416
Children's Basic Health Plan	44,932,224	13,441,786	2,700,691	0	28,789,747
Medicare Modernization Act	2,290,743	2,290,743	0	0	0
Office of Community Living	91,289,009	66,438,134	(14,413,395)	0	39,264,270
TOTAL	**$868,194,556**	**$383,322,191**	**$45,706,876**	**$15,098,476**	**$424,067,013**
Percent Change					
Medical Services Premiums	6.1%	8.9%	4.3%	15.1%	5.0%
Behavioral Health	2.6%	5.0%	2.2%	n/a	1.8%
Children's Basic Health Plan	26.7%	55.3%	7.9%	n/a	26.2%

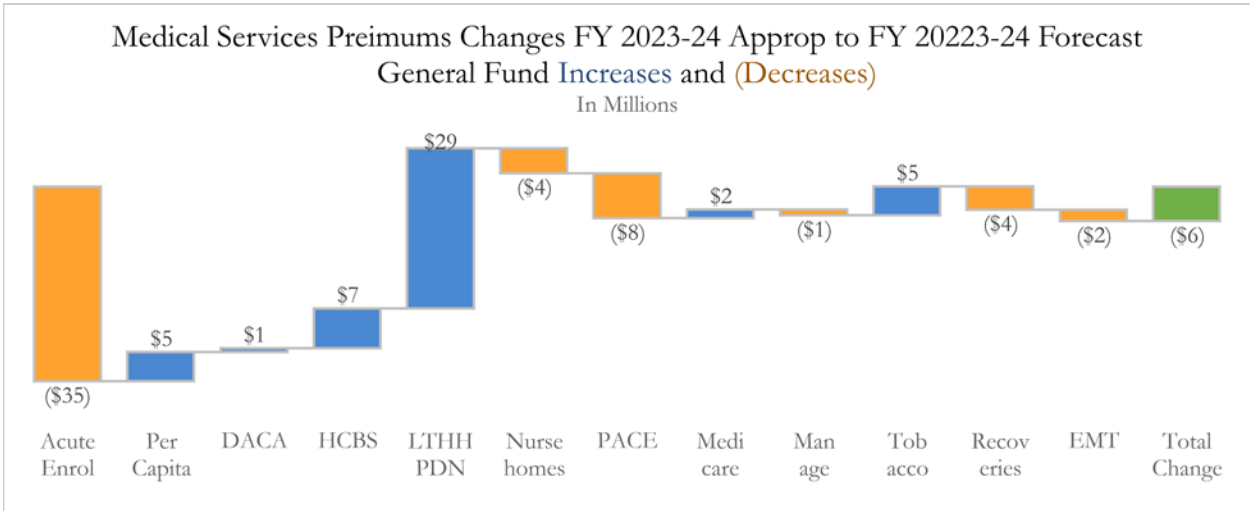
FY 2024-25					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicare Modernization Act	0.9%	0.9%	n/a	n/a	n/a
Office of Community Living	8.6%	13.1%	-54.6%	n/a	7.5%
TOTAL	**6.2%**	**9.0%**	**3.2%**	**15.1%**	**5.1%**

The forecast requests covered in this briefing include R1 Medical Services Premiums, R3 Child Health Plan Plus, and R5 Medicare Modernization Act. See the briefings for Behavioral Health and the Office of Community Living for discussions of the other forecast requests.

R1 Medical Services Premiums

FY 2023-24

The projection for FY 2023-24 is down $81.6 million total funds, including a decrease of $5.7 million General Fund. The graph below shows the major contributors to the General Fund change from the FY 2023-24 appropriation to the Department's November 2023 forecast for FY 2023-24. It does not show differences from FY 2022-23 expenditures. The decrease in the projection for enrollment is largely offset by an increase in the projected costs for Long-Term Home Health, Private Duty Nursing, and Hospice.



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

FY 2023-24 Medical Services Premiums Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2023-24 Appropriation	$11,506,136,779	3,216,123,250	1,348,273,106	6,941,740,423
Acute Care				
Enrollment	(117,300,327)	(34,945,922)	(4,740,848)	(77,613,557)
Per capita	(40,987,591)	5,241,732	23,645,080	(69,874,403)
DACA recipients	1,374,126	687,063	0	687,063
Subtotal - Acute Care	*(156,913,792)*	*(29,017,127)*	*18,904,232*	*(146,800,897)*
Long-term Care Programs				
HCBS waivers	30,362,000	7,151,537	7,725,843	15,484,620
Long-Term Home Health/PDN/Hospice	55,338,505	28,775,938	0	26,562,567
Nursing homes	(9,067,755)	(4,473,675)	246,475	(4,840,555)

FY 2023-24 Medical Services Premiums Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
PACE	(16,196,160)	(8,098,080)	0	(8,098,080)
Subtotal - Long-term Care Programs	*60,436,590*	*23,355,720*	*7,972,318*	*29,108,552*
Medicare & private premiums	2,909,408	1,585,630	0	1,323,778
Service management	(1,775,412)	(1,054,766)	1,537,338	(2,257,984)
Tobacco forecast	0	5,200,600	(5,200,600)	0
Recoveries	0	(4,201,037)	9,365,094	(5,164,057)
EMT certified public expenditures	14,104,037	(2,053,263)	6,833,252	9,324,048
Other financing	(355,824)	438,424	(1,353,184)	558,936
TOTAL	**$11,424,541,786**	**$3,210,377,431**	**$1,386,331,556**	**$6,827,832,799**
Increase/(Decrease)	(81,594,993)	(5,745,819)	38,058,450	(113,907,624)
Percentage Change	-0.7%	-0.2%	2.8%	-1.6%

ACUTE CARE

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

Enrollment

Actual enrollment is coming in below the assumptions in the appropriation for most enrollment categories. The elderly and people with disabilities account for about a third of the total dollar change and more than half of the General Fund change. These eligibility categories have high per capita costs. The forecast for people with disabilities is down about 3,000 people.

Per Capita

In FY 2022-23 actual per capita costs were higher than expected for the elderly and people with disabilities but lower than expected for children, parents, pregnant women, and the ACA expansion. There is a net $3.8 million total funds increase, including an increase of $11.3 million General Fund, that the Department indicates is mostly attributable to an increase in utilization of non-emergent medical transportation (NEMT) and a change in the mix of who is utilizing the service that impacts the federal match rate.

DACA Recipients

The forecast assumes a new proposed federal regulation will be implemented imminently that would require Colorado to provide Medicaid coverage to children and pregnant people with Deferred Action for Childhood Arrivals (DACA) status who meet the income qualifications. The Department has statutory authority to implement provisions of Medicaid that are necessary to comply with federal regulation. Given that authority and that the Department does not have a choice but to comply, the Long Bill is a reasonable place to provide the needed funding. However, the Department is proposing legislation to align state statute with the new federal regulation.

The Department did not submit an official request for the JBC to carry the alignment legislation, but the JBC staff thinks that the JBC should consider carrying the bill. If funding for the DACA recipients is provided in the Long Bill and then a separate bill authorizes the services, it could appear that the JBC is providing special favor for another legislator's bill. If the JBC sponsors the bill it reduces this potential perception challenge. Another option would be to provide the funding in the authorizing bill, rather than the Long Bill. However, if the authorizing bill were to fail, the Department would still need the funding.

DACA recipients who otherwise meet the Medicaid eligibility criteria are currently eligible only for emergency services. The Department anticipates that the new regulation will primarily impact non-delivery maternity services. Most DACA recipients are older and do not require significant childhood medical services. The Department estimate the regulation will extend coverage to approximately 237 DACA recipients.

LONG-TERM CARE PROGRAMS

The long-term care programs include nursing homes, in-home nursing services, and community supports that help people live at home.

HCBS waivers

The Department is seeing higher than expected increases in utilization in the waivers and higher-than-expected costs in the Community Mental Health Services waiver.

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.

Long-Term Home Health/PDN/Hospice

The Department increased the forecast due to higher than expected utilization of long-term home health and specifically the home health basic and extended services.

Long-term home health (LTHH) and private duty nursing (PDN) are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS 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.

Nursing homes

Year-to-date bed days are running lower than the assumptions in the appropriation.

PACE

The Department had projected aggressive enrollment growth and actual enrollment is coming in somewhat less, but still strong.

The Program of All-inclusive Care for the Elderly is a managed care program that includes both acute care and long-term care programs.

OTHER

MEDICARE & PRIVATE PREMIUMS

The forecast makes an adjustment for actual enrollment to date. For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. In a small number of cases the Department also pays private insurance premiums.

SERVICE MANAGEMENT
The forecast reflects the change in expected enrollment. Service management is primarily administrative payments to the Regional Accountable Entities for the Accountable Care Collaborative on a per enrollee basis.

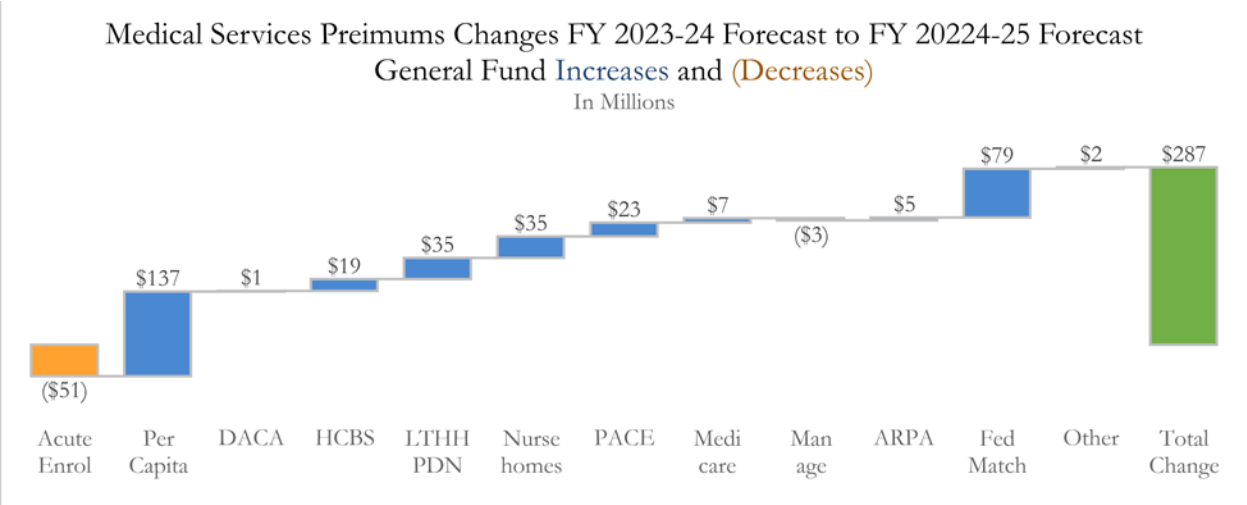
TOBACCO FORECAST
The Department decreased the expected funding from the Health Care Expansion Fund that offsets the need for General Fund based on lower tobacco revenues.

RECOVERIES
The Department increased the projected recoveries that offset General Fund and federal fund expenditures.

EMT CERTIFIED PUBLIC EXPENDITURES
The Department increased the forecast of expenditures by public Emergency Medical Transportation providers that the Department can certify as public expenditures to increase reimbursements to EMT providers. The Department retains a small portion of the increased federal funds to offset General Fund, which is a way of recovering the Department's administrative costs in operating the program.

OTHER FINANCING
The Department made miscellaneous other changes to the forecasted financing expenditures.

FY 2024-25
The Department projects expenditures will increase a net $699.5 million total funds, including an increase of $287.2 million General Fund from FY 2023-24 to FY 2024-25. The graph below shows the major contributors to the General Fund change. Projected increases for acute per capita costs, the federal match, and all other services more than offset the decline in enrollment that is projected due to the end of the continuous eligibility requirement during the federal COVID public health emergency.



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

FY 2024-25 Medical Services Premiums Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2024-25 Projection	$11,424,541,786	3,210,377,431	1,386,331,556	6,827,832,799
Acute Care				
Enrollment	(201,265,203)	(50,879,700)	(12,370,045)	(138,015,458)
Per capita	576,959,507	137,037,077	38,271,185	401,651,245
DACA recipients	2,061,189	1,030,594	0	1,030,595
Subtotal - Acute Care	*377,755,493*	*87,187,971*	*25,901,140*	*264,666,382*
Long-term Care Programs				
HCBS waivers	45,313,942	18,975,950	1,478,324	24,859,668
Long-Term Home Health/PDN/Hospice	69,140,833	34,570,416	0	34,570,417
Nursing homes	67,518,987	34,628,856	(72,037)	32,962,168
PACE	45,004,604	22,502,302	0	22,502,302
Subtotal - Long-term Care Programs	*226,978,366*	*110,677,524*	*1,406,287*	*114,894,555*
Medicare & private premiums	11,972,395	6,780,906	0	5,191,489
Service management	(12,537,243)	(3,414,704)	(2,197,780)	(6,924,759)
One-time ARPA funding	0	4,757,905	(4,757,905)	0
Federal match	0	78,955,084	(7,478,349)	(71,476,735)
Supplemental payments	73,608,431	0	37,878,799	35,729,632
CUSOM payments	10,713,271	0	15,098,476	(4,385,205)
Other financing	10,981,543	2,304,505	4,724,817	3,952,221
TOTAL	**$12,124,014,042**	**$3,497,626,622**	**$1,456,907,041**	**$7,169,480,379**
Increase/(Decrease)	699,472,256	287,249,191	70,575,485	341,647,580
Percentage Change	6.1%	8.9%	5.1%	5.0%

ACUTE CARE

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

Enrollment

The Department projects continued decreases in enrollment as it unwinds the continuous coverage requirement during the federal COVID public health emergency. Overall, the Department projects a 3.5 percent decrease in enrollment.

Per capita

Although the Department projects enrollment to decline, the Department expects the people leaving Medicaid will be low utilizers of services, resulting in an increase in per capita expenditures for the remaining population. In addition, the Department projects increases in per capita expenditures based on prior year trends.

DACA Recipients

The forecast assumes a new proposed federal regulation will be implemented imminently that would require Colorado to provide Medicaid coverage to children and pregnant people with Deferred Action for Childhood Arrivals (DACA) status who meet the income qualifications. The Department has statutory authority to implement provisions of Medicaid that are necessary to comply with federal regulation. Given that authority and that the Department does not have a choice but to comply, the Long Bill is a reasonable place to provide the needed funding. However, the Department is proposing legislation to align state statute with the new federal regulation.

The Department did not submit an official request for the JBC to carry the alignment legislation, but the JBC staff thinks that the JBC should consider carrying the bill. If funding for the DACA recipients is provided in the Long Bill and then a separate bill authorizes the services, it could appear that the JBC is providing special favor for another legislator's bill. If the JBC sponsors the bill it reduces this potential perception challenge. Another option would be to provide the funding in the authorizing bill, rather than the Long Bill. However, if the authorizing bill were to fail, the Department would still need the funding.

DACA recipients who otherwise meet the Medicaid eligibility criteria are currently eligible only for emergency services. The Department anticipates that the new regulation will primarily impact non-delivery maternity services. Most DACA recipients are older and do not require significant childhood medical services. The Department estimate the regulation will extend coverage to approximately 237 DACA recipients.

LONG-TERM CARE PROGRAMS

The long-term care programs include nursing homes, in-home nursing services, and community supports that help people live at home.

HCBS Waivers

The Department projects enrollment growth of 2.0 percent and a 6.9 percent increase in costs per utilizer based on prior year trends.

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.

Long-term Home Health/PDN/Hospice

The increase is primarily driven by continuation of the high utilization trend for the home health basic and extended services.

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.

Nursing homes

The increase is due to a projected 3.6 percent increase in patient days and the statutory increase in per diem rates.

PACE

The Department projects continued strong growth in both per capita costs (11.5 percent) and enrollment (11.0 percent).

The Program of All-inclusive Care for the Elderly is a managed care program that includes both acute care and long-term care programs.

MEDICARE INSURANCE PREMIUMS
The projected change is primarily due to inflation in Medicare premiums. For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums.

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

ONE-TIME ARPA FUNDING
The forecast reflects the end of appropriations from one-time federal funds deposited in the HCBS Improvement Fund and used to improve or enhance Home- and Community-Based Services.

FEDERAL MATCH
The Department projects a large increase in General Fund and decrease in federal funds for the end of the temporary extra 6.2 percent federal match provided through the federal Families First Coronavirus Response Act. The higher federal match was available for services from January 2020 through March 2023 and then it began to step down. The Department will continue to receive a smaller enhanced match through December 2023. The FY 2024-25 budget needs to take into account that there will be no enhanced match for any portion of the fiscal year.

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

CUSOM PAYMENTS
The Department's forecast assumes an increase in transfers from the University of Colorado School of Medicine (CUSOM) that are used to match federal funds and increase Medicaid reimbursements to CUSOM providers. This will be updated based on the JBC's actions on the higher education budget.

OTHER FINANCING
The Department made miscellaneous other changes to the forecasted financing expenditures.

R3 CHILD HEALTH PLAN PLUS (CHP+)

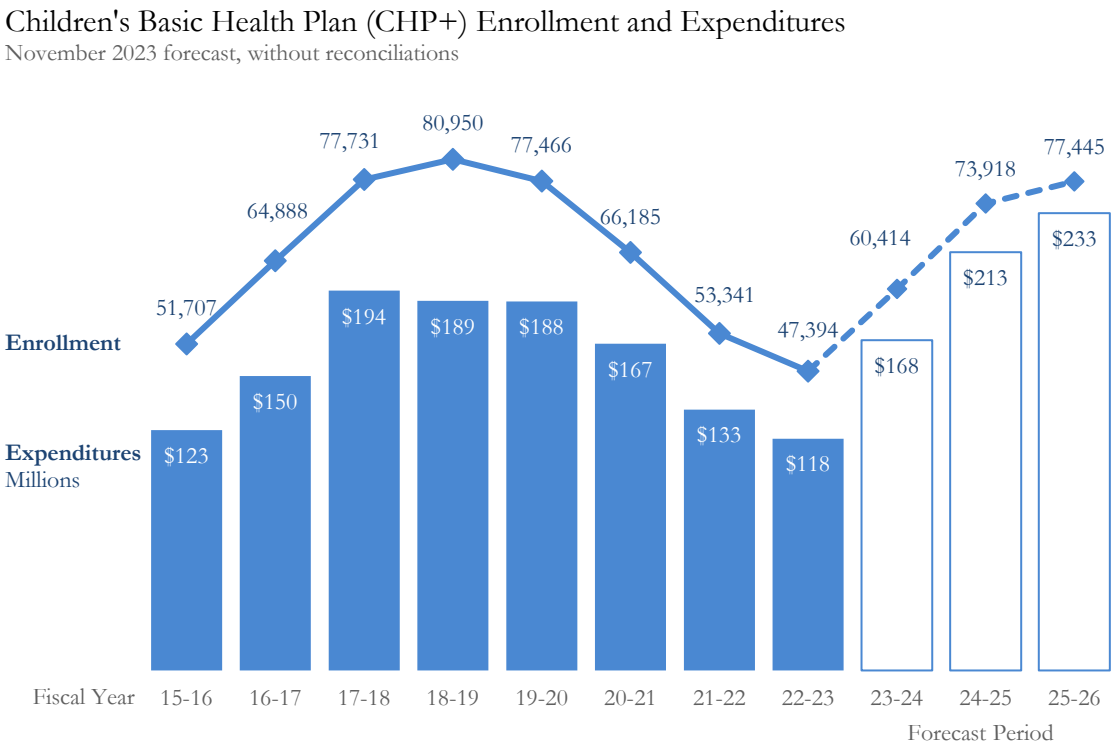
The overall forecast for CHP+ is deeply intertwined with the forecast for Medicaid. The Department expects members who are locked in on Medicaid with a CHP+ income level will enroll in CHP+ as Medicaid continuous coverage ends.

Favorable federal match rates from FY 15-16 through FY 19-20 made General Fund costs for CHP+ minimal and allowed for the accumulation of a fund balance in the CHP+ Trust. When the favorable federal match rates began to phase out, the General Assembly spent down the reserves in the CHP+ Trust to soften the blow to the General Fund. That balance in the CHP+ Trust is now gone. In

addition, the projected expiration of the enhanced federal match through the federal Families First Coronavirus Response Act requires more General Fund in FY 2024-25. The chart below summarizes the projected cash flow for the Children's Basic Health Plan Trust.

Children's Basic Health Plan Trust					
	FY 21-22	FY 22-23	FY 23-24	FY 24-25	FY 25-26
Beginning Fund Balance	$843,772	$5,222,715	$4,444,784	$0	$0
Revenue	$15,856,503	$16,450,529	$16,448,833	$15,908,833	$15,284,833
Fees	157,784	933	0	0	0
Tobacco Settlement	15,583,445	15,992,063	16,164,000	15,624,000	15,000,000
Interest	112,133	457,533	284,833	284,833	284,833
Recoveries	3,141	0	0	0	0
Expenses	$11,477,560	$17,228,460	$20,893,617	$15,908,833	15,284,833
Net Cash Flow	$4,378,943	($777,931)	($4,444,784)	$0	$0
Ending Fund Balance	$5,222,715	$4,444,784	$0	$0	$0

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



FY 2023-24

The table below shows the major contributors to the change from the FY 2023-24 appropriation to the Department's November 2023 forecast for FY 2023-24. It does not show differences from the FY 2022-23 expenditures.

FY 2023-24 Children's Basic Health Plan Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2023-24 Appropriation	$175,334,025	$19,597,188	$40,607,383	$115,129,454
Enrollment	(6,040,962)	2,144,175	(4,216,225)	(3,968,912)
Per capita	(819,036)	692,135	(209,945)	(1,301,226)
Tobacco forecast	0	1,881,451	(1,881,451)	0
TOTAL	**$168,474,027**	**$24,314,949**	**$34,299,762**	**$109,859,316**
Increase/(Decrease)	(6,859,998)	4,717,761	(6,307,621)	(5,270,138)
Percentage Change	-3.9%	24.1%	-15.5%	-4.6%

ENROLLMENT

The Department slightly lowered the enrollment projection overall, but increased the projection for the lowest income populations where the state match comes from the General Fund. For the somewhat higher income expansion population the state match comes from the HAS Fee. Although the Department lowered the enrollment forecast, the Department is still projecting enrollment will increase from the FY 2022-23 level by a whopping 42.4 percent.

PER CAPITA

The Department lowered the projection overall, but increased the projection for the lowest income populations where the state match comes from the General Fund. For the slightly higher income expansion population the state match comes from the HAS Fee. The General Fund increase is driven by delivery payments, newborn reinsurance, and the RSV vaccine.

TOBACCO FORECAST

The Department lowered the forecast of tobacco settlement funds that will be available for CHP+ to offset the need for General Fund.

FY 2024-25

The table below shows the major contributors to the change from the FY 2023-24 forecast to the FY 2024-25 forecast.

FY 2024-25 Children's Basic Health Plan Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2022-23 Projection	$168,474,027	$24,314,949	$34,299,762	$109,859,316
Enrollment	38,336,039	10,283,227	2,304,221	25,748,591
Per capita	6,596,185	1,973,294	396,470	4,226,421
Federal match	0	1,185,265	0	(1,185,265)
TOTAL	**$213,406,251**	**$37,756,735**	**$37,000,453**	**$138,649,063**
Increase/(Decrease)	44,932,224	13,441,786	2,700,691	28,789,747
Percentage Change	26.7%	55.3%	7.9%	26.2%

ENROLLMENT

The Department expects members who are locked in on Medicaid with a CHP+ income level will enroll in CHP+ as Medicaid continuous coverage ends, resulting in a 26.7 percent increase in enrollment.

PER CAPITA

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

FEDERAL MATCH RATE

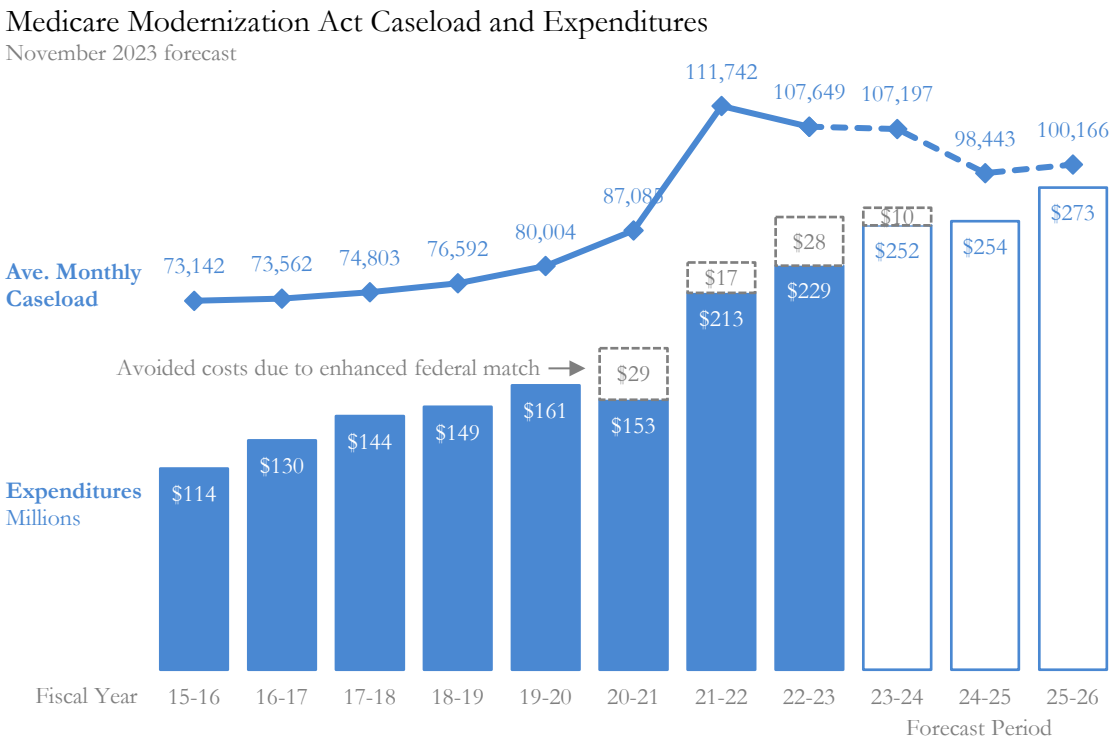
The forecast includes an increase in General Fund and a corresponding decrease in federal funds due to the phase out of the enhanced federal match through the Families First Coronavirus Relief Act.

R4 MEDICARE MODERNIZATION ACT

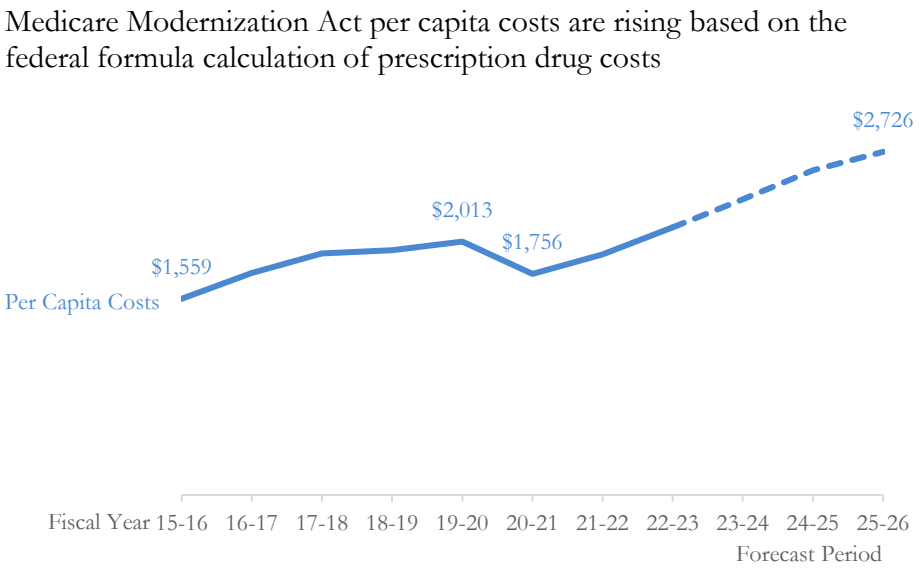
The Department requests a decrease of $3.0 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. The total requested change is the sum of the forecasted changes in FY 2023-24 and in FY 2024-25. The Department will officially submit a supplemental request for FY 2023-24 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2023.

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

The enhanced federal match through the federal Families First Coronavirus Response Act reduced the state obligation under the Medicare Modernization Act. The Department estimates Colorado is saving about $9.9 million General Fund in FY 2023-24 due to the enhanced federal match. The slight projected increase in expenditures from FY 2023-24 to FY 2024-25 when enrollment is expected to decrease is a function of the end of the enhanced federal match, combined with projected pharmaceutical inflation.



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



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

ISSUE: PROVIDER RATES (R6A AND R6B)

The Department $244.2 million total funds, including $71.3 million General Fund, for provider rate increases. This includes an increase of $82.7 million total funds, including $29.5 million General Fund, for a 1.0 percent increase for eligible providers and $161.5 million total funds, including $41.8 million General Fund, for targeted rate increases, primarily for dental services and wages for Home- and Community-Based Servcies.

SUMMARY

- The Department and the Medicaid Provider Rate Review Advisory Committee (MPRRAC) review the subset of rates that are not adjusted annually by a federal or state statute or rule at least once every three years.
- For the rates reviewed by MPRRAC, the Department's request is generally lower than the MPRRAC recommendation, although there are a few cases where the Department is recommending changes that go beyond what was reviewed or recommended by the MPRRAC.
    - The primary reason provided for these modifications was budget considerations
    - The Department's modifications generally prioritize the MPRRAC recommendation or higher for preventive services and a lower amount for all other services
- The issue brief raises questions about the Department's method for selecting benchmark comparison rates for pediatric behavioral therapies, dental services, and cardiovascular surgeries
- Outside of the rate adjustments related to the MPRRAC review, the largest increase requested by the Department is for wages for Home- and Community-Based Services and it is driven by increases in the minimum wage in Denver and statewide.

DISCUSSION

PROVIDER RATE REVIEW PROCESS

The Department reviews provider rates on a three-year cycle. The rate reviews are intended to inform the Governor's annual budget request and the General Assembly's deliberations about funding for the Department. As part of the review, the Department must:

- Compare Medicaid rates to available benchmarks
- Use metrics to assess whether payments are sufficient to allow provider retention and client access and support appropriate reimbursement of high-value services

The rate reviews are conducted with input from the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The Department and MPRRAC meet at least quarterly to discuss provider rates and receive public input. In addition to the JBC, the MPRRAC can direct a change to the rate review schedule.

The Department must submit a report by November 1 each year summarizing: their analysis of the provider rates under review; the public input received and the Department's response; how the public input informed the Department's recommendations; and the Department's rate recommendations.

The most recent report is available through the Department's web site: 2023 Medicaid Provider Rate Review Analysis and Recommendation Report.

EVALUATING RATE SUFFICIENCY

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

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

EXEMPT SERVICES

The Department may exempt rates from review because the rates are adjusted periodically based on another state or federal law or regulation. A little over 65 percent of the Department's appropriations for services are exempted from the rate review process.

Rates Reviewed by MPRRAC	
	FY 2024-25
Projected Expenditures (November forecast)	
Medical Services Premiums	$12,124,014,043
Behavioral Health	1,195,530,466
Children's Basic Health Plan	213,406,251
Medicare Modernization Act	254,045,148
Office of Community Living	1,152,316,773
Expenditures	**$14,939,312,681**
Estimated $s Exempt from MPRRAC Review	
Financing (mostly provider fee sup payments)	$2,041,492,903
Hospitals	1,888,377,046
Behavioral health managed care	1,183,133,861
CHP+ Managed care	1,152,316,773
Nursing	825,037,817
HMOs	644,218,202
Pharmaceuticals	588,496,040
PACE Managed care	344,423,972
Insurance (Medicare premiums & buy in)	285,066,131
Accountable Care Collaborative & disease management	257,141,264
Medicare Modernization Act	254,045,148
FQHCs and RHCs	233,210,017
Administrative case management contracts	90,949,271
Hospice	74,626,600

Rates Reviewed by MPRRAC	
	FY 2024-25
Office of Community Living State-only Program	21,373,241
Exempt	**$9,883,908,286**
Subject to MPRRAC Review	**$5,055,404,395**
Percent of Expenditures	33.8%

R6A PROVIDER RATES

The Department requests a 1.0 percent across-the-board provider rate increase for eligible community providers. The Governor is requesting a 2.0 percent provider rate increase for community providers outside of the Department of Health Care Policy and Financing.

The Governor has done something similar for several years in a row, with little explanation or policy justification, and it always puts the JBC in a difficult position. The purpose of the provider rate common policy is to recognize inflationary pressures faced by all providers and to give them all equitable treatment. The common policy serves as the baseline assumption for what providers should receive. Then departments, providers, or advocates that want higher rates have a burden of proof to explain why they, or their particular micro economic conditions, justify an exception to the common policy.

The primary explanation for why the Governor proposes different provider rate increases for different departments is that the budget would not accommodate a larger increase. The Department believes the targeted rate adjustments are essential for access to care. To make room for those targeted rate adjustments, the Department proposes decreasing the common policy increase for other HCPF providers. The Governor's proposal is not really a common policy, since HCPF providers are treated differently than all other providers. The JBC staff argues that the proper solution would have been for the Governor to reduce the common policy increase for all providers, rather than just the HCPF providers.

By balancing the budget on the backs of just a subset of providers, the Governor is forcing the JBC to choose between challenging options that probably boil down to:

- Come up with the money to make the HCPF providers whole
- Approve a smaller increase for the non-HCPF providers after the Governor already promised them something larger
- Explain to the HCPF providers that they are going to get something less than the non-HCPF providers, which might be blamed on the JBC rather than the Governor

The best policy explanation the JBC staff has heard for why the Governor continues this unequal treatment of providers is that HCPF has a formal process for reviewing provider rates at least once every three years that is lacking in other departments. However, the JBC staff remains unconvinced by the argument. While it is true that HCPF has a formal process for reviewing provider rates, other departments can and occasionally do submit requests for exceptions to the common policy, just like HCPF. Also, if the executive branch's plan is to short HCPF providers an inflationary increase because the adequacy of their rates will be reviewed every three years, then presumably those reviews will just

result in larger recommended increases. Delaying inflationary increases for three years, at which point a provider with small margins might be facing a crisis, seems less desirable than providing more adequate inflationary increases every year.

Not all of the Department's providers are eligible for the common-policy rate adjustment. A large portion of the Department's providers have rates that are adjusted annually or periodically based on a federal, or occasionally state, statute or regulation. For these providers, the Department forecasts the rate adjustments and includes them in the forecast requests (R1-R5). The table below summarizes the forecasted expenditures and the estimated portion of those expenditures eligible for the common policy provider rate increase.

Community Provider Rate Exemptions	
	FY 2024-25
Projected Expenditures (November forecast)	
Medical Services Premiums	$12,124,014,043
Behavioral Health	1,195,530,466
Children's Basic Health Plan	213,406,251
Medicare Modernization Act	254,045,148
Office of Community Living	1,152,316,773
Expenditures	**$14,939,312,681**
Estimated $s Exempt from Community Provider Rate	
Financing (mostly provider fee sup payments)	$2,041,492,903
Behavioral health managed care	1,183,133,861
CHP+ Managed care	213,406,251
Nursing facilities	825,037,817
Pharmaceuticals	588,496,040
PACE Managed care	344,423,972
Insurance (Medicare premiums & disabled buy-in)	285,066,131
Medicare Modernization Act	254,045,148
FQHCs and RHCs	233,210,017
Hospice	74,626,600
Exempt	**$6,042,938,740**
Eligible for Community Provider Rate	**$8,896,373,941**
Percent of Expenditures	59.6%

The largest exception to the common policy provider rate adjustment is for financing payments, which is mostly the supplemental payments to hospitals and nursing homes that are financed with provider fees. These payments are based on the revenues generated from the provider fees within federal limits, rather than the provider rate common policy. The next major exception to the common policy is for managed care rates. Managed care rates must be adjusted annually pursuant to federal regulation to ensure that they are actuarially sound and reasonably expected to cover provider costs. For nursing facilities there is a formula that sets the General Fund share of the rates at the lesser of actual allowable costs or a percent increase designated in statute through FY 2025-26 (the increase is 3 percent for FY 2024-25), after which the rates will be based on appropriations and presumably included in the annual common policy provider rate adjustment. For pharmaceuticals there is a state formula, approved by the federal government, that attempts to set rates at cost. Insurance costs are mostly for when the state pays the Medicare premiums for eligible Medicaid clients and the premium rates for Medicare are set by the federal government. The Medicare Modernization Act is a state reimbursement to the federal government for prescription drug costs for clients who are dually eligible for Medicare and Medicaid and the payment is set by a federal formula that takes into account pharmaceutical inflation.

The rates for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are adjusted annually based on a state formula, approved by the federal government, that looks at actual allowable costs. Hospice rates are adjusted annually based on a federal formula.

In addition to the standard annual exceptions to the common policy provider rate adjustment that are noted above, the Department requests that the targeted rate adjustments as a result of the MPRRAC rate review would be in lieu of, rather than in addition to, the common policy provider rate adjustment, since this is a rebase of the rates relative to a benchmark. For the four requested targeted rate increases outside of the MPRRAC rate review (Wages for HCBS, Single Assessment Tool, Primary Care Fund, and Regional Center transitions), the Department proposes that these would be in addition to the common policy provider rate adjustment.

The cost of the common policy provider rate adjustment is calculated based on 11 months in order to account for the cash basis accounting of claims processing. As a result, the requested increase would result in a $2.7 million General Fund annualization cost in FY 2025-26.

R6B TARGETED PROVIDER RATES

The Department requests an increase of $161.5 million total funds, including $41.8 million General Fund, for targeted provider rate increases. The largest dollar increases are for dental services and for the wage component of Home- and Community-Based Services.

R6b Targeted Provider Rates					
Rate	Change	Total Funds	General Fund	Cash Funds	Federal Funds
Adjustments based on the MPRRAC Rate Review					
Dental	15 preventative codes to 100% 13 diagnostic codes to 70%	$78,485,021	$14,331,366	$11,851,238	$52,302,417
Pediatric behavioral therapies	100% of benchmark without NE	11,934,437	5,967,219	0	5,967,218
Maternity	14 preventive rates to 100% 12 other rates to 80%	7,786,537	3,893,269	0	3,893,268
Surgeries	70-100% most surgeries 100% preventive digestive & integumentary 70-125% cardiovascular to non-facility	6,773,293	1,982,002	280,956	4,510,335
Ambulatory surgery centers	Increase rates below 70% to 70%	4,002,748	1,171,284	166,034	2,665,430
Co-surgeries	Expand billable codes	1,613,031	472,005	66,908	1,074,118
Autism spectrum screening	Restore 2 codes to previous levels	1,507,144	753,572	0	753,572
Abortion	100% of benchmark	298	149	0	149
Anesthesia	100% of benchmark	(9,073,136)	(2,654,982)	(376,353)	(6,041,801)
Subtotal - MPRRAC		$103,029,373	$25,915,884	$11,988,783	$65,124,706
Other targeted rate adjustments					
Wages for HCBS	Minimum wage increase	$53,856,751	$13,605,949	$13,322,439	$26,928,363
Single Assessment Tool	Implementation cost	2,556,493	1,278,246	0	1,278,247
Primary Care Fund	Serve clients 201-250% of FPL	1,113,806	556,902	0	556,904
Regional Center transitions	1-year enhanced rate for transitions	948,008	474,004	0	474,004
Subtotal - Other		$58,475,058	$15,915,101	$13,322,439	$29,237,518
TOTAL		**$161,504,431**	**$41,830,985**	**$25,311,222**	**$94,362,224**

The Department divided the request into adjustments based on the MPRRAC rate review and other targeted rate adjustments.

ADJUSTMENTS BASED ON THE MPRRAC RATE REVIEW

The dollar amounts in the tables that are included with each description below describe the estimated full year fiscal impact. They differ from the amounts requested for FY 2024-25 due to an adjustment to account for claims billed in the fiscal year that will not be paid until the next fiscal year.

DENTAL

The Department requests $78.5 million total funds, including $14.3 million General Fund, to increase 28 dental services rates. Of the 28 rates, 24 were identified by the Colorado Dental Association as critical and recommended in order to have the most immediate impact. These 24 codes represent 44.6 percent of all dental utilization. In addition to the 24 codes, the Department is requesting increasing another 4 highly used preventative codes that together represent 12 percent of utilization, including 3 codes related to sealants and 1 code for silver diamine fluoride to arrest decay. The Department believes that increasing these codes will incentivize preventive services, which could reduce more costly utilization. The Department made a distinction between preventative, endodontic, and periodontic codes that it proposes increasing to 100 percent of the benchmark and diagnostic services that it proposes increasing to 70 percent of the benchmark.

The Department describes the MPRRAC analysis of dental rates as a "partial" review. The MPRRAC requested an out-of-cycle review of dental rates based on concerns raised by the Colorado Dental Association. Due to the out-of-cycle request, the Department did not have time to compare Colorado's dental rates to other state Medicaid programs. Instead, the Department used survey data from the American Dental Association (ADA) to establish benchmarks. There were 350 Colorado Medicaid dental codes with valid utilization in FY 2021-22 and only 151 of them could be compared to the ADA survey, but these 151 codes represent 84 percent of total dental expenditures and 90 percent of total utilization, so Department feels the benchmark comparison was valid. The Department plans a "full" review of dental rates in 2024 that will include comparisons to other state Medicaid programs.

It is important to note that the selected benchmark was the ADA survey that provides average fees from all payers, including both public and private. The Department compares most rates to Medicare rates that attempt to pay providers at cost and are typically below private insurance rates. When comparable Medicare rates are not available, as is the case for dental services, the Department usually defaults to comparing Colorado rates to other state Medicaid rates, which are usually below private insurance rates. The Department used the ADA survey as the best available information, but it likely resulted in a higher benchmark than would have been established for other services where Medicare or other state Medicaid rate data was available.

MPRRAC	HCPF
49.8%/American Dental Association (ADA) 2022 survey data	49.8%/American Dental Association (ADA) 2022 survey data
• Increase 24 dental codes recommended by Colorado Dental Association to 100% of the benchmark to have the most immediate impact on the dental community	• Increase 15 preventative, endodontic and periodontic codes to 100% of the benchmark • 13 diagnostic service dental codes to 70% of the benchmark • **Reason:** ADA benchmark is a nationwide average of self-reported fees charged by dentists. Commercial fees are typically

MPRRAC	HCPF
	significantly higher than Medicaid rates; Medicaid does not generally pay providers based on billed charges. • **Reason:** Budgetary consideration
TF = $104,138,137 GF = $19,015,624	TF = $85,620,023 GF = $15,634,217

PEDIATRIC BEHAVIORAL THERAPIES

The Department requests $11.9 million total funds, including $6.0 million General Fund, to increase four pediatric behavioral therapy (PBT) codes for the treatment of children with autism to 100 percent of a benchmark based on 9 other state Medicaid rates. Significantly, the Department's benchmark excludes rates from Nebraska that the Department describes as extreme outliers with rates that are 41 percent to 508 percent of other states. There are a total of 5 PBT codes and the Department recommends no change to the 5th code that is already 128.5 percent of the benchmark.

Advocates continue to raise concerns about the exclusion of Nebraska from the Department's analysis. Part of the objection is that representing the request as meeting 100 percent of the benchmark makes it hard to advocate for additional increases in future budget cycles, if the Department's request is the maximum the current year budget can accommodate. The advocates complain that the Department threw out the high outlier but not low outliers. The Department argues that none of the other state Medicaid rates are statistical outliers.

Also, advocates argue that HCPF made some technical errors in identifying the correct comparison rates in some states. The JBC staff is investigating, but it is not clear that HCPF agrees there are technical errors, or that changing these individual state comparison rates would significantly change the overall analysis.

Finally, the advocates express frustration that the Department's criteria for choosing comparison states was not transparent. According to the advocates, the Department's only stated criteria was a preference for states with fee-for-services payments rather than managed care, but several of the benchmark states selected by the Department use managed care. A similar complaint surfaced a few years ago when the Department reviewed HCBS rates. The Department does not have any written policies on how it selects benchmark comparisons and handles each rate on a case-by-case basis. The Department considers the views of stakeholders and the professional opinions of Department program staff. The JBC staff believes there might be opportunities for the Department and MPRRAC to be more consistent and transparent in the way benchmarks are selected by developing written guidelines and then regularly reviewing and updating those guidelines based on lessons learned each review cycle.

The JBC staff wonders whether other state Medicaid programs are an appropriate target for determining the adequacy of rates when a Medicare comparison is unavailable. In most cases, the Department compares rates to Medicare. The Medicare rates attempt to reimburse providers at cost. Medicare uses documented and public procedures to estimate provider costs and regularly updates the rate analysis to reflect current conditions. Other state Medicaid programs do not necessarily go through a similarly standardized process. The JBC staff suspect many states set rates based more on budgetary and political concerns than any objective criteria intended to determine the adequacy of the

rates. There are flaws in the Medicare rate setting, but at least there is a reason to believe that the Medicare rates might be a good proxy for provider costs. That is not necessarily true of other state Medicaid rates. It might be that comparisons to other state Medicaid rates only tell you that your rates are just as imbalanced as everyone else's.

The HCBS rates are an interesting case study, because the Department has both estimates of provider costs and comparisons to other state Medicaid rates. For each HCBS rate, the Department applies a (sometimes rather large) budget neutrality factor to the estimate of provider costs to arrive at a rate that fits the appropriated funds. The size of the budget neutrality factor often does not correlate with how far Colorado's rates are from the benchmark comparison states. If Colorado's estimate of provider costs is accurate, then this implies that other states are struggling to align their HCBS rates with provider costs in similarly random and idiosyncratic ways as Colorado. The Department would need more resources to do the kind of analysis it does for HCBS rates for other rates, such as the autism rates, where there is no equivalent Medicare comparison.

MPRRAC	**HCPF**
78.7%/10 other states	90.7%/9 other states
• Increase PBT rates to 100% of the benchmark including Nebraska • Open up a list of codes that are not currently covered by Colorado Medicaid	• Increase four PBT rates to 100% of the benchmark excluding Nebraska leaving one procedure code (97158) with a benchmark ratio as 128.5% at its current rate • Reason: Nebraska is an extreme outlier with rates that are between 41% - 508% above other states in the benchmark cohort. • Reason: In the past, CMS has not approved when we've requested to open up the list of codes.
TF = $34,281,532 GF = $17,140,766	TF = $13,019,386 GF = $6,509,693

MATERNITY

The Department requests an increase of $7.8 million total funds, including $3.9 million General Fund, to increase maternity rates. Specifically, the Department proposes increasing 14 of 18 general maternity service and care codes to 100 percent of the benchmark (the remaining 4 codes are already above 90 percent of the benchmark and would remain unchanged) and 12 of 14 pregnancy and non-viable pregnancy codes to 80 percent of the benchmark (the remaining 2 codes are already above 80 percent of the benchmark and would remain unchanged). The benchmark is Medicare. Most Medicare recipients are elderly, but Medicare also covers people with permanent disabilities and end-stage renal disease and it offers maternity benefits to these clients. The Department says the differential treatment of the codes is intended to incentivize utilization of services that improve pregnancy outcomes and reduce maternal morbidity and mortality. Through Medicaid and CHP+ the Department covers approximately 43 percent of births in Colorado. Medicaid is a major payer for maternity care.

MPRRAC	**HCPF**
76.10%/Medicare	76.10%/Medicare

MPRRAC	HCPF
• An increase of maternity rates to 100% of the benchmark	• 14 general maternity service and care codes increase to 100% of the benchmark • 12 pregnancy or non-viable pregnancy codes increase to 80% of the benchmark • **Reason:** Recommended increases in rates for codes focused on supporting provider's provision of specific maternity-related services, with the purpose to promote improved pregnancy outcomes, reduce maternal morbidity and mortality, etc.
TF = $8,942,246 GF = $4,471,123	TF = $8,494,404 GF = $4,247,202

SURGERIES

The Department requests $6.8 million General Fund, including $2.0 million General Fund, to rebalance surgery rates to within 70-100 percent of the benchmark with the following exceptions:

- Increase preventative digestive and Integumentary surgery codes to 100% of the benchmark and leave any codes above the benchmark alone; and
- Rebalance cardiovascular surgeries to within 70-125 percent of the benchmark using only non-facility Medicare rates as the benchmark.

When the Department rebalances rates it means that any rate below the threshold is increased to the threshold minimum and any rate above the threshold is decreased to the threshold maximum. Within a specialty area, the net change in appropriations is usually a good indicator of whether providers are coming out ahead or behind, but there can be different impacts by provider depending on the specific codes a provider bills most often.

The following specialties would see net decreases in payments while all other specialty areas would see net increases in payments of varying sizes:

- Digestive ($1.2 million)
- Respiratory ($223,909)
- Eye and Auditory ($383,945)

The Department says the exception for preventative digestive and Integumentary surgeries is intended to incentivize preventative procedures that can improve health outcomes and reduce the utilization of more expensive care.

The Department says the wider range for cardiovascular surgeries rates is because the Department is having trouble attracting providers in this specialty that are willing to serve Medicaid clients. This is also the reason the Department provided for using non-facility Medicare rates as the benchmark even when the Medicaid services is not provided in that setting.

The JBC staff believes that playing with the benchmark for the purpose of influencing the recommended provider rates is problematic. The benchmark should be an objective and defensible number based on the best available data. The benchmark should be selected and calculated with as consistent a process as possible from one group of provider rates to the next. The Department can still argue for paying above the benchmark because the provider participation rate is low. What the

Department did obscures how generous the Department's proposed rates are compared to other providers.

MPRRAC	HCPF
84.7%/Medicare	77.0%/Medicare
• Keeping preventative surgery codes at 100% of the benchmark for digestive surgeries • Rebalance to 80% of the benchmark for all other codes for digestive and Musculoskeletal • Rebalance to 80% - 100% of the benchmark for the rest surgeries	• Keeping preventative surgery codes at 100% of the benchmark for digestive and Integumentary • Rebalance to 70% - 100% for all surgeries except for Cardiovascular surgeries • For Cardiovascular surgeries, rebalance to 70% - 125% of the benchmark using only non-facility Medicare rates as the benchmark repricing • **Reason:** Budgetary consideration • **Reason**: Cardiovascular surgeries category has the lowest provider participation ratio among all surgery services (40%)
TF = $864,139 GF = $252,865	TF = $7,389,047 GF = $2,162,184

AMBULATORY SURGERY CENTERS

The Department requests $4.0 million total funds, including $1.2 million General Fund, to increase rates below 70 percent of the benchmark to 70 percent.

MPRRAC	HCPF
53.5%/Medicare	53.5%/Medicare
• An increase of ASC rates to at least 80% of the benchmark	• Increasing ASC rates to 75% of the benchmark • Change the payment methodology for ASC • **Reason:** To encourage greater utilization of lower-cost options for surgeries while working towards an updated payment methodology that will address the majority of ASC rate concerns
TF = $5,379,889 GF = $1,574,264	TF = $4,366,634 GF = $1,277,764

CO-SURGERIES

The Department requests $1.6 million total funds, including $472,005 General Fund, to expand the billable codes that provide reimbursement when two surgeons with different specialties collaborate on a complex procedure. At the MPRRAC hearing the Department described opening billing codes as a benefit change, rather than a provider rate change, but in this case the Department included the proposed change in the provider rate request.

The Department indicates that the MPRRAC did not receive data on co-surgeries and therefore did not make a recommendation. The Department does not explain why it did not provide data to the MPRRAC or seek the MPRRAC's feedback. Nor does the Department explain why this proposed rate increase is described as a part of the MPRRAC review when the MPRRAC had no input.

MPRRAC	HCPF
NA	NA
• NA (no data for co-surgery)	• Expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1' • **Reason:** Increase access to high quality care for highly complex procedures • **Reason:** Align more closely with Medicare's co-surgery policy and create clarity for providers
NA	TF = $1,759,670 GF = $514,915

AUTISM SPECTRUM SCREENING

The Department requests $1.5 million total funds, including $753,572 General Fund, to restore the rates for two codes related to screenings and assessments for Autism Spectrum Disorder (ASD) that were reduced in FY 2023-24. This appears in the request and in the 2023 Medicaid Provider Rate Review Analysis and Recommendation Report under the heading Behavioral Health Fee-for-Service, but the Department did not recommend changes to any other fee-for-service rates.

The codes were reduced last year at the recommendation of the MPRRAC, but the Department says the MPRRAC was not provided complete information. Federal regulations require the Department to separate developmental screenings from ASD screenings. A stakeholder group recommended using these two codes. Medicare covers these two codes, but not for the same Colorado-specific purposes. The rates for the two codes were intentionally set higher than Medicare because of their role in assessing children for autism. This information was not provided to the MPRRAC. The Department wants to encourage screenings based on research demonstrating the value of early interventions. Also, the Department says that current reduced rates are not sustainable for providers.

The Department's request related to the autism spectrum and development screenings originated outside the MPRRAC. The MPRRAC did have some recommendations related to fee-for-service behavioral health, summarized in the table below, that the Department did not include in the budget request.

MPRRAC	HCPF
97%/Medicare	97%/Medicare
• Add a language translation modifier for native language speakers for testing codes • Increasing rates to 100% of the benchmark especially four psychological testing codes (96132, 96133, 96136, 96137)	• Reverting the rates for 2 Autism Spectrum Disorder (ASD)/ Development screening assessment codes (96110 and 96127) to $18.39 • **Reason:** No appropriate Medicare benchmarks for 96110 and 96127, which are important testing codes for developmental screenings and ASD
TF = $319,452 GF = $159,726	TF = $1,664,157 GF = $822,078

ABORTION

The Department requests $298 total funds, including $149 General Fund, to increase two codes related to abortion services. Per federal guidelines, Medicaid covers abortion services if there is a life-endangering condition for the pregnant individual or under situations of rape or incest.

Due to very low utilization, federal privacy regulations prevented the Department from providing data to the MPRRAC. The MPRRAC recommended increasing rates closer to other state Medicaid rates, but also raised concerns about using other state rates as the benchmark rather than Medicare. The Department's report does not describe a consensus recommendation from the MPRRAC.

The Department recommends increasing the rate for dilation and curettage to $354.54 and the rate for dilation and evacuation to $1,150.00 based on average state Medicaid rates in California, Oregon, and Illinois, which are higher than if Medicare had been selected as the benchmark.

ANESTHESIA

The Department requests a decrease of $9.1 million total funds, including a decrease of $2.7 million General Fund, to reduce anesthesia rates to 100 percent of the benchmark. Medicare reduced anesthesia rates in 2021 and Colorado's rates are now on average 137.5 percent of the benchmark.

MPRRAC	**HCPF**
137.5%/Medicare	137.5%/Medicare
• Bringing down the rate to 100% of the benchmark • Add a travel rate	• Reduction in anesthesia service rates to 100% of the benchmark • **Reason:** Disagrees with the travel rate - hard to differentiate services by traveling anesthesiologists from other anesthesia services
TF = ($9,897,967) GF = ($2,896,344)	TF = ($9,897,967) GF = ($2,896,344)

OTHER TARGETED RATE ADJUSTMENTS

WAGES FOR HCBS

The Department requests $53.9 million total funds, including $13.6 million General Fund, to increase the direct care wage component of Home- and Community-Based Services (HCBS) rates commensurate with increases in the minimum wage. 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. Many direct care workers are paid near minimum wage and providers compete with other industries for these workers.

To determine HCBS rates, the Department estimates the cost of care, including direct care wages and indirect costs for administration, utilities, etc. The Department then typically applies a budget neutrality factor to keep the rates within the appropriated funding. To calculate the request, the

Department increased the direct care wage component of the rates to reflect the increase in the minimum wage to $18.29 per hour in Denver and $16.55 per hour outside Denver.

Different rates for services in Denver versus the rest of the state can be problematic, especially for providers in communities immediately surrounding Denver that compete in the same labor pool. The Department estimates it would cost $97.3 million total funds, including $48.7 million General Fund, to increase the direct care wage component of provider rates outside of Denver to $18.29. If other local governments follow the lead of Denver and implement local minimum wages it could drive additional costs for the Department to maintain competitive rates.

The requested percentage increase in an individual rate is not the same as the percentage increase in the minimum wage, because all other components of the rate calculation were held constant. In addition to the wage increase for HCBS, the Department is proposing that HCBS services would get the 1.0 percent across-the-board community provider rate increase, so there would be some money for providers for inflation in the components of the rates that are not related to direct care wages.

Similar to last year, the Department proposes using federal funds deposited in the HCBS Improvement Fund to offset the cost of the increase. This is a federally allowed use of the HCBS Improvement Fund, because it enhances HCBS services, but the proposed rate increase will result in an on-going obligation and the money in the HCBS Improvement Fund is time-limited. The offset to General Fund costs in FY 2024-25 is $13.3 million and the annualization cost in FY 2025-26 would be $13.3 million.

The Department anticipates needing to realign HCBS rates in the near future as a result of implementing Community First Choice, pursuant to S.B. 23-289. Many of the HCBS will transition from assistance that is provided only to clients on a Medicaid waiver to assistance that is provided to all Medicaid clients with qualifying needs through the State Plan. When a new waiver is implemented, the Department goes through an extensive process to establish the rates and justify them for federal approval, but once the rates are set they are adjusted only when the General Assembly approves funding. As a result, there are currently HCBS rates for largely identical services that differ across waivers. This type of variation is permissible from one waiver to the next, but when the services are part of the State Plan it will not be feasible. The HCBS rates are up for review by the MPRRAC in 2024 and the Department plans to use that process to inform rate realignment requests for FY 2025-26. The Department may propose rebalancing rates in a manner that is budget neutral, or request additional funds for rates that are below the standards paid to other services.

The Department projects current HCBS workforce shortages will increase from 2018 to 2028. The Department reports Colorado's older adult population and life expectancy are both growing by an estimated 49 percent. Meanwhile, Colorado's labor pool of people 16-64 is only projected to grow less than 14 percent. Providers report that HCBS positions are already hard to fill and the population trends are likely to compound current challenges.

SINGLE ASSESSMENT TOOL

The Department requests $2.6 million total funds, including $1.3 million General Fund, for costs associated with the single assessment tool mandated by S.B. 16-192, sponsored by the JBC. The costs increase to $6.9 million total funds, including $3.5 million General Fund, in FY 2025-26 and ongoing.

The Single Assessment Tool includes several components:

- Level of Care Screen – determines functional eligibility for the range of long-term care programs from Home- and Community-Based Services to nursing care and services in between, such as long-term home health, private duty nursing, and PACE.
- Needs Assessment – for Home- and Community-Based Services, determines the services a person qualifies to utilize.
- Person Centered Budget Algorithm – determines the client's budget for HCBS, including participant directed services.
- Optional Questions – voluntary questions that help the case manager know the client and may result in better advice for the client on how to navigate to services that meet the client's needs.

The original fiscal note for S.B. 16-192 assumed reassessment costs once the Single Assessment Tool was implemented, but it did not include an estimate of on-going costs. As implementation of the Single Assessment Tool has been delayed, each forecast request from the Department has included a revised estimate of the timing and amount required for the reassessment costs. For FY 2023-24 and the first part of FY 20224-25, the reassessments are built into the Department's forecast R5 Office of Community Living. In R6 the Department is requesting on-going funding assuming that rollout of the Single Assessment Tool will begin in March 2024 and on-going funding will be needed beginning in March 2025.

Since the request was submitted, the Department has determined that additional delays in implementing the Single Assessment Tool are necessary due to concurrent stresses on the delivery system, including the unwind of the federal public health emergency's continuous eligibility policy, the case management redesign initiative, and the launch of the new information technology Care and Case Management System. In addition, the Department is reconsidering previous budget presentation decisions that included the first year reassessment costs in the forecast, rather than in a budget request with the on-going costs. As a result, the Department anticipates a budget amendment to revise this request in January and a different treatment of the reassessment costs in the February forecast.

The request includes a small amount of savings from the Level of Care Screen component being less expensive to administer than the existing tools it will replace. Also, it includes some savings from the Needs Assessment component replacing a few existing tools. However, the request is net positive because with the Single Assessment Tool: (1) a large number of clients will start getting a Needs Assessment who were not previously getting one; and (2) clients will be reassessed every year. In FY 2022-23 there were 53,662 Medicaid clients receiving HCBS. Whether these clients had any type of initial or annual standardized needs assessment beyond the judgement of the case manager and service team depends on the type of waiver where the client was enrolled. The Department indicates that 24,639 of the clients would not have had a standardized needs assessment and the Department requires on-going funding to make the needs assessment a part of the clients' annual experience once the Single Assessment Tool is implemented.

Despite the inclusion of the Single Assessment Tool in the provider rate request, an argument could be made that this request is more about the implementation (after years of delays) of a new statutory requirement, rather than a provider rate increase.

The Department is not currently forecasting any change in HCBS utilization patterns with the implementation of the Single Assessment Tool. The Department says the vendor conducted a comparative analysis of the new Level of Care Screen with existing tools and was able to make

adjustments to eligibility thresholds during the initial pilot. As a result, the Department does not anticipate fewer members being determined eligible for services. Once determined eligible, services are federally required to be authorized based on assessed need and, therefore, the Department does not anticipate significant changes.

The JBC staff would point out that the Single Assessment Tool came about in part due to a lack of faith in the ability of existing practices to accurately, consistently, and fairly assess needs. It seems unlikely to the JBC staff that the Department could design a standardized assessment tool that would completely mimic the outcomes of the current assessment procedures that are often described as flawed and overly subjective. Furthermore, if perfect maintenance of the status quo was the actual outcome of implementing the Single Assessment Tool, it might not be consistent with the original intent of the bill. While the JBC staff understands the Department's reluctance to forecast a change in utilization with limited data to support such a forecast, the JBC staff assumes there will be disruptions in utilization patterns. There is uncertainty about what implementation of the Single Assessment Tool will do to overall costs for HCBS. Whatever the overall cost outcome, there will inevitably be some people who are authorized for different services or service levels as a result of the Single Assessment Tool and that will almost certainly generate complaints to legislators, whether justified or not. This is a common historic pattern when the Department implements new assessments and the JBC staff sees no reason why the Single Assessment Tool would break that pattern. What is potentially different about the Single Assessment Tool is the large volume of people who will be impacted by the implementation.

Please see Appendix D for a timeline describing the implementation of the Single Assessment Tool, a high level explanation of the delays, and a list of existing items that will be replaced by the Single Assessment Tool.

PRIMARY CARE FUND [POTENTIAL LEGISLATION]

The Department requests an increase of $1.1 million total funds, including $556,902 General Fund, for the Primary Care Fund. The Department uses the money in the Primary Care Fund to make grants to providers that:

- 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. The primary beneficiaries of grants from the Primary Care Fund are Federally Qualified Health Centers (FQHCs).

Senate Bill 21-212, sponsored by the JBC, altered the way the grant program works in order to draw matching federal funds for eligible providers. At the same time, the JBC eliminated funding for clinics

participating in the Colorado Indigent Care Program (CICP). The CICP is a program where providers agree to charge patients with income up to 250 percent of the federal poverty guidelines on a sliding scale based on the client's income. The net result was an increase in payments to Medicaid providers of $19.3 million. Some of the recipients of grants from the Primary Care Fund are not Medicaid providers and they did not see any net change in their payments.

In FY 2023-24, the JBC added $14.0 million total funds, including $7.0 million General Fund, to increase grants from the Primary Care Fund for that fiscal year. This was funding initiated by the JBC, rather than requested by the Department. There were discussions about one-time needs of the FQHCs as they recovered from the pandemic and as their payments, which are based on prior year actual allowable costs, lagged actual salary inflation. The Department's request for FY 2024-25 removes that one-time $14.0 million from the base, but then asks for the $1.1 million in this request as on-going funding.

The Department's justification for the on-going funding is based on serving clients with incomes from 201 percent of the federal poverty guidelines to 250 percent of the federal poverty guidelines. Money in the Primary Care Fund is currently distributed based on services to clients with income up to 200 percent of the federal poverty guidelines. The Department says that the number of clinics participating in CICP has decreased from 18 to 11 since the funding for Clinic Based Indigent Care was eliminated in FY 2021-22.

The declining provider participation in the CICP is neither surprising nor concerning to the JBC staff. Since the clinics are no longer being paid through the CICP, there is no financial incentive for them to go through the administrative hassle of participating in the CICP. Ending participation in the CICP does not necessarily mean these mission-driven providers have stopped serving low-income clients or stopped charging those clients based on their ability to pay. The JBC staff does not see why participation in the CICP would be an indicator of whether affordable care is more or less available. The changes to the Primary Care Fund that were directed by the JBC resulted in significant increases in payments to providers that should have made it easier for them to serve clients with income from 201 to 250 percent, rather than harder. The JBC staff sees no evidence in what the Department has presented that people with income from 201 to 250 percent of the federal poverty guidelines are receiving less care.

The Medicaid rates for FQHCs are adjusted annually based on actual allowable costs. When costs are changing rapidly, there can be delays between when changes in costs are accurately and sufficiently captured in the Medicaid rates. The Department applies inflationary adjustments to the actual allowable costs when determining the rates, but they are not always consistent with actual inflation. This is usually a temporary problem that eventually goes away when the rate setting catches up to reality. The Department's justification for the request does not mention any such temporal problem with the current Medicaid rates for the FQHCs.

The client mix for the FQHCs can change over time and increases in the percentage of uninsured or underinsured clients can cause financial stress as well as decreases in the percentage of privately insured clients. If this is causing problems for the FQHCs, it is not mentioned in the Department's request.

The problem the Department is trying to solve with the request, and how the proposed level of funding would fix it, is not at all clear to the JBC staff.

In addition to the funding, the Department requests that the JBC sponsor legislation to eliminate the CICP and move some of the program elements into the statutes for the Primary Care Fund and for the Healthcare Affordability and Sustainability (HAS) Fee. The proposed legislation is based on the recommendations of the CICP Stakeholder Advisory Council as described in the report, dated May 23, 2022, titled Final Proposal: CICP Program Future. The goals include eliminating requirements that are now anachronistic based on the way other similar programs have evolved and reducing administrative burdens for providers and the Department associated with the current CICP. The Department indicates it will provide draft language for the JBC to consider "soon".

REGIONAL CENTER TRANSITION

The Department requests $948,008 total funds, including $474,004 General Fund, to implement a transition rate for clients leaving a Regional Center for people with intellectual and developmental disabilities to go to a community setting. The transition rate would apply for one year and after that the rate would be based on the acuity and needs assessment for the client. The Department estimates the transition rate would apply to approximately 20 clients per year.

According to the Department, clients wait an average of 297 days after a determination of transition readiness or a decision to leave a Regional Center before they are actually placed in a community setting. The Department believes that part of the problem is the rates paid for clients leaving a Regional Center. On a scale of 1-7, clients entering a Regional Center have an average needs assessment of Level 4. However, for clients leaving a Regional Center the providers are often seeking and sometimes achieving a Level 7 rate that is individually negotiated. Somebody has to request a Level 7 rate for a client, but providers are not necessarily willing to take a client from a Regional Center without a Level 7 rate, so there is a chicken and egg problem where nobody is identified to request a Level 7 rate because nobody is willing to take the client without a Level 7 rate. The Department can't just reassess a client as a Level 7, because a provider needs to propose a suite a services tailored to the needs of the client and then the Department needs to review the proposal. Negotiating a Level 7 rate is a time-intensive and often controversial process.

The Department describes the role of the Regional Centers as providing short-term stabilization for individuals with very high needs. Something is happening that causes clients with otherwise very average looking assessment scores of Level 4 to enter a Regional Center. Client needs are not static over their lifetime. Once that thing happens that was not picked up on the original needs assessment, the Department describes the providers as reluctant to take the clients back in a community setting at the original rate. The Department hopes to entice more providers to take clients from Regional Centers with a higher rate in the first transition year. Once a client is placed with a provider, the provider can request a Level 7 negotiated rate and the Department can evaluate the merits of the request and may or may not approve a Level 7 negotiated rate.

The proposed transition rate is $350 per day. The average negotiated Level 7 rate is $415 per day. Not all clients transitioning rom a Regional Center will end up with a negotiated Level 7 rate. The average cost to treat a client in a Regional Center is $952 per day. The Department does not project a savings from faster transition to community settings, because the Department anticipates empty space in Regional Centers will be filled by other clients. This request appears to be more about serving clients in the appropriate and desired setting and opening capacity in the Regional Centers, rather than achieving cost savings by seeing clients in the community.

ISSUE: ONE-TIME FUNDS

During the 2020 special session, 2021, 2022, and 2023 legislative sessions, the General Assembly allocated significant one-time funding to the Department of $597.6 million.

SUMMARY

- HCBS Improvement -- The Department is spending $552.3 million to enhance Home- and Community-Based Services (HCBS) programs
    - The American Rescue Plan Act (ARPA) temporarily increased the federal match for HCBS by 10 percentage points and required states to use the saved state funds to strengthen and improve HCBS. The state savings were deposited in the HCBS Improvement Fund and ARPA HCBS account of the HAS Fee
    - Of the total, the Department has budgeted $256 million to offset the cost of rate increases
    - For the non-rate related initiatives, the Department is developing sustainability plans and the request includes General Fund to continue a handful of the projects
- Primary Care and Behavioral Health Statewide Integration Grant Program -- The Department recently announced 81 grants totaling $29 million that will support integrated behavioral health services at 147 locations statewide.
- Rural Provider Stimulus Grant – The Department has awarded $10.6 million to 24 hospitals and medical centers. The smallest grants are $100,000 and the largest $650,000

RECOMMENDATION

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

DISCUSSION

During the 2020 special session, 2021, 2022, and 2023 legislative sessions, the General Assembly and Governor allocated $597.6 million in one-time funding to the Department of Health Care Policy and Financing. To assist the Committee in tracking the use of these funds, the table below shows the sum of allocations provided for FY 2020-21, FY 2021-22, FY 2022-23, and FY 2023-24 and expenditures through September 30, 2023. The focus of the table is on one-time stimulus funds where there were discretionary choices on how to use the money and it seems likely the JBC would want to track the funding because the Department has opportunities to spend the money over multiple years and/or there are deadlines by when the money must be spent. The Department received other one-time federal funds related to the pandemic that did not meet these criteria and are not included in the table. For example, the Department received an enhanced federal match of an additional 6.2 percentage points for Medicaid services that helped balance the budget but cannot reasonably be identified as the source for any specific discretionary projects.

Department of Health Care Policy and Financing One-time ARPA Funds			
Bill Number and Short Title	Appropriation/ Transfer of Funds	Spent or encumbered through 09/30/23	Brief Description of Program and Anticipated Use of the Funds
S.B. 21-286 HCBS Improvement and subsequent supplemental and Long Bill appropriations	$552,267,997	$351,630,000	Expand, and strengthen Home- and Community-Based Services (HCBS) for older adults and people with disabilities. ARPA temporarily increased the federal match for HCBS by 10 percentage points and required states to use the saved state funds to strengthen and improve HCBS. The state savings were deposited in the HCBS Improvement Fund and ARPA HCBS account of the HAS Fee, which are both subject to appropriation by the General Assembly. Most of the expenditures receive a federal match.
H.B. 22-1302 Primary Care Behavioral Health Integrations	34,750,000	1,444,523	$31.8M for the Primary Care and Behavioral Health Statewide Integration Grant Program and $3.0M to develop a universal contract for behavioral health services.
S.B. 22-200 Rural Provider Stimulus Grant	10,000,000	50,425	$4.8 million for grants for health-care affordability projects, $4.8 million for grants for health-care access projects, and up to $400,000 for administration.
S.B. 21-288 ARPA of 2021 Cash Fund	278,886	189,832	Increase immunizatons. HCPF received off budget funding from the Governor, per Section 24-75-226 (4)(a), C.R.S., for 2.0 FTE for research, analysis, and coordination of immunization efforts.
S.B. 21-137 Behavioral Health Recovery Act	250,000	250,000	Training in substance use screening, brief intervention, and referral to treatment (SBIRT)
S.B. 21-288 ARPA of 2021 Cash Fund	80,000	80,000	HCBS improvement planning. HCPF received off budget funding from the Governor, per Section 24-75-226 (4)(a), C.R.S., to kick start HR, accounting, and procurement related to the HCBS improvement plan authorizzed in S.B. 21-286.
TOTAL	**$597,626,883**	**$353,644,780**	

IMPLEMENTATION UPDATES AND ITEMS OF NOTE

SB 21-286 HCBS IMPROVEMENT

The American Rescue Plan Act (ARPA) provided an enhanced federal match of an additional 10 percentage points for Home- and Community-Based Services (HCBS) delivered from April 1, 2021, through March 31, 2022, and required that states use the saved state funds to enhance or expand HCBS.

Traditional 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. For purposes of the ARPA funds, federal guidance also included rehabilitative behavioral health services as part of HCBS.

Senate Bill 21-286 ensured that the saved state funds were deposited in the HCBS Improvement Fund and the ARPA Account of the HAS Fee. The bill required the Department to develop a spending plan

and submit quarterly updates[6] to the Joint Budget Committee. There are currently 63 initiatives the Department is spending the money on that are detailed in the quarterly reports. The moneys in the HCBS Improvement Fund and ARPA Account of the HAS Fee are subject to appropriation by the General Assembly and there have been several supplemental modifications to the appropriations.

The Department anticipates it will submit a supplemental in January to make additional modifications to the HCBS Improvement Fund appropriations. The Department says the focus of the supplemental will be on issues where the forecast of expenditures used for the appropriation is proving either higher or lower than the actual experience. In initial discussions, the Department suggested the supplemental would not include any changes in priorities or reallocations of funding because an initiative was failing to make progress. In subsequent conversations, the Department has said there might be some modifications around the edges and that the Department is still assessing and developing the proposed supplemental.

When the Department spends money from the HCBS Improvement Fund on eligible Medicaid activities, it can draw a federal match. The money is intended to encourage innovation and not all of the activities the Department is spending the money on are traditional Medicaid services that are eligible for a federal match.

Federal guidance extended the deadline for spending the money to March 31, 2025 from the original deadline of March 31, 2024. The Department indicates that most projects are adhering to the original deadline, but the leadership team is allowing some projects with substantial risks to underspending or not completing the project to extend the timeline for completion. The Department plans to conclude spending by December 31, 2024.

Of the $552 million in funds available, the Department has budgeted approximately $256 million for rate increases. The Department replaced some of those one-time funds with General Fund in FY 2023-24 and the Department has more annualizations to replace the HCBS Improvement Fund money with General Fund in the request for FY 20225-25. In R6 the Department proposes spending $13.3 million to partially offset the first year costs of the Wages for HCBS request.

For FY 2024-25, the Department is requesting on-going General Fund for a handful of non-rate initiatives that were originally launched with the HCBS Improvement Fund. In R7 the Department proposes General Fund for the Statewide Supportive Housing Expansion pilot program that received money from the HCBS Improvement Fund. In R9 the Department is requesting to continue the Centers for Excellence in Pain Management pilot program that was started with the HCBS Improvement Fund. In R11 the requests for HCBS systems support, the direct care workforce unit, and the Person-Centered Budget Algorithm are related to projects started with the HCBS Improvement Fund. Another part of R11 is a little similar but not quite the same. It is for a preventative care outreach analyst that would continue some work around vaccines that was started with federal State and Local Fiscal Recovery Funds, rather than the HCBS Improvement Fund, but the Department is also proposing new duties for the positon around general preventative care that go beyond what was originally financed with the federal funds.

The Department says it sought input from all project teams on what HCBS Improvement Fund initiatives might need ongoing resources. The teams needed to demonstrate that the initiatives were

[6] https://hcpf.colorado.gov/arpa

making sufficient progress in meeting their goals by the HCBS Improvement Fund expenditure deadline. In addition, they had to show how the outcomes of the initiative would be negatively affected if ongoing resources were not provided and that the impact of the initiative on the Department's broader goals and members was significant enough to warrant ongoing resources. The Department plans to complete first drafts of post project sustainability plans for all the initiatives in the next quarter. It is not clear to the JBC staff if the November 1 requests represent the sum of all the non-rate initiatives where the Department will request ongoing funding, or if more requests will come forward as the Department completes these sustainability plans.

H.B. 22-1302 PRIMARY CARE BEHAVIORAL HEALTH INTEGRATIONS

The bill:

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

The Department recently announced that it has awarded 81 grants totaling $29 million that will support integrated behavioral health services at 147 locations statewide.

The Department's ARPA Grant Incentives, Pilots, and Community Funding Opportunities has a description of the Healthcare Practice Transformation: Integrated Behavioral Health Grant Program and a list of the grantees can be found on the Department's Integrated Care website.

S.B. 22-200 RURAL PROVIDER STIMULUS GRANT

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

In FY 2023-24 the General Assembly appropriated an additional $1.0 million General Fund to supplement the federal funds provided for the grant program. Any money in the grant program's fund that is not expended or encumbered by July 1, 2024, reverts to the Economic Recovery and Relief Cash Fund.

Grants totaling $10.6 million have been awarded to 24 hospitals and medical centers. The smallest grants are $100,000 and the largest $650,000. The Department's Rural Provider Access and Affordability Stimulus Grant Program website has a list of the grantees.

The Department is required to provide an update on the grant program to the committees of reference at it's SMART Act hearing.

ISSUE: DENVER HEALTH (R15)

The Department asserts that Denver Health's financial structure is "unsustainable" and that immediate funding is needed. In R15 Denver Health the Department requests that the JBC sponsor legislation to authorize a one-time $5.0 million General Fund payment to Denver Health.

SUMMARY

- From March 2022 to June 2023, Denver Health saw a decline in cash on hand from 97 days to 81 days, compared to the Colorado median for urban hospitals of 245 days.
- The Department is already maximizing Medicaid payments to Denver Health and cannot draw additional matching funds through increased Medicaid payments.
- The Department did not request any commensurate increase in payments to rural critical access hospitals.

DISCUSSION

The Department requests that the JBC sponsor legislation authorizing a one-time payment of $5.0 million General Fund to Denver Health for uncompensated care costs. The JBC sponsored a similar bill last year, S.B. 2-138, that allowed payments in FY 2022-23 and FY 2023-24. The General Assembly provided $5.0 million General Fund in FY 2023-24 and $1.0 million in FY 2023-24.

The Department indicates that "the financial structure of Denver Health's operations are unsustainable" with negative operating profit margins in 2020, 2021, and 2022.

From March 2022 to June 2023, Denver Health saw a decline in cash on hand from 97 days to 81 days. This compares to the Colorado median for urban hospitals of 245 days. According to the Department, hospitals that receive top bond agency ratings typically have 210-240 days of cash on hand.

The one-time funds are intended to buy time for Denver Health while it implements structural changes to resolve the operating issues. The Department indicates that Denver Health's leadership is implementing several strategies to address the problem, including:

- Revenue improvement (billing processes etc.) via improvements in billing and collections for functions that suffered a bit under COVID-19 due to staffing challenges and turnover
- Negotiation of increased rates for commercial insurance contracts
- Cost reduction, including productivity management for labor (performance metrics and targets for every team) and various supply chain measures for non-labor cost
- Strategic growth for areas that provide a return on investment in order to utilize the net gains to offset losses on uninsured, governmental payers and other services

The Department says it would make the proposed payment to Denver Health contingent on the hospital agreeing to certain requirements that could include improving and modernizing information technology systems, improvements to the nurse advice line, and processing eligibility applications in a

timely manner. It is not clear if the Department proposes that these performance requirements would be written into the bill or delegated to the Department to determine.

The Department is constrained from increasing Medicaid payments to Denver Health by federal limits, and so this is a request for a General Fund-only payment outside of the Medicaid payment structure. The sum of Medicaid payments cannot exceed the inpatient and outpatient Upper Payment Limits. An increase in Medicaid payments to Denver Health would, necessarily, result in a reduction in Disproportionate Share Hospital (DSH) payments to Denver Health to stay within the hospital-specific federal limits, resulting in no net gain to Denver Health. There would be a reduction in HAS Fee charges to hospitals as more of the payments to Denver Health were financed with the General Fund, but those would be spread across all hospitals and only a small portion of the benefit would go to Denver Health. As a result, the Department believes that the most cost effective way to get money to Denver Health is through a General Fund payment outside of the Medicaid payment structure.

The Department provided the following information to justify the Department's claim that Denver Health's financial structure is "unsustainable" and to address whether the cause is inefficient management.

> HCPF is using a blend of financial measures and year-over-year trends to determine that, without significant structural changes to its business operations, Denver Health will continue deteriorating financially into failure. This is commonly referred to in business as a “death spiral”.
>
> The financial status of Denver Health has *not* fallen too far to impact solvency or short-term spending obligations, and there exists a period of time where organizational changes can be made to reverse course, increase profitability, stabilize liquidity, and put Denver Health on firmer financial footing, as detailed in responses to other questions below. The combination of increasing costs (which are affecting all hospitals) and degrading payer mix is likely the cause of Denver Health's reduction in operating margin to unsustainable levels. HCPF’s request to offer immediate funding and infusions help jump-start the process of organizational changes while enabling Denver Health to continue its critical community-serving and safety net functions for not just the Denver community, but other communities throughout the state.
>
> HCPF’s financial review is based on four primary financial measures: Payer mix, Liquidity, Profitability, and Solvency.
>
> Payer mix is the proportion of different types of payers a hospital has: Commercial insurance, Medicaid, Medicare, Self Pay, Uninsured, etc. Liquidity measures the ability of a business to meet its short-term expenses (things like payroll, supplies purchasing, etc). Profitability measures the ability of the business to create revenues and cover expenses. Solvency measures whether the organization generates enough resources to cover its near-term and long-term liabilities (things like replacing or upgrading equipment as it ages, repairing or renovating buildings, and paying off debt).

Denver Health as a Consolidated System demonstrates not just a below-normal and falling days cash on hand amount (liquidity measure), but also a deteriorating and now negative Operating Margin and Total Margin (profitability measures).[7] Denver Health Hospital's debt-to-asset ratio appears in the range of other Colorado hospitals (one of several solvency measures).[8] These three factors together indicate that Denver Health's decreasing profitability is a contributing factor in the decreasing short-term liquidity, and either further decreases or extended times of this reduction in cash generation would lead to short-term liquidity issues and long-term solvency failure.

We can also tell from our work that the reduction in Denver Health's profits may be driven by a recent increase in operating costs such as labor, inelastic commercial reimbursement rates, and a degrading payer mix. We can also determine what is *not* driving the reduction of profits for Denver Health, both sides of this analysis are supported by the information below.

1) We can determine the reduction is not caused by long-term growth of costs or cost inefficiency (through 2021), Denver Health Medical Center is comparable to other CO hospitals through 2021. While this finding is through 2021, recent economic trends have shown that costs, especially labor costs, have drastically increased in 2022 which is impacting all hospitals.[9] This increase in costs is eroding margins and a contributing factor to the shift in Denver Health's financial status changing from stable/profitable to unsustainable from 2021 to 2023. Commercial reimbursement (from insurance carriers) set by contracts may be inelastic and not yet renegotiated to reflect increased costs of care.
2) We can also determine that other non-hospital financial shifts are not a driving factor in profit reduction. While Denver Health has other non-Medical Center components, it is clear from Financial Statement breakouts that the reduction of profitability for Denver Health Medical Center is what is driving the reduction in profits for the business as a whole. We can also determine that it is operating margins that are being eroded, and it is *not* solely non-operating aspects such as investments driving these reductions.[10]
3) Denver Health's payer mix is slowly eroding commercial care and adding additional government payers to an already higher-than-normal amount.

[7] Days Cash on Hand and Profitability measures are from Financial Statements, both submitted to the Department and publicly available at www.EMMA.org, running into 2023.

[8] Debt to Assets for Colorado hospitals is drawn from Medicare Cost Report data through hospital fiscal year 2021. This finding was validated with Denver Health's consolidated financial statements, showing a Debt-to-asst ratio of 0.48 for 2022. Merritt research provides a benchmark of 0.43 when using hospital medians for assets and liabilities: https://www.merrittresearch.com/benchmark-central/hospital

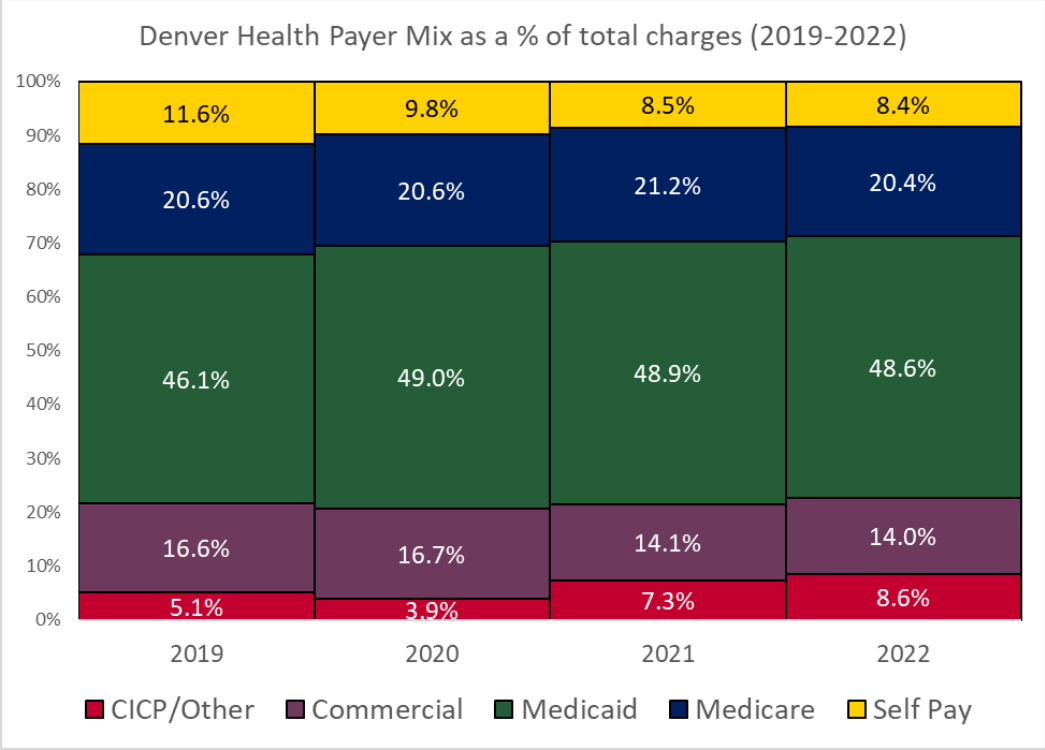
[9] Draft CHASE Annual Report includes additional information on labor expenses for hospitals.

[10] 2019/2018 financials page 120 and 121: https://emma.msrb.org/RE1353955-RE1039594-RE1461484.pdf 2022/2021 financials page 117 and 116: https://emma.msrb.org/P21697482-P21306072-P21737450.pdf

This leads to lower operating profits since commercial patients provide more revenue for services than government payers. Denver Health provides services for low-income and uninsured patients from a broad range of areas throughout the state, not just the Denver area, and other hospitals should be encouraged to "shoulder their weight" with providing care to low-income individuals in their area.

In addition to providing funding for Denver Health last year, the General Assembly supplemented the money federal funds for the Rural Provider Stimulus Grants with $1.0 million General Fund. These grants go primarily to rural hospitals. The two initiatives were not explicitly linked in any way, but they might have been linked politically for some legislators. The Department did not request legislation to authorize additional payments to the Rural Provider Stimulus Grants (legislation would be required, since any money in the fund that is not expended or encumbered by July 1, 2024, reverts to the Economic Recovery and Relief Cash Fund). The Department's explanation for why is provided below.

Denver Health is the state's largest safety net hospital serving a higher proportion of Medicaid and uninsured patients than other hospitals. More than 65% of Denver Health's patients are covered by Medicaid or are uninsured (CICP, self pay), with 20% covered by Medicare and 14% covered by commercial insurance. For Colorado hospitals overall, about 30% are Medicaid or uninsured, 22% are covered by Medicare, and more than 30% are covered by commercial insurance.



The state's Critical Access Hospitals (CAHs) have access to resources which Denver Health does not. Medicare is the largest payer group from CAHs at about

40% of their patients. Medicare reimburses CAHs at 101% of costs verses about 72% of costs for other hospitals like Denver Health. About 18% of CAH patients are covered by Medicaid and about 31% are covered by Medicare.[11, 12]

In addition, the state has dedicated resources to lower resourced rural hospitals, including $10.6 million in access and affordability grants via Senate Bill 22-200 ($1M of which was added in the FY 2023-24 Long Bill) and $12 million per year for each of 5 years under the Hospital Transformation Program Rural Support Fund. As noted above, like Denver Health, CAHs are reimbursed through the HAS fee up to their hospital-specific DSH limits.

[11] In 2022 in aggregate the state's payer mix was: CICP/Other at 5.5%, commercial payers at 30.2%, Medicaid at 21.5%, Medicare at 39.8%, and Self Pay at 3.0%.

[12] From hospital reported data to the Department, Draft status. CICP/Other includes Champus/Tricare as well.

APPENDIX A
NUMBERS PAGES

Appendix A details actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. This information is listed by line item and fund source.

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
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	51,242,435	62,060,344	68,472,030	69,896,451	*
FTE	600.5	704.7	741.4	754.8	
General Fund	16,861,340	21,628,822	25,204,598	26,759,754	
Cash Funds	4,699,898	5,859,142	7,546,836	6,306,168	
Reappropriated Funds	1,772,301	1,388,133	2,674,462	3,157,365	
Federal Funds	27,908,896	33,184,247	33,046,134	33,673,164	
Health, Life, and Dental	7,071,991	9,139,400	10,436,584	12,876,641	*
General Fund	2,642,297	3,552,746	4,144,398	5,431,601	
Cash Funds	660,834	796,123	753,615	849,992	
Reappropriated Funds	166,554	229,292	221,797	275,782	
Federal Funds	3,602,306	4,561,239	5,316,774	6,319,266	
Short-term Disability	104,617	93,895	98,551	120,729	*
General Fund	50,803	35,944	38,706	51,187	
Cash Funds	10,843	7,760	7,097	6,907	
Reappropriated Funds	3,300	2,119	1,911	2,302	
Federal Funds	39,671	48,072	50,837	60,333	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Paid Family and Medical Leave Insurance	0	0	0	370,096	*
General Fund	0	0	0	156,866	
Cash Funds	0	0	0	27,160	
Reappropriated Funds	0	0	0	1,101	
Federal Funds	0	0	0	184,969	
S.B. 04-257 Amortization Equalization Disbursement	2,428,087	2,935,436	3,290,125	4,024,566	*
General Fund	924,349	1,123,363	1,292,773	1,705,257	
Cash Funds	211,103	243,684	237,090	232,848	
Reappropriated Funds	52,920	66,241	62,817	75,048	
Federal Funds	1,239,715	1,502,148	1,697,445	2,011,413	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	2,428,087	2,935,437	3,290,125	4,024,565	*
General Fund	924,349	1,123,363	1,292,773	1,705,257	
Cash Funds	211,103	243,684	237,090	232,849	
Reappropriated Funds	52,920	66,241	62,817	75,048	
Federal Funds	1,239,715	1,502,149	1,697,445	2,011,411	
Salary Survey	1,273,930	1,739,584	3,665,128	3,569,073	
General Fund	474,954	701,453	1,410,419	1,527,117	
Cash Funds	98,663	117,370	269,626	254,689	
Reappropriated Funds	29,439	32,730	53,934	0	
Federal Funds	670,874	888,031	1,931,149	1,787,267	

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
PERA Direct Distribution	1,077,010	667,352	187,621	1,459,499	
General Fund	430,205	0	73,824	620,495	
Cash Funds	83,411	74,345	13,754	105,849	
Reappropriated Funds	24,889	21,079	2,869	2,869	
Federal Funds	538,505	571,928	97,174	730,286	
Temporary Employees Related to Authorized Leave	0	0	5,978	5,978	
General Fund	0	0	2,411	2,411	
Cash Funds	0	0	403	403	
Reappropriated Funds	0	0	112	112	
Federal Funds	0	0	3,052	3,052	
Worker's Compensation	160,590	194,996	184,274	262,815	
General Fund	64,817	74,668	67,923	99,543	
Cash Funds	14,502	16,333	20,123	26,658	
Reappropriated Funds	976	6,497	7,224	9,117	
Federal Funds	80,295	97,498	89,004	127,497	
Operating Expenses	2,528,896	3,091,508	3,703,098	3,107,076	*
General Fund	1,209,995	1,398,738	1,424,388	1,278,465	
Cash Funds	233,675	339,880	461,677	259,380	
Reappropriated Funds	13,297	59,204	40,724	60,363	
Federal Funds	1,071,929	1,293,686	1,776,309	1,508,868	
Legal Services	1,172,759	956,323	1,814,684	2,660,697	
General Fund	384,389	371,762	669,628	1,001,613	
Cash Funds	206,798	92,356	198,037	292,906	
Reappropriated Funds	0	21,289	71,089	71,089	
Federal Funds	581,572	470,916	875,930	1,295,089	

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Administrative Law Judge Services	807,180	890,066	544,650	876,047	
General Fund	330,731	249,650	200,760	334,180	
Cash Funds	70,687	77,698	59,475	87,048	
Reappropriated Funds	2,172	117,685	21,350	29,336	
Federal Funds	403,590	445,033	263,065	425,483	
Payment to Risk Management and Property Funds	173,686	383,340	252,280	159,111	
General Fund	68,525	126,297	92,991	55,481	
Cash Funds	16,390	45,201	27,549	19,797	
Reappropriated Funds	1,928	20,172	9,889	7,644	
Federal Funds	86,843	191,670	121,851	76,189	
Leased Space	1,363,822	2,339,116	3,925,908	3,759,127	*
General Fund	443,581	871,723	1,477,587	1,486,442	
Cash Funds	238,330	265,993	448,474	353,698	
Reappropriated Funds	0	31,842	38,849	38,849	
Federal Funds	681,911	1,169,558	1,960,998	1,880,138	
Payments to OIT	5,765,418	6,481,886	11,702,619	14,276,583	
General Fund	1,971,816	2,306,188	4,624,921	5,645,755	
Cash Funds	910,893	917,510	1,192,403	1,455,720	
Reappropriated Funds	0	16,751	41,739	41,739	
Federal Funds	2,882,709	3,241,437	5,843,556	7,133,369	
IT Accessibility	0	0	2,933,182	0	
General Fund	0	0	1,145,158	0	
Cash Funds	0	0	297,857	0	
Reappropriated Funds	0	0	5,431	0	
Federal Funds	0	0	1,484,736	0	

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
CORE Operations	112,780	168,766	134,190	54,478	*
General Fund	56,303	65,526	49,463	17,354	
Cash Funds	5,835	15,046	14,653	7,934	
Reappropriated Funds	0	6,740	5,261	3,379	
Federal Funds	50,642	81,454	64,813	25,811	
General Professional Services and Special Projects	15,288,124	24,920,490	62,877,160	34,972,095	*
General Fund	3,837,133	5,695,511	13,811,567	12,961,778	
Cash Funds	2,892,967	6,848,472	16,155,462	2,643,155	
Reappropriated Funds	69,000	60,500	81,000	81,000	
Federal Funds	8,489,024	12,316,007	32,829,131	19,286,162	
DPA Administrative Services	0	0	0	83,322	*
General Fund	0	0	0	33,329	
Cash Funds	0	0	0	5,831	
Reappropriated Funds	0	0	0	2,500	
Federal Funds	0	0	0	41,662	
Division of Human Resources State Agency Services	0	0	0	126,390	*
General Fund	0	0	0	50,556	
Cash Funds	0	0	0	8,845	
Reappropriated Funds	0	0	0	3,793	
Federal Funds	0	0	0	63,196	
Division of Human Resources Training Services	0	0	0	25,477	*
General Fund	0	0	0	10,191	
Cash Funds	0	0	0	1,783	
Reappropriated Funds	0	0	0	764	
Federal Funds	0	0	0	12,739	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Division of Human Resources Labor Relations Services	0	0	0	181,872	*
General Fund	0	0	0	72,749	
Cash Funds	0	0	0	12,730	
Reappropriated Funds	0	0	0	5,456	
Federal Funds	0	0	0	90,937	
Financial Ops and Reporting Services	0	0	0	101,119	*
General Fund	0	0	0	40,447	
Cash Funds	0	0	0	7,079	
Reappropriated Funds	0	0	0	3,034	
Federal Funds	0	0	0	50,559	
Procurement and Contracts Services	0	0	0	62,627	*
General Fund	0	0	0	25,050	
Cash Funds	0	0	0	4,385	
Reappropriated Funds	0	0	0	1,880	
Federal Funds	0	0	0	31,312	
Capitol Complex Leased Space	651,086	625,497	0	0	
General Fund	266,637	275,727	0	0	
Cash Funds	57,078	48,468	0	0	
Reappropriated Funds	1,828	588	0	0	
Federal Funds	325,543	300,714	0	0	
Universal Contract for Behavioral Health Services	0	1,019,520	0	0	
General Fund	0	0	0	0	
Cash Funds	0	1,019,520	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Statewide training	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Merit Pay	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (A) General Administration	93,650,498	120,642,956	177,518,187	157,056,434	(11.5%)
FTE	600.5	704.7	741.4	754.8	1.8%
General Fund	30,942,224	39,601,481	57,024,288	61,072,878	7.1%
Cash Funds	10,623,010	17,028,585	27,941,221	13,203,814	(52.7%)
Reappropriated Funds	2,191,524	2,147,103	3,403,275	3,949,570	16.1%
Federal Funds	49,893,740	61,865,787	89,149,403	78,830,172	(11.6%)
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	182,668	186,850	202,194	202,194	
General Fund	91,334	93,425	101,097	101,097	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	91,334	93,425	101,097	101,097	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Early Intervention, Early Childhood	0	4,003,824	9,457,463	9,940,111	*
General Fund	0	1,769,044	4,634,158	4,970,056	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	2,234,780	4,823,305	4,970,055	
Nurse Home Visitor Program, Early Childhood	193,475	268,101	3,010,000	3,010,000	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	73,254	111,259	1,505,000	1,505,000	
Federal Funds	120,221	156,842	1,505,000	1,505,000	
Host Home Regulation, Local Affairs	89,070	95,760	136,096	317,431	*
General Fund	44,535	47,880	68,048	158,716	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	44,535	47,880	68,048	158,715	
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	296,990	208,808	313,881	313,881	
General Fund	148,495	104,404	156,941	156,941	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	148,495	104,404	156,940	156,940	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Facility Survey and Certification, Public Health and Environment	7,065,278	7,073,798	8,477,125	8,477,125	
General Fund	2,445,321	2,484,420	3,153,491	3,153,491	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,619,957	4,589,378	5,323,634	5,323,634	
Prenatal Statistical Information, Public Health and Environment	5,888	5,888	5,887	5,887	
General Fund	2,944	2,944	2,944	2,944	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,944	2,944	2,943	2,943	
Nurse Aide Certification, Regulatory Agencies	324,041	324,040	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,652	14,651	14,652	14,652	
Federal Funds	162,020	162,020	162,020	162,020	
Reviews, Regulatory Agencies	0	0	3,750	3,750	
General Fund	0	0	1,875	1,875	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	1,875	1,875	
Hospital Tax Exemptions, Revenue	0	0	100,000	100,000	
Cash Funds	0	0	50,000	50,000	
Federal Funds	0	0	50,000	50,000	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Local Public Health Agencies, Public Health and Environment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Hospital Tax Exemptions, Revenue	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Regulation of Medicaid Transportation Providers, Regulatory Agencies	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (B) Transfers to Other Departments	8,157,410	12,167,069	22,030,437	22,694,420	3.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,879,998	4,649,486	8,265,923	8,692,489	5.2%
Cash Funds	0	0	50,000	50,000	0.0%
Reappropriated Funds	87,906	125,910	1,519,652	1,519,652	0.0%
Federal Funds	5,189,506	7,391,673	12,194,862	12,432,279	1.9%

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	10,393,942	7,767,294	114,169,537	104,310,431	*
General Fund	0	16,340	16,757,266	17,766,424	
Cash Funds	1,135,444	1,495,618	11,042,019	9,361,274	
Reappropriated Funds	0	0	12,204	12,204	
Federal Funds	9,258,498	6,255,336	86,358,048	77,170,529	
Colorado Benefits Management Systems, Operating and Contract Expenses	41,290,899	52,741,144	56,067,055	62,736,377	*
General Fund	5,741,240	9,741,310	11,608,377	12,685,004	
Cash Funds	4,784,644	6,364,853	6,470,009	6,879,558	
Reappropriated Funds	147	1,556	1,657	1,122,632	
Federal Funds	30,764,868	36,633,425	37,987,012	42,049,183	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	1,893,968	1,635,740	2,142,862	2,172,998	
General Fund	608,896	528,326	679,389	689,160	
Cash Funds	328,882	283,227	377,956	383,151	
Reappropriated Funds	6	19	73	73	
Federal Funds	956,184	824,168	1,085,444	1,100,614	
Office of eHealth Innovations Operations	4,385,240	5,096,812	6,465,845	6,465,845	
FTE	0.0	0.0	3.0	3.0	
General Fund	2,296,332	2,621,444	3,372,367	3,372,367	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,088,908	2,475,368	3,093,478	3,093,478	

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
All-Payer Claims Database	4,733,994	7,406,357	5,562,903	5,435,778	
General Fund	2,962,231	4,254,769	4,598,136	4,471,011	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,771,763	3,151,588	964,767	964,767	
Health Information Exchange Maintenance and Projects	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State Innovation Model Operations	0	0	0	0	
FTE	0.0	0.0	0.0	0.0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Connect for Health Colorado Systems	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
SUBTOTAL - (C) Information Technology Contracts and Projects	62,698,043	74,647,347	184,408,202	181,121,429	(1.8%)
FTE	0.0	0.0	3.0	3.0	0.0%
General Fund	11,608,699	17,162,189	37,015,535	38,983,966	5.3%
Cash Funds	6,248,970	8,143,698	17,889,984	16,623,983	(7.1%)
Reappropriated Funds	153	1,575	13,934	1,134,909	8044.9%
Federal Funds	44,840,221	49,339,885	129,488,749	124,378,571	(3.9%)
(D) Eligibility Determinations and Client Services					
Contracts for Special Eligibility Determinations	0	2,839,066	12,039,555	12,039,555	
General Fund	0	718,427	1,129,071	1,129,071	
Cash Funds	0	459,509	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	1,661,130	6,567,016	6,567,016	
County Administration	79,214,462	102,184,661	132,209,721	112,703,966	*
General Fund	14,337,301	19,193,620	22,999,538	18,626,996	
Cash Funds	14,734,326	25,643,473	26,966,487	25,778,391	
Reappropriated Funds	0	0	0	0	
Federal Funds	50,142,835	57,347,568	82,243,696	68,298,579	
Medical Assistance Sites	825,542	805,753	1,531,968	1,531,968	
General Fund	0	0	0	0	
Cash Funds	402,419	402,984	402,984	402,984	
Reappropriated Funds	0	0	0	0	
Federal Funds	423,123	402,769	1,128,984	1,128,984	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Administrative Case Management	1,752,340	2,603,944	869,744	869,744	
General Fund	876,170	1,301,972	434,872	434,872	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	876,170	1,301,972	434,872	434,872	
Customer Outreach	2,623,526	2,596,573	3,461,519	3,461,519	
General Fund	992,812	979,335	1,394,139	1,394,139	
Cash Funds	318,951	318,951	336,621	336,621	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,311,763	1,298,287	1,730,759	1,730,759	
Centralized Eligibility Vendor Contract Project	6,731,692	6,777,665	6,122,400	7,959,455	*
General Fund	0	0	0	0	
Cash Funds	2,347,766	2,279,719	2,279,719	2,753,409	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,383,926	4,497,946	3,842,681	5,206,046	
Connect for Health Colorado Eligibility Determination	10,220,546	8,680,778	10,642,710	11,174,846	
General Fund	0	0	0	0	
Cash Funds	5,343,099	4,504,089	4,757,291	4,995,156	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,877,447	4,176,689	5,885,419	6,179,690	
Eligibility Overflow Processing Center	740,475	1,542,528	1,904,677	1,904,677	
General Fund	110,923	208,691	285,320	285,320	
Cash Funds	74,196	176,941	190,849	190,849	
Reappropriated Funds	0	0	0	0	
Federal Funds	555,356	1,156,896	1,428,508	1,428,508	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Returned Mail Processing	1,337,726	1,936,317	3,298,808	3,298,808	
General Fund	418,000	598,008	985,808	985,808	
Cash Funds	100,758	138,267	244,919	244,919	
Reappropriated Funds	31,303	44,751	111,942	111,942	
Federal Funds	787,665	1,155,291	1,956,139	1,956,139	
Work Number Verification	1,500,105	1,896,699	3,305,114	11,341,713	*
General Fund	502,685	635,584	1,089,815	1,741,440	
Cash Funds	247,367	312,766	545,013	1,093,988	
Reappropriated Funds	0	0	0	0	
Federal Funds	750,053	948,349	1,670,286	8,506,285	
Medical Identification Cards	1,650,386	0	0	0	
General Fund	481,831	0	0	0	
Cash Funds	343,362	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	825,193	0	0	0	
SUBTOTAL - (D) Eligibility Determinations and Client Services	106,596,800	131,863,984	175,386,216	166,286,251	(5.2%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	17,719,722	23,635,637	28,318,563	24,597,646	(13.1%)
Cash Funds	23,912,244	34,236,699	40,067,351	40,139,785	0.2%
Reappropriated Funds	31,303	44,751	111,942	111,942	0.0%
Federal Funds	64,933,531	73,946,897	106,888,360	101,436,878	(5.1%)

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	19,970,962	15,350,105	27,236,877	29,244,825 *	
General Fund	6,803,020	6,750,711	7,301,755	7,786,405	
Cash Funds	995,697	1,292,227	2,112,987	2,147,661	
Reappropriated Funds	0	0	0	0	
Federal Funds	12,172,245	7,307,167	17,822,135	19,310,759	
SUBTOTAL - (E) Utilization and Quality Review Contracts	19,970,962	15,350,105	27,236,877	29,244,825	7.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	6,803,020	6,750,711	7,301,755	7,786,405	6.6%
Cash Funds	995,697	1,292,227	2,112,987	2,147,661	1.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	12,172,245	7,307,167	17,822,135	19,310,759	8.4%
(F) Provider Audits and Services					
Professional Audit Contracts	3,507,957	3,151,518	4,281,019	4,135,919	
General Fund	1,524,776	1,418,458	1,645,679	1,598,629	
Cash Funds	346,850	157,301	565,801	540,301	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,636,331	1,575,759	2,069,539	1,996,989	
SUBTOTAL - (F) Provider Audits and Services	3,507,957	3,151,518	4,281,019	4,135,919	(3.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,524,776	1,418,458	1,645,679	1,598,629	(2.9%)
Cash Funds	346,850	157,301	565,801	540,301	(4.5%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,636,331	1,575,759	2,069,539	1,996,989	(3.5%)

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	749,055	961,962	1,165,841	1,165,841	
General Fund	0	0	0	0	
Cash Funds	374,527	480,981	582,920	582,920	
Reappropriated Funds	0	0	0	0	
Federal Funds	374,528	480,981	582,921	582,921	
Third-Party Liability Cost Avoidance Contract	4,622,500	2,279,120	8,417,842	8,838,738	
General Fund	1,465,509	763,341	2,777,888	2,916,784	
Cash Funds	845,741	376,219	1,431,033	1,502,585	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,311,250	1,139,560	4,208,921	4,419,369	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	5,371,555	3,241,082	9,583,683	10,004,579	4.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,465,509	763,341	2,777,888	2,916,784	5.0%
Cash Funds	1,220,268	857,200	2,013,953	2,085,505	3.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	2,685,778	1,620,541	4,791,842	5,002,290	4.4%
(H) Indirect Cost Assessment					
Indirect Cost Assessment	1,143,073	1,054,856	922,619	1,055,716	
General Fund	0	0	0	0	
Cash Funds	132,859	112,605	198,368	273,818	
Reappropriated Funds	106,490	90,368	107,638	131,273	
Federal Funds	903,724	851,883	616,613	650,625	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
SUBTOTAL - (H) Indirect Cost Assessment	1,143,073	1,054,856	922,619	1,055,716	14.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	132,859	112,605	198,368	273,818	38.0%
Reappropriated Funds	106,490	90,368	107,638	131,273	22.0%
Federal Funds	903,724	851,883	616,613	650,625	5.5%
TOTAL - (1) Executive Director's Office	301,096,298	362,118,917	601,367,240	571,599,573	(4.9%)
FTE	600.5	704.7	744.4	757.8	1.8%
General Fund	72,943,948	93,981,303	142,349,631	145,648,797	2.3%
Cash Funds	43,479,898	61,828,315	90,839,665	75,064,867	(17.4%)
Reappropriated Funds	2,417,376	2,409,707	5,156,441	6,847,346	32.8%
Federal Funds	182,255,076	203,899,592	363,021,503	344,038,563	(5.2%)

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	9,756,293,144	10,921,010,282	11,506,136,779	12,327,679,826 *	
General Fund	2,179,055,708	2,630,296,339	2,034,930,085	2,367,886,137	
General Fund Exempt	0	0	1,181,193,165	1,181,193,165	
Cash Funds	1,087,673,430	1,294,227,032	1,248,504,293	1,371,044,499	
Reappropriated Funds	82,610,308	90,000,798	99,768,813	114,867,290	
Federal Funds	6,406,953,698	6,906,486,113	6,941,740,423	7,292,688,735	
TOTAL - (2) Medical Services Premiums	9,756,293,144	10,921,010,282	11,506,136,779	12,327,679,826	7.1%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,179,055,708	2,630,296,339	2,034,930,085	2,367,886,137	16.4%
General Fund Exempt	0	0	1,181,193,165	1,181,193,165	0.0%
Cash Funds	1,087,673,430	1,294,227,032	1,248,504,293	1,371,044,499	9.8%
Reappropriated Funds	82,610,308	90,000,798	99,768,813	114,867,290	15.1%
Federal Funds	6,406,953,698	6,906,486,113	6,941,740,423	7,292,688,735	5.1%

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
Healthcare Affordability and Sustainability Cash Fund.					
Behavioral Health Capitation Payments	852,041,516	1,073,070,076	1,207,509,714	1,187,271,197 *	
General Fund	0	215,820,743	282,270,782	289,844,351	
Cash Funds	63,158,906	92,271,268	90,368,457	91,168,440	
Reappropriated Funds	0	0	0	0	
Federal Funds	788,882,610	764,978,065	834,870,475	806,258,406	
Behavioral Health Fee-for-service Payments	12,592,071	8,929,133	10,973,366	12,510,241 *	
General Fund	2,280,953	1,692,019	2,431,933	3,005,954	
Cash Funds	871,824	558,233	661,577	742,124	
Reappropriated Funds	0	0	0	0	
Federal Funds	9,439,294	6,678,881	7,879,856	8,762,163	
TOTAL - (3) Behavioral Health Community Programs	864,633,587	1,081,999,209	1,218,483,080	1,199,781,438	(1.5%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,280,953	217,512,762	284,702,715	292,850,305	2.9%
Cash Funds	64,030,730	92,829,501	91,030,034	91,910,564	1.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	798,321,904	771,656,946	842,750,331	815,020,569	(3.3%)

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	3,129,269	3,254,836	3,469,613	3,469,613	
FTE	29.1	33.7	39.5	39.5	
General Fund	1,307,493	1,643,703	1,858,480	1,858,480	
Cash Funds	210,643	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,611,133	1,611,133	1,611,133	1,611,133	
Operating Expenses	72,072	70,769	431,510	356,510	
General Fund	36,038	35,384	239,636	202,136	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	36,034	35,385	191,874	154,374	
Community and Contract Management System	62,840	62,528	137,480	137,480	
General Fund	31,420	31,264	89,362	89,362	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	31,420	31,264	48,118	48,118	
Support Level Administration	51,404	59,317	58,350	58,350	
General Fund	25,702	29,403	28,920	28,920	
Cash Funds	0	255	255	255	
Reappropriated Funds	0	0	0	0	
Federal Funds	25,702	29,659	29,175	29,175	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Cross-System Response Pilot Program Services	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	3,315,585	3,447,450	4,096,953	4,021,953	(1.8%)
FTE	29.1	33.7	39.5	39.5	0.0%
General Fund	1,400,653	1,739,754	2,216,398	2,178,898	(1.7%)
Cash Funds	210,643	255	255	255	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,704,289	1,707,441	1,880,300	1,842,800	(2.0%)
Medicaid Programs					
Adult Comprehensive Waiver Services	593,246,267 0.0	660,264,798 0.0	771,570,563	840,396,437	*
General Fund	188,425,770	274,738,522	368,919,010	418,837,312	
Cash Funds	31,135,458	15,581,089	9,151,410	1,360,909	
Reappropriated Funds	0	0	0	0	
Federal Funds	373,685,039	369,945,187	393,500,143	420,198,216	
Adult Supported Living Waiver Services	68,257,740	76,193,493	93,765,842	101,049,045	*
General Fund	19,279,569	25,140,173	38,926,121	42,200,264	
Cash Funds	5,981,477	7,593,201	7,024,708	8,324,262	
Reappropriated Funds	0	0	0	0	
Federal Funds	42,996,694	43,460,119	47,815,013	50,524,519	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Children's Extensive Support Services	37,846,959	51,164,467	62,870,839	72,882,421	*
General Fund	13,413,358	22,227,459	29,190,545	35,615,090	
Cash Funds	623,899	0	1,649,152	826,122	
Reappropriated Funds	0	0	0	0	
Federal Funds	23,809,702	28,937,008	32,031,142	36,441,209	
Children's Habilitation Residential Program	9,153,153	11,513,849	14,689,243	16,746,315	*
General Fund	3,335,090	5,074,425	7,068,174	8,306,455	
Cash Funds	5,089	6,829	132,200	66,702	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,812,974	6,432,595	7,488,869	8,373,158	
Case Management for People with IDD	80,740,234	88,501,594	115,903,041	137,834,693	*
General Fund	36,766,240	40,634,931	52,206,300	68,033,327	
Cash Funds	762,621	2,266,858	6,064,491	1,540,922	
Reappropriated Funds	0	0	0	0	
Federal Funds	43,211,373	45,599,805	57,632,250	68,260,444	
Home and Community Based Services for People with Intellectual and Developmental Disabilities	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Eligibility Determination and Waiting List Management	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Case Management Services	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	789,244,353	887,638,201	1,058,799,528	1,168,908,911	10.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	261,220,027	367,815,510	496,310,150	572,992,448	15.5%
Cash Funds	38,508,544	25,447,977	24,021,961	12,118,917	(49.6%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	489,515,782	494,374,714	538,467,417	583,797,546	8.4%
State-only Programs					
Family Support Services Program	9,818,346	10,311,298	11,048,853	11,150,134 *	
General Fund	9,373,496	10,311,298	11,048,853	11,150,134	
Cash Funds	444,850	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
State Supported Living Services	4,898,139	4,724,417	5,193,524	5,241,131	*
General Fund	4,898,139	4,724,417	5,193,524	5,241,131	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State Supported Living Services Case Management	4,494,161	4,682,356	5,061,041	5,107,434	*
General Fund	4,494,161	4,682,356	5,061,041	5,107,434	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Preventive Dental Hygiene	64,894	64,894	69,823	70,463	*
General Fund	64,894	64,894	69,823	70,463	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Supported Employment Provider and Certification Reimbursement	148,800	148,800	303,158	0	
General Fund	148,800	148,800	303,158	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Eligibility Determination and Waiting List Management	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Supported Employment Pilot Program	415,969	0	0	0	
General Fund	415,969	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State-only Programs for People with Intellectual and Developmental Disabilities	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	19,840,309	19,931,765	21,676,399	21,569,162	(0.5%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	19,395,459	19,931,765	21,676,399	21,569,162	(0.5%)
Cash Funds	444,850	0	0	0	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	0	0	0	0	0.0%

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
TOTAL - (4) Office of Community Living	812,400,247	911,017,416	1,084,572,880	1,194,500,026	10.1%
FTE	29.1	33.7	39.5	39.5	0.0%
General Fund	282,016,139	389,487,029	520,202,947	596,740,508	14.7%
Cash Funds	39,164,037	25,448,232	24,022,216	12,119,172	(49.6%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	491,220,071	496,082,155	540,347,717	585,640,346	8.4%

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	254,743,330	259,498,036	226,610,307	226,610,308	
General Fund	0	0	0	0	
Cash Funds	110,819,422	122,721,974	111,039,051	113,305,154	
Reappropriated Funds	0	0	0	0	
Federal Funds	143,923,908	136,776,062	115,571,256	113,305,154	
Pediatric Specialty Hospital	10,764,010	10,764,010	10,764,010	10,764,010	
General Fund	4,714,636	4,746,928	5,274,365	5,382,005	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,049,374	6,017,082	5,489,645	5,382,005	
Appropriation from Tobacco Tax Fund to the General Fund	364,131	339,124	305,324	305,324	
General Fund	0	0	0	0	
Cash Funds	364,131	339,124	305,324	305,324	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Primary Care Fund	51,647,973	47,449,654	59,118,641	45,830,960	*
General Fund	0	0	7,000,000	556,902	
Cash Funds	22,755,511	21,438,852	22,494,290	22,494,290	
Reappropriated Funds	0	0	0	0	
Federal Funds	28,892,462	26,010,802	29,624,351	22,779,768	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request		Request vs. Appropriation
Children's Basic Health Plan Administration	2,336,020	1,403,394	3,864,405	3,864,405	*	
General Fund	0	0	0	0		
Cash Funds	716,224	432,716	1,325,491	1,352,542		
Reappropriated Funds	0	0	0	0		
Federal Funds	1,619,796	970,678	2,538,914	2,511,863		
Children's Basic Health Plan Medical and Dental Costs	133,119,234	118,283,242	175,334,025	227,274,951	*	
General Fund	11,045,841	381,798	19,291,864	40,374,162		
General Fund Exempt	0	0	305,324	305,324		
Cash Funds	30,065,351	36,255,947	40,607,383	38,931,747		
Reappropriated Funds	0	0	0	0		
Federal Funds	92,008,042	81,645,497	115,129,454	147,663,718		
Clinic Based Indigent Care	0	0	0	0		
General Fund	0	0	0	0		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	0	0	0	0		
TOTAL - (4) Indigent Care Program	452,974,698	437,737,460	475,996,712	514,649,958		8.1%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	15,760,477	5,128,726	31,566,229	46,313,069		46.7%
General Fund Exempt	0	0	305,324	305,324		0.0%
Cash Funds	164,720,639	181,188,613	175,771,539	176,389,057		0.4%
Reappropriated Funds	0	0	0	0		0.0%
Federal Funds	272,493,582	251,420,121	268,353,620	291,642,508		8.7%

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	26,085	41,155	10,000,000	10,000,000	
General Fund	0	0	0	0	
Cash Funds	26,085	41,155	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Senior Dental Program	3,989,494	3,972,404	3,990,358	3,990,358	
General Fund	3,962,510	3,962,510	3,962,510	3,962,510	
Cash Funds	26,984	9,894	27,848	27,848	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	9,400,725	9,513,898	9,490,170	9,490,170	
General Fund	3,920,417	3,997,108	4,429,684	4,520,085	
Cash Funds	0	0	0	0	
Reappropriated Funds	197,100	198,450	220,500	225,000	
Federal Funds	5,283,208	5,318,340	4,839,986	4,745,085	
Medicare Modernization Act State Contribution Payment	213,480,167	216,337,023	257,069,930	254,045,148	*
General Fund	213,480,167	216,337,023	257,069,930	254,045,148	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Public School Health Services Contract Administration	845,196	915,650	2,000,000	2,000,000	
General Fund	422,598	457,825	1,000,000	1,000,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	422,598	457,825	1,000,000	1,000,000	
Public School Health Services	131,544,830	152,899,688	161,383,372	161,383,372	
General Fund	0	0	0	0	
Cash Funds	58,592,464	68,247,434	78,719,855	78,719,855	
Reappropriated Funds	0	0	0	0	
Federal Funds	72,952,366	84,652,254	82,663,517	82,663,517	
Rural Provider Access and Affordability Fund, Created in Section 25.5-1-207 (6)(a), C.R.S.	0	0	1,000,000	0	
General Fund	0	0	1,000,000	0	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	750,000	1,500,000	1,500,000	1,500,000	
General Fund	0	0	0	0	
Cash Funds	750,000	1,500,000	1,500,000	1,500,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Reproductive Health Care for Individuals Not Eligible for Medicaid	0	242,952	3,614,490	3,614,490	
General Fund	0	242,952	3,614,490	3,614,490	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
ARPA HCBS State-only Funds	0	8,758,574	46,817,018 4.0	433,996 0.0	
General Fund	0	0	0	0	
Cash Funds	0	8,758,574	46,817,018	433,996	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Denver Health and Hospital Authority	0	5,000,000	1,000,000	5,000,000	*
General Fund	0	5,000,000	1,000,000	5,000,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Doula Scholarship Program	0	0	100,000	0	
General Fund	0	0	100,000	0	
Health Benefits for Colorado Children and Pregnant Persons	0	0	0	2,102,665	
General Fund	0	0	0	2,102,665	
Urban Indian Health Organizations State Only Payments	70,825	48,025	0	0	
General Fund	70,825	48,025	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
Primary Care and Behavioral Health Statewide Integration Grant Program	0	127,944	0 0.0	0	
General Fund	0	0	0	0	
Cash Funds	0	127,944	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State University Teaching Hospitals Denver Health and Hospital Authority	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
State University Teaching Hospitals University of Colorado Hospital	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
TOTAL - (5) Other Medical Services	360,107,322	399,357,313	497,965,338	453,560,199	(8.9%)
FTE	0.0	0.0	4.0	0.0	(100.0%)
General Fund	221,856,517	230,045,443	272,176,614	274,244,898	0.8%
Cash Funds	59,395,533	78,685,001	137,064,721	90,681,699	(33.8%)
Reappropriated Funds	197,100	198,450	220,500	225,000	2.0%
Federal Funds	78,658,172	90,428,419	88,503,503	88,408,602	(0.1%)

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	106,428,624	156,318,850	122,226,550	125,983,843	3.1%
FTE	0.0	704.7	0.0	0.0	0.0%
General Fund	44,517,842	63,303,334	58,091,948	60,822,381	4.7%
Cash Funds	1,888,903	7,779,925	1,936,723	1,888,903	(2.5%)
Reappropriated Funds	0	1,388,133	0	0	0.0%
Federal Funds	60,021,879	83,847,458	62,197,879	63,272,559	1.7%
TOTAL - Department of Health Care Policy and Financing	12,653,933,920	14,269,559,447	15,506,748,579	16,387,754,863	5.7%
FTE	629.6	1,443.1	787.9	797.3	1.2%
General Fund	2,818,431,584	3,629,754,936	3,344,020,169	3,784,506,095	13.2%
General Fund Exempt	0	0	1,181,498,489	1,181,498,489	0.0%
Cash Funds	1,460,353,170	1,741,986,619	1,769,169,191	1,819,098,761	2.8%
Reappropriated Funds	85,224,784	93,997,088	105,145,754	121,939,636	16.0%
Federal Funds	8,289,924,382	8,803,820,804	9,106,914,976	9,480,711,882	4.1%

APPENDIX B
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

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

17 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, Personal Services; Operating Expenses; Leased Space -- These line items include $588,486 total funds, including $202,545 General Fund, and 6.4 FTE for the purpose of expanding and strengthening operational compliance and program oversight and accountability. It is the General Assembly's intent that none of the $588,486 total funds be used for the Recovery Audit Contractor program or related appeals.

Comment: This footnote was added by the JBC to ensure that none of the funding provided was used for the Recovery Audit Contractor program. The Department is in compliance with the footnote.

18 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects -- Of this appropriation, $2,921,400 total funds, including $1,460,750 General Fund, remains available for expenditure until the close of the 2024-25 fiscal year.

Comment: This footnote provides flexibility for the Department to rollforward up to $2.9 million of the FY 2023-24 appropriation to FY 2024-25 related to the Department's alternative payment models.

19 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 through EPSDT. Senate Bill 23-289 repealed the autism waiver and program evaluation. The Department did not prepare the requested report. Statutory changes and appropriation modifications are needed. See the discussion above of the Departmen't cash funds detail for more information.

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 -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

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

21 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 2024-25 state fiscal year.

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

22 Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- The appropriation is based on the assumption that anesthesia rates for services delivered by anesthesiologists and nurse anesthesiologists are not subject to rebalancing of any codes above 100 percent of Medicare and these codes are subject to the common policy community provider rate adjustment.

Comment: The footnote explains the General Assembly's assumptions regarding FY 2023-24 provider rates for anesthesia. The Department is in compliance with the footnote.

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

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

24 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Adult Comprehensive Services -- Of this appropriation, cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote.

25 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Adult Supported Living Services -- Of this appropriation, cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote.

26 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Children's Extensive Support Services -- Of this appropriation, cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote.

27 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Children's Habilitation Residential Program -- Of this appropriation, cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote.

28 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Case management for People with Disabilities -- Of this appropriation, cash funds appropriated from the Home- and Community-based Services Improvement Fund remain available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote.

29 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs, Case management for People with Disabilities -- Of this appropriation, $168,000 General Fund is appropriated for financial

closeout activities for Case Management Agencies and Single Entry Points, and is available for expenditure until the close of the 2024-25 state fiscal year.

Comment: This footnote provides roll-forward authority for a portion of the appropriation related to financial closeout activities for Case Management Agencies and Single Entry Points. The Department is complying with the footnote.

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

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

31 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, State-only Programs, Preventive Dental Hygiene - It is the General Assembly's intent that this appropriation be used to provide special dental services for persons with intellectual and developmental disabilities.

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

32 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: The footnote explains the purpose of the appropriation to support the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The Department is in compliance with the footnote.

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

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

33a Department of Health Care Policy and Financing, 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 $88,640,763, 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 $88,640,763 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

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

UPDATE ON LONG BILL REQUESTS FOR INFORMATION

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

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

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

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

1 All Departments -- The Departments are requested to provide by November 1 of each fiscal year Schedule 9 reports for every annually and continuously appropriated cash fund administered by the Department as part of the standard November 1 budget submission. The Office of State Planning and Budgeting, in coordination with the Office of the State Controller, the Department of the Treasury, and the independent agencies, is further requested to provide by November 1 of each fiscal year a consolidated report that includes the following information for all continuously appropriated cash funds:

- The name of the fund;
- The statutory citation for the fund;
- The year the fund was created;
- The department responsible for administering the fund;
- The total cash balance as of July 1, 2023;
- The unobligated cash balance as of July 1, 2023; and
- The unencumbered cash balance as of July 1, 2023.

Comment: The Department submitted the Schedule 9s with the budget as requested. The focus of this request for information is on the continuously appropriated funds that in some cases are off budget and might not have historically been included in a department's standard cash fund reporting. The Department does not have any off budget continuously appropriated funds.

5 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.

Comment: The Department submitted the report, FY23 CUSOM Interagency Agreement, as requested. Through the agreement, the Department uses General Fund appropriated to the Department of Higher Education for the University of Colorado School of Medicine (CUSOM) to match federal funds and increase Medicaid payments to CUSOM providers. In FY 2022-23, the agreement drew $103.2 million federal funds that would not otherwise have been available.

According to the report, the number of Medicaid members seen by CUSOM providers increased 49 percent. The exact beginning and end dates for this statistic are not detailed in the report, but from FY 2017-18 to FY 2022-23 Medicaid enrollment increased 31 percent, so it appears that CUSOM is seeing a greater share of Medicaid patients, which was one of the goals of the agreement. It is unknown what would have happened without the agreement.

The report highlights the following accomplishments with the additional federal funds:
- 91 programs funded
- Increases in telemedicine (21%) and eConsults (31%) in FY 2022-23
- Increases in behavioral health services provided (6% compared to 5% overall in Medicaid)
- Increases in access to specialty care through brick and mortar expansions and innovative telehealth, asynchronous e-consults, and co-management with local providers
- Improved transitions of care programs for unhoused members leaving the hospital and Arapahoe County Detention Center

6 Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of Human Services, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Department of Military and Veterans Affairs, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of Personnel, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division, Administration, General Disease Control, and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by October 1, 2023 for each program funded with Tobacco Master Settlement Agreement money: the name of the program; the amount of Tobacco Master Settlement Agreement money received and expended by the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals.

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

7 Department of Health Care Policy and Financing and Department of Human Services, Behavioral Health Administration -- The departments are requested to provide the following updates regarding the implementation of the Non-Medicaid Behavioral Health Eligibility and Claims

System by November 1, 2024: (1) the specific non-Medicaid programs that are utilizing the system for eligibility and/or claims purposes, including the specific uses for each program; (2) the number and percentage of clients and claims for which each program is using the system; (3) the number and percentage of providers that are using the system for each program; (4) the Departments' plans to expand the utilization to other programs (including programs housed outside of the BHA) and other providers through FY 2024-25 and in subsequent years; and (5) any efficiencies or payment issues identified through the use of the system thus far.

Comment: *See the briefing for behavioral health programs for a discussion of this request for information.*

DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

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

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

2 Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit reports by June 15, 2023, and November 1, 2023, providing updates on prior authorization reviews (PARs) for private duty nursing, including data over time on approvals, partial denials, and full denials and on technical denials due to inadequate documentation. For clients and families requesting private duty nursing, the report should address utilization of appropriate available wrap-around services, the Department's communication with Regional Accountable Entities regarding unmet needs, and outreach and education to providers focused on the PAR process and requirements related to missing/supporting documentation.

Comment: The Department submitted the reports, Private Duty Nursing (PDN) Prior Authorization Request (PAR) Report and Update to June 15, 2023, Private Duty Nursing (PDN) Prior Authorization Request (PAR) Report, as requested. Private Duty Nursing provides skilled nursing services in the home that are more individualized and continuous than care available under the home health benefit or routinely provided in a hospital or nursing facility. The costs per person are very high and the Department has a strict Prior Authorization Request (PAR) process in place to ensure proposed services are reviewed and determined to be medically necessary before

payments are authorized. PARs can be denied because the circumstance do not meet the criteria for services but also for technical reasons, such as incomplete or inaccurate paperwork.

In response to stakeholder concerns about excessive and inappropriate PAR denials, the Department temporarily suspended the PDN PARs from October 2022 to April 2023 and switched to a process of administrative approvals that did not include the rigorous review for medical necessity. During the suspension of the PARs the Department and contractor conducted outreach and training for providers and clients around the PAR criteria, how to properly submit PARs, and available benefits. The Department also received funding from the General Assembly for nurse navigators to help clients and providers understand and access the available benefits.

The Department's June report indicated 948 members had a case submitted for PDN services since November 2021 with the following outcomes:

- 86.5% of PDN cases were fully approved.
- 8.8% of PDN cases were partially denied.
  - Most partial denials are to reduce requested hours due to lack of medical necessity for the full amount requested.
- 4.7% of PDN cases were fully denied.
  - Of those full denials 55% were for medical necessity; 45% were for technical issues with the submission (technical denials often result in approvals once they are resolved.)

3 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by November 1, 2023, discussing member utilization of capitated behavioral health services in FY 2021-22 and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year 2022, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

Comment: *Please see the briefing on behavioral health programs for an analysis of this request for information.*

4 Department of Health Care Policy and Financing, Medical Services Premiums – The Department is requested to submit a report by November 1, 2023, discussing specialty drug costs and reimbursements to providers. The report should include the percent of cost paid for specialty

drugs, how the amounts were determined, and how they have changed over time. The report should address both the historic and appropriate settings for administering specialty drugs. The report should discuss projections for specialty drug costs and emerging policy issues.

Comment: The Department submitted the report, Discussion of Specialty Drugs, Their Costs and Provider Reimbursement, as requested. The report defines specialty drugs as those used to treat rare or complex disease states. The report says that based on special handling requirements, the need for individualized dosing, specialized administration, premixing or reconstitution, these drugs are often supplied by a limited distribution network. The report estimates specialty drugs represent 48 percent of pharmacy expenditures and 1 percent of pharmacy claims. The Department's reimbursement rates depend on the setting and the report describes four settings:

- Outpatient retail and mail order – Rates are based on the lowest value comparing a pharmacy's submitted ingredient cost, a pharmacy's usual and customary charge, the listed Colorado Medicaid Average Acquisition Cost (AAC), the National Average Drug Acquisition Cost (NADAC), or if neither AAC nor NADAC is available, the Maximum Allowable Cost (MAC). Pursuant to H.B. 21-1275, long-acting injectable medications for mental health or substance use disorder recently became eligible for coverage. The Department projects costs in FY 2024-25 of $533.3 million plus $2.7 million for drugs in the pipeline.
- Physician administered – The Department's reimbursement is based on the Average Sales Price plus 2.5 percent, if the information is available, or the Wholesale Acquisition Cost. The Department projects expenditures in FY 2024-25 of $119.8 million, plus $2.5 million for drugs in the pipeline.
- Outpatient – Reimbursements have historically been made through bundled payments that include average provider resources, supplies, drugs, and testing appropriate to the visit type. When the current methodology was implemented in 2016, it was benchmarked to 72 percent of costs, but the report indicates significant adjustments have been made since. The drugs administered in this setting are those that require specialized administration and/or the need for specialized equipment. The Department's vendor updates the rates using a proprietary tool based historic claim and cost data and changing market conditions. As a result, the Department cannot estimate the portion of the bundled payments attributable to specialty drugs. The report indicates that specialty drugs that entered the market after the historic data period are not properly reflected and paid in the current bundled payments model.
- Outpatient specialty carve out – In response to stakeholders, the Department obtained federal authorization to address unrealistic reimbursements for emerging specialty drugs. For the approved carve out drugs, the reimbursement is currently approximately 95 percent of net invoice cost, including increased federal matching funds earned with the HAS Fee. Pending federal approval, the Department plans to increase reimbursements to 97 percent of net invoice costs in 2024. The Department projects costs in FY 2024-25 of $8.8 million plus $90.2 million for specialty drugs anticipated to gain FDA approval.
- Inpatient – Similar to outpatient reimbursements, the Department uses bundled payments for specialty drugs administered inpatient. The methodology looks at expected costs based on the diagnosis codes present in the hospital claim. With the expected utilization derived from historic data, the costs of new-to-market specialty drugs are not effectively captured in the model.
- Inpatient specialty carve out – The Department is developing a carve out method for outlier specialty drugs. Implementing it will require federal approval and approval of a rule change by

the Medical Services Board. The aim is to reimburse 97 percent of net invoice cost, or 100 percent of net invoice cost when provided through qualifying sole pediatric treatment centers. The Department estimates FY 2024-25 expenditures for the drugs under consideration for the carve out is $77.8 million.

5 Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs -- The Department is requested to submit a report by 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.

Comment: The Department submitted the report, Children's Basic Health Plan (CHP+) Administration, as requested. According to the report, 8 of the 10 backlogged issues have been resolved and the Department projects that it is on pace to resolve the remaining 2 backlog issues by June 30, 2024. The report concludes that the funding for additional staff provided by the General Assembly has been sufficient to get the program back to a level that can maintain compliance with federal and state regulations and implement periodic best practice improvements. No additional staffing is needed, according to the Department.

6 Department of Health Care Policy and Financing, Office of Community Living -- The Department is requested to submit a report by November 1, 2023, detailing the progress on all outstanding issues with administration of the Case Management Redesign. The report should include a progress report on the number of CMAs who applied, and which ones were selected as part of the redesign, and a report on the populations served by each awarded contract. Finally, the report should include the Department's plans for enforcing a case management ratio of 65 clients per case manager, as well as any stakeholder feedback on the 65:1 ratio.

Comment: *Please see the briefing for the Office of Community Living for an analysis of this request for information.*

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

Comment: The Department submitted the report as requested. The full report is available from the Department's website for Legislative Requests for Information.

When schools provide health services to public school children with disabilities, as required by federal and state law[13], and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, and specialized non-emergency transportation services. In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

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

APPENDIX C
DEPARTMENT ANNUAL PERFORMANCE REPORT

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

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2024-25 budget request, the FY 2022-23 Annual Performance Report and the FY 2023-24 Performance Plan can be found at the following link:

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

APPENDIX D
SINGLE ASSESSMENT TOOL

Below are selected excerpts from the Department's responses to JBC staff questions about the Single Assessment Tool. The material includes an implementation timeline for the Single Assessment Tool, a high level explanation of what caused the implementation delays, and a list of existing items that will be replaced by the Single Assessment Tool.

1. Please provide a history of the Single Assessment and the funding for it.

2016 - 2017:

- Senate Bill 16-192 required the Department to select a singular assessment tool for all LTSS programs by July 1, 2018.
- The Department and contracted vendors worked with stakeholders to identify an assessment instrument and determined there was not a current assessment available that would meet Coloradan's needs and a decision was made to develop a unique assessment process and assessments for Colorado.
- The Colorado Assessment Process Development Final Report was issued March 2017, outlining the development process.
- Funding:
    - SB 16-192: $21,522,162 total funds over five years
    - R-17: Shifted spending authority related to the implementation of SB 16-192
    - R-17: $2,500,588 in FY 2017-18 funding from the Testing Experience and Functional Assessment Tools (TEFT) in Community-Based Long Term Service and Supports (CB-LTSS) Grant.

2018-2019:

- Continued working with a contractor and stakeholders to refine the development of the Single Assessment Tool.
- The Single Assessment Tool was automated in an IT system called Ariel.
- Began piloting the assessment tool (called the new LTSS Assessment and Support Plan) at the end of 2018.
- Funding:
    - Requested the reallocation of SB 16-192 appropriated funds between fiscal years and planned roll-forward authority for all contractor work in order to complete projects.

2020-2021:

- Discontinued the contract with the vendor for the IT platform (Ariel) and entered into a contract with a new vendor and began the design and development process for the new assessment in the new Care & Case Management system (CCM).
- Began work with a contractor and stakeholders on developing the Person-Centered Budget Algorithm (PCBA), an objective, equitable way to allocate resources for LTSS.

- The COVID-19 pandemic presented potential impacts to the integrity of the results from the new LTSS Assessment and Support Plan pilot study, which was essential for PCBA development. (The COVID-19 pandemic required the pilot assessments to be completed remotely.)
- PCBA development was paused until more assessments could be collected.
- Funding:
    - Requested to extend roll-forward authority on funds appropriated in FY 2019-20 to avoid the reversion of unspent funds.

2022-2023:

- Continued stakeholder engagement to review and seek feedback on the proposed training for case managers, garner input to the draft rules related to the new assessment process and conduct "mock" Level of Care (LOC) Screens to increase understanding of the experience of members.
- Continued to work with the CCM vendor on the new assessment process design in the IT system, but it became clear that a shift was needed to launch and stabilize the IT system before implementing a new assessment process.
- Launched the Care and Case Management (CCM) IT system on July 5th, 2023 using the legacy ULTC 100.2 assessment.
- Continued stakeholder engagement around the Colorado Single Assessment (CSA) and the PCBA, focusing on lessons learned from the Department's experience with the SIS and Support Level Algorithm.
- Convened a CSA/PCSP Working Sessions group with stakeholders.
- Worked with the PCBA contractor and the two vendors for the Care & Case Management system (CCM) to build the PCBA functionality within the system as a placeholder to accommodate the PCBA once developed.
- Funding:
    - The Department had MMIS APD funding for this work at a 90/10 match of Federal Financial Participation

2. Why has implementation been delayed from the assumption in the original fiscal note that it would be in place by FY 2019-20?

There were several reasons for the delayed implementation:

- As noted in Question 1, stakeholders helped the Department determine that an off-the-shelf assessment would not fit Colorado's needs, thus we needed additional time to fully design a new assessment process, called the Colorado Single Assessment and Person-Centered Support Plan (CSA/PCSP).
- Further, the new assessment process was designed to be dynamic depending on the individual being assessed and to be fully integrated into Colorado's case management IT system. The legacy Case Management systems were antiquated and needed to be replaced in order to implement the new assessment process.

- Unfortunately, the Department had to delay the implementation originally planned for FY 2019-2020 because the vendor for the IT system being used at the time was not able to complete the assessment by the implementation date.
- The Department had to end the contract just weeks before the planned implementation and start the procurement process to contract agreement with a new vendor, requiring the design and development to start over.

- COVID also became a factor, as it required some changes to the pilot design and presented potential impacts on data reliability for stakeholders.

3. Please list and describe all the existing tools that the Single Assessment Tool will replace.

The tools which are being replaced by the Colorado Single Assessment (CSA) process are listed below

Tools that are being replaced:

1. **ULTC Intake**-initial screen to ascertain if CM should proceed with 100.2
2. **ULTC 100.2** Functional Eligibility Assessment-to determine eligibility for LTSS and/or HCBS waivers
3. Instrumental Activities of Daily Living **(IADL) Assessment**-to score needs in areas such as shopping, household and money management
4. **Developmental Disabilities Section** of the Service Plan-an addendum used only by CMAs serving Members with IDD that includes information such as supervision levels, rights modifications processes and risk mitigation needs/strategies
5. **Supports Intensity Scale (SIS)**- Assessment for Members with IDD to identify the type, frequency and duration of daily supports needed. This is used as inputs into the SIS/Support Level Algorithm
6. **Support Level Calculation** Sheet for HCBS for Persons with Developmental Disabilities **(HCBS-DD)** Waiver-used to manually calculate the Support Level (SL) which translates into direct service provider reimbursement rates for the Residential Habilitation and Day Habilitation services for Members with IDD
7. **Support Level Calculation** Sheet for HCBS-Supported Living Services **(HCBS-SLS)** Waiver -used to manually calculate the SL which translates into the Service Plan Authorization Limit (SPAL); the annual budget for services in the SLS waiver
8. Children's Addendum 0-59 Months 12
9. Children's Addendum 5 to 18 Year Old Children
10. **HCBS Cost Containment** Form-used by CMAs to submit to the Department when a Member's combined daily costs of LTHH and HCBS exceeds the rate set by the Department for budget neutrality
11. **Inventory for Client & Agency Planning (ICAP)**-needs assessment used to establish support levels and rates for providers serving children and youth in the Children's Habilitation Residential Program (CHRP) waiver

12. **Physician's Life Limiting Illness** Form-used for the Children with Life Limiting Illness (CLLI) waiver for physicians to attest that the child has a Life Limiting Illness

Tools that are being modified for alignment or are still under evaluation:

13. Brain Injury **Supportive Living Program (SLP)** Assessment (Likely being replaced when PCBA is implemented)-needs assessment identifying specific services and supports needs of Members with Brain Injury to thrive in the SLP setting
14. Brain Injury (BI)-**Transitional Living** Assessment (Likely being replaced when PCBA is implemented)-needs assessment identifying services and supports needs of Members with Brain Injury to thrive in the Transitional Living setting
15. **Brain Injury Behavioral Acuity** assessment (Likely being replaced when PCBA is implemented)-needs assessment specific to the behavioral acuity of Members with Brain Injury to tie to rates paid to BI providers