JOINT BUDGET COMMITTEE

# STAFF FIGURE SETTING
# FY 2024-25

# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

## (Executive Director's Office, Medical Services Premiums, Indigent Care, Other Medical Services)

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

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MARCH 4, 2024

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## HOW TO USE THIS DOCUMENT

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

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

# DEPARTMENT OVERVIEW

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

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

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

## SUMMARY OF STAFF RECOMMENDATIONS

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

| DEPARTMENT OF HEALTH CARE POLICY AND FINANCING | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $15,340,335,131 | $4,509,692,766 | $1,788,606,414 | $117,280,880 | $8,924,755,071 | 805.5 |
| Long bill supplemental | (419,219,039) | (75,781,862) | (34,873,709) | 0 | (308,563,468) | 0.0 |
| **TOTAL** | **$14,921,116,092** | **$4,433,910,904** | **$1,753,732,705** | **$117,280,880** | **$8,616,191,603** | **805.5** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $14,921,116,092 | $4,433,910,904 | $1,753,732,705 | $117,280,880 | $8,616,191,603 | 805.5 |
| Enrollment/utilization trends | | | | | | |
| R1 Medical Services Premiums | 488,069,566 | 310,722,337 | 48,532,452 | 0 | 128,814,777 | 0.0 |
| R2 Behavioral Health | (62,726,430) | 17,277,008 | (4,262,821) | 0 | (75,740,617) | 0.0 |
| R3 Child Health Plan Plus | 71,926,571 | 15,997,713 | 9,821,673 | 0 | 46,107,185 | 0.0 |
| R4 Medicare Modernization Act | (729,368) | (729,368) | 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 |
| BA9 Public school health services | 9,682,177 | 0 | 9,246,240 | 0 | 435,937 | 0.0 |
| *Subtotal - Enrollment/utilization trends* | *551,224,520* | *372,258,331* | *65,805,051* | *0* | *113,161,138* | *0.0* |
| Eligibility/benefit changes | | | | | | |
| R9 Access to benefits | 308,000 | 153,999 | 0 | 0 | 154,001 | 0.9 |
| Provider rates | | | | | | |
| R6a Provider rates | 181,974,452 | 69,860,142 | 7,242,701 | 0 | 104,871,609 | 0.0 |
| R6b Targeted provider rates | 198,389,998 | 57,140,818 | 27,182,819 | 0 | 114,066,361 | 0.0 |
| *Subtotal - Provider rates* | *380,364,450* | *127,000,960* | *34,425,520* | *0* | *218,937,970* | *0.0* |
| Administration and other | | | | | | |
| R7 Behavioral health continuum | 4,409,298 | 945,354 | 318,817 | 0 | 3,145,127 | 1.4 |
| R8 Eligibility process compliance | 8,479,360 | 788,878 | 633,101 | 0 | 7,057,381 | 1.8 |
| R10 Assessments for skilled nursing | 1,938,600 | 484,650 | 0 | 0 | 1,453,950 | 0.0 |
| R11 Program support | 570,508 | 223,810 | 16,635 | 0 | 330,063 | 2.9 |
| R12a Accessibility | 353,971 | 134,310 | 42,675 | 0 | 176,986 | 0.9 |
| R12b Senior dental administration | 75,000 | 75,000 | 0 | 0 | 0 | 0.0 |
| R13 Convert contracts to FTE | 133,723 | (53,845) | (33,016) | 307,417 | (86,833) | 12.6 |
| R14 Contract true up | 43,910 | 90,668 | (47,844) | 0 | 1,086 | 0.0 |
| R15 Denver Health | 0 | 0 | 0 | 0 | 0 | 0.0 |
| BA6 Public health emergency unwind | 21,670,244 | 5,378,942 | 1,805,859 | 0 | 14,485,443 | 3.2 |
| BA7 Transportation credentialing and reviews | 279,533 | 83,861 | 55,907 | 0 | 139,765 | 0.7 |
| BA8 Community-based access to services | 118,959 | 325,564 | 19,150 | 0 | (225,755) | 0.0 |
| BA10 CO Benefits Management System | 0 | 0 | 0 | 0 | 0 | 0.0 |
| BA11 ARPA HCBS adjustments | 4,608,068 | 0 | 2,495,840 | 0 | 2,112,228 | 29.0 |
| BA14 Legal services | 237,200 | 71,160 | 47,440 | 0 | 118,600 | 0.0 |
| DACA Recipients | (2,061,189) | (1,030,594) | 0 | 0 | (1,030,595) | 0.0 |
| Autism report | (62,000) | (31,000) | 0 | 0 | (31,000) | 0.0 |
| Payments to OIT | 7,888,029 | 1,665,364 | 688,427 | 1,068,127 | 4,466,111 | 0.0 |
| Centrally appropriated items | 10,530,499 | 4,757,805 | 781,868 | 23,179 | 4,967,647 | 0.0 |
| Human Services | 3,868,746 | 2,786,159 | (47,820) | 0 | 1,130,407 | 0.0 |
| Transfers to other departments | 745,851 | 352,690 | 0 | 0 | 393,161 | 0.0 |
| Indirect costs | 136,603 | (136,603) | 77,822 | 161,372 | 34,012 | 0.0 |
| Annualize prior year funding | (53,277,109) | 23,193,213 | (63,660,167) | 445 | (12,810,600) | (24.2) |
| **TOTAL** | **$15,863,700,866** | **$4,973,429,580** | **$1,797,157,970** | **$118,841,420** | **$8,974,271,896** | **834.7** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$942,584,774** | **$539,518,676** | **$43,425,265** | **$1,560,540** | **$358,080,293** | **29.2** |
| Percentage Change | 6.3% | 12.2% | 2.5% | 1.3% | 4.2% | 3.6% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$16,460,377,917** | **$4,970,656,091** | **$1,844,949,470** | **$134,016,094** | **$9,510,756,262** | **832.2** |
| Request Above/(Below) Recommendation | $596,677,051 | ($2,773,489) | $47,791,500 | $15,174,674 | $536,484,366 | (2.5) |

# DESCRIPTION OF INCREMENTAL CHANGES

## FY 2023-24

**RECOMMENDED LONG BILL ADD-ON:** Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast and technical corrections. See the descriptions of R1 through R5 for more information. The staff recommendation also includes a technical adjustment to fund sources.

## FY 2024-25

### ENROLLMENT/UTILIZATION TRENDS

**R1 MEDICAL SERVICES PREMIUMS:** Staff recommends a net increase of $488.1 million total funds, including an increase of $310.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item.

**R3 CHILD HEALTH PLAN PLUS:** Staff recommends an increase of $71.9 million total funds, including $16.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan.

**R4 MEDICARE MODERNIZATION ACT:** Staff recommends decrease of $729,368 General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

**BA9 PUBLIC SCHOOL HEALTH SERVICES:** Staff recommends an increase of $9.7 million total funds for public school health services based on an updated projection of certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

### BENEFITS/ELIGIBILITY ADJUSTMENTS

**R9 ACCESS TO BENEFITS [POTENTIAL LEGISLATION]:** Staff recommends an increase of $308,000 total funds, including $153,999 General Fund, to continue for another two years a pain management pilot program that was started with federal stimulus funds. The program is intended to address a perceived shortage of available Medicaid providers to treat members with chronic pain. It provides training to primary care medical providers, peer-to-peer consultations with pain specialists for primary care physicians, and a benefit specialist that helps coordinate appropriate referrals to mental health, substance use disorder, or chronic pain providers.

In addition, staff recommends legislation to add autism spectrum disorder treatments as covered services under the Children's Basic Health Plan at a projected cost of $18.6 million total funds, including $3.9 million General Fund.

The JBC staff does not recommend the requested contract resources to plan for a transplant nurse navigator program.

## PROVIDER RATES

**R6A PROVIDER RATES:** Staff recommends 182.0 million total funds, including $69.9 million General Fund, for a 2.5 percent across-the-board community provider rate increase for eligible providers, consistent with the JBC's common policy. This is higher than the Department's request for a 1.0 percent increase and updated for the Department's February forecast of enrollment and expenditures.

**R6B TARGETED PROVIDER RATES:** Staff recommends an increase of $198.4 million total funds, including $57.1 million General Fund, for targeted provider rate increases. The largest dollar increases are for dental services and for wages for Home- and Community-Based Services.

R6b Targeted Provider Rates - Staff Recommendation

| Rate | Change | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
|---|---|---|---|---|---|
| **Adjustments based on the MPRRAC Rate Review** | | | | | |
| Dental | 15 preventive codes to 100%<br>13 diagnostic codes 70% | $92,710,684 | $16,928,971 | $13,999,314 | $61,782,399 |
| Pediatric behavioral therapies | 100% of benchmark with NE | 34,281,532 | 17,140,766 | 0 | 17,140,766 |
| Maternity | 100% of the benchmark | 8,197,058 | 4,098,529 | 0 | 4,098,529 |
| Surgeries | 100% preventive digestive<br>80% digestive & musculoskeletal<br>80-100% all others | 792,128 | 231,793 | 32,857 | 527,478 |
| Ambulatory surgery centers | At least 80% of benchmark | 4,931,565 | 1,443,074 | 204,562 | 3,283,929 |
| Co-surgeries | Expand billable codes | 0 | 0 | 0 | 0 |
| 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** | | **$133,347,273** | **$37,941,872** | **$13,860,380** | **$81,545,021** |
| | | | | | |
| **Other targeted rate adjustments** | | | | | |
| Wages for HCBS | Minimum wage increase | $65,042,725 | $19,198,936 | $13,322,439 | $32,521,350 |
| Single Assessment Tool | Implementation cost | 0 | 0 | 0 | 0 |
| Primary Care Fund | Serve clients 201-250% of FPL | 0 | 0 | 0 | 0 |
| Regional Center transitions | 1-year enhanced rate for transitions | 0 | 0 | 0 | 0 |
| **Subtotal - Other** | | **$65,042,725** | **$19,198,936** | **$13,322,439** | **$32,521,350** |
| | | | | | |
| **TOTAL** | | **$198,389,998** | **$57,140,808** | **$27,182,819** | **$114,066,371** |

The JBC staff recommendation is higher than the request by $36.9 million total funds, including $15.3 million General Fund.

## ADMINISTRATION AND OTHER

**R8 ELIGIBILITY PROCESS COMPLIANCE:** Staff recommends $8.5 million total funds, including $788,878 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.

**R10 ASSESSMENTS FOR SKILLED NURSING:** Staff recommends $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.

**R11 PROGRAM SUPPORT:** Staff recommends $570,508 total funds, including $223,810 General Fund and 2.9 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 conducts surveys and gathers data to inform policy making.
- Preventive care outreach analyst – The position would conduct research and develop strategies to increase preventative care utilization with a focus on childhood vaccines.
- 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.

**R12A ACCESSIBILITY:** Staff recommends $353,971 total funds, including $134,310 General Fund, and 0.9 FTE for on-going costs associated with ensuring department communications are accessible to people with disabilities and compliant with H.B. 21-1110.

**R12B SENIOR DENTAL ADMINISTRATION:** Staff recommends $75,000 General Fund, increasing to $150,000 General Fund in out years, for contract services to assist with invoicing, reporting, and eligibility verifications for the senior dental program that provides roughly $4.0 million per year in grants to serve 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.

**R13 CONVERT CONTRACTS TO FTE:** Staff recommends a net increase of $133,723 total funds, including a reduction of $53,845 General Fund, to convert some appropriations for contract services to state FTE.

**R14 CONTRACT TRUE UP:** Staff recommends $43,910 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.

**R15 DENVER HEALTH [POTENTIAL LEGISLATION]:** Staff does not recommend the requested legislation to provide $5.0 million General Fund to Denver Health for uncompensated care costs.

**BA6 PUBLIC HEALTH EMERGENCY UNWIND:** Staff recommends $21.7 million total funds, including $5.4 million General Fund, to provide resources for the surge in eligibility determinations associated with the end of the Medicaid continuous coverage requirement during the federal public health emergency. The General Assembly already approved a supplemental for FY 2023-24. This budget amendment would continue and annualize the supplemental changes and add some new funding related to appeals and communications in FY 2024-25. All of the short-duration appropriations would go away in FY 2025-26. The biggest adjustment moves $9.2 million for county eligibility administration work from FY 2023-24 to FY 2024-25 to allow more time for the counties to spend it.

**BA7 TRANSPORTATION CREDENTIALING AND REVIEWS:** Staff recommends $279,533 total funds, including $83,861 General Fund, to annualize a supplemental that increased oversight of the non-emergent medical transportation (NEMT) benefit 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, and coordinate with law enforcement investigating the alleged fraud.

**BA10 CO BENEFITS MANAGEMENT SYSTEM:** Staff recommends continuation of a supplemental action that aligned reappropriated funds spending authority from the Department of Human Services with how the Colorado Benefits Management System is being operated by the Executive Branch. The changes are already in the FY 2023-24 base and there is no additional incremental change to continue the policy into FY 2024-25.

**BA11 ARPA HCBS ADJUSTMENTS:** Staff recommends $4.6 million total funds, including $2.5 million cash funds from the Home- and Community-Based Services (HCBS) Improvement Fund, and 29.0 FTE to extend the duration of term-limited positions that are implementing the Department's spending plan for the American Rescue Plan Act (ARPA) HCBS funds. The ARPA temporarily increased the federal match rate for HCBS by 10 percentage points from April 1, 2021 through March 31, 2022. It required that the state savings from the higher match be used to enhance, expand, or strengthen HCBS. The Department submitted a spending plan to the General Assembly and has received a series of appropriations to implement 63 projects identified in the plan. To administer the projects, the Department hired 58.5 term-limited FTE with start and end dates that vary according to the specific timelines originally forecasted for each project. The funding would extend the end dates for all of the term-limited FTE to at least December 31, 2024 and extend the end date for 15.0 positions that will be involved in the close out accounting and reporting to March 31, 2025.

**BA14 LEGAL SERVICES:** Staff recommends $237,200 total funds, including $71,160 General Fund for legal services attributable to increases in fraud referrals, audit requirements, and appeals.

**AUTISM REPORT:** Staff recommends a reduction of $62,000 total funds, including $31,000 General Fund, from the General Professional Services and Special Projects line item. The purpose of the

funding was the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. Senate Bill 23-289 repealed the autism waiver and program evaluation.

**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 request reflects adjustments for several programs that are financed with Medicaid funds, but operated by the Department of Human Services.

**TRANSFERS TO OTHER DEPARTMENTS:** The Department requests an increase of $745,851 total funds, including $352,690 General Fund, for transfers to programs administered by other departments.

**INDIRECT COSTS:** Staff recommends an increase of $136,603 due to an increase in statewide indirect cost assessments and using the additional recoveries to offset General Fund costs for the Department's administration.

**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/FY 23-24 BA8/FY 24-25 S11 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 R7Rrate 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 Continuous 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/FY 23-24 BA8/FY 24-25 S11 HCBS ARPA | (50,278,560) | 0 | (44,556,482) | 0 | (5,722,078) | (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 24-25 Pediatric behavioral therapy rates | (10,425,342) | (5,212,671) | 0 | 0 | (5,212,671) | 0.0 |
| FY 23-24 NP1 Housing vouchers | (9,001,786) | (4,549,261) | 0 | 0 | (4,452,525) | 0.0 |
| 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 24-25 S14 Litigation monitoring | (250,000) | (125,000) | 0 | 0 | (125,000) | 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** | **($53,277,109)** | **$23,193,213** | **($63,660,167)** | **$445** | **($12,810,600)** | **(24.2)** |

## MAJOR DIFFERENCES FROM THE REQUEST

The largest dollar differences between the request and the JBC staff recommendation are due to the JBC staff using the Department's February 2024 forecast of expenditures for Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, the Medicare Modernization Act, and the Office of Community Living rather than the November 2023 forecast that was used for the Governor's request. The table below summarizes the differences between the February 2024 and November 2023 forecasts for all of the forecasted programs.

| February 2024 Forecast Higher/(Lower) than November 2023 Forecast | | | | | |
|---|---|---|---|---|---|
| | Total Funds | General Fund | Cash Funds | Reappropriated Funds | Federal Funds |
| **FY 23-24** | | | | | |
| Medical Services Premiums | ($332,880,325) | ($53,536,217) | ($35,176,800) | $0 | ($244,167,308) |
| Behavioral Health | (108,852,544) | (19,208,995) | (6,273,719) | 0 | (83,369,830) |
| Children's Basic Health Plan | 28,879,255 | 3,328,775 | 6,576,810 | 0 | 18,973,670 |
| Medicare Modernization Act | (6,365,425) | (6,365,425) | 0 | 0 | 0 |
| Office of Community Living | (11,702,691) | (5,751,524) | 19,750 | 0 | (5,970,917) |
| **TOTAL** | **($430,921,730)** | **($81,533,386)** | **($34,853,959)** | **$0** | **($314,534,385)** |
| % Change *from Nov Forecast* | -3.1% | -1.9% | -2.4% | 0.0% | -3.8% |
| | | | | | |
| **FY 24-25** | | | | | |
| Medical Services Premiums | (522,488,237) | (15,786,694) | (48,443,744) | (15,098,476) | (443,159,323) |
| Behavioral Health | (178,813,516) | (22,998,771) | (13,049,881) | 0 | (142,764,864) |
| Children's Basic Health Plan | 56,574,535 | 6,128,850 | 13,672,237 | 0 | 36,773,448 |
| Medicare Modernization Act | (9,385,536) | (9,385,536) | 0 | 0 | 0 |
| Office of Community Living | (12,465,855) | (6,250,368) | 17,442 | 0 | (6,232,929) |
| **TOTAL** | **($666,578,609)** | **($48,292,519)** | **($47,803,946)** | **($15,098,476)** | **($555,383,668)** |
| % Change *from Nov Forecast* | -4.9% | -1.2% | -3.4% | -15.1% | -7.0% |
| | | | | | |
| **Cumulative Over Both Years** | | | | | |
| Medical Services Premiums | (855,368,562) | (69,322,911) | (83,620,544) | (15,098,476) | (687,326,631) |
| Behavioral Health | (287,666,060) | (42,207,766) | (19,323,600) | 0 | (226,134,694) |
| Children's Basic Health Plan | 85,453,790 | 9,457,625 | 20,249,047 | 0 | 55,747,118 |

| February 2024 Forecast Higher/(Lower) than November 2023 Forecast | | | | | |
|---|---|---|---|---|---|
| | Total Funds | General Fund | Cash Funds | Reappropriated Funds | Federal Funds |
| Medicare Modernization Act | (15,750,961) | (15,750,961) | 0 | 0 | 0 |
| Office of Community Living | (24,168,546) | (12,001,892) | 37,192 | 0 | (12,203,846) |
| **TOTAL** | **($1,097,500,339)** | **($129,825,905)** | **($82,657,905)** | **($15,098,476)** | **($869,918,053)** |
| % Change *from Nov Forecast* | -4.0% | -1.5% | -2.9% | -7.6% | -5.4% |

Other major differences include:

- R9 Access to benefits – Staff increased the projected cost of a bill to add autism spectrum disorder treatments as a benefit under the Child Health Plan Plus (CHP+) by $4,760,134 total funds, including $1,003,172 General Fund, based on the JBC's supplemental action to increase rates for pediatric behavioral therapy. Also, the JBC staff recommends no contract resources to plan for a transplant nurse navigator program.
- R6a Provider rates – The staff recommendation is higher than the request by $99.3 million total funds, including $40.4 million General Fund, based on the JBC's common policy for a 2.5 percent provider rate increase instead of the requested 1.0 percent increase and updating the estimated total costs and fund sources based on the Department's February 2024 forecast.
- R6b Targeted rates – The staff recommendation is higher than the request by $36.9 million total funds, including $15.3 million General Fund. The largest differences are for correcting a technical error in the benchmark rates for dental services, applying the JBC's supplemental action to increase pediatric behavioral therapy rates, and recommending a $1.00 statewide increase in the HCBS minimum base wages rather than the requested $1.00 in Denver and $0.80 outside of Denver.
- R11 Program support – Staff does not recommend the requested funding for Direct Care Career Center training and job hub.

# DECISION ITEMS AFFECTING MULTIPLE DIVISIONS

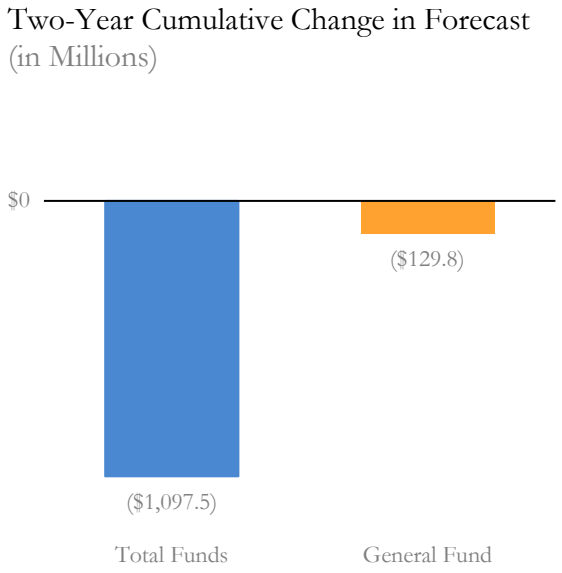
## ENROLLMENT/UTILIZATION TRENDS

Requests R1 through R5 and BA9 propose changes to both FY 2023-24 and FY 2024-25 based on a new forecast of caseload and expenditures under current law and policy. They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

On February 15, 2024, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2023 forecast used for the Governor's request incorporated data through June 2023. The February 2024 forecast incorporates data through December 2023.

The table below shows the incremental difference between the February 2024 forecast and the November 2023 forecast for the forecast requests. This comparison can be useful in understanding how much more or less there is to work with in the overall budget compared to the Governor's request, based on the new information in the February forecast. For this purpose, it is most useful to focus on the cumulative change over both years.

| February 2024 Forecast Higher/(Lower) than November 2023 Forecast | | | | | |
|---|---|---|---|---|---|
| | Total Funds | General Fund | Cash Funds | Reappropriated Funds | Federal Funds |
| **FY 23-24** | | | | | |
| Medical Services Premiums | ($332,880,325) | ($53,536,217) | ($35,176,800) | $0 | ($244,167,308) |
| Behavioral Health | (108,852,544) | (19,208,995) | (6,273,719) | 0 | (83,369,830) |
| Children's Basic Health Plan | 28,879,255 | 3,328,775 | 6,576,810 | 0 | 18,973,670 |
| Medicare Modernization Act | (6,365,425) | (6,365,425) | 0 | 0 | 0 |
| Office of Community Living | (11,702,691) | (5,751,524) | 19,750 | 0 | (5,970,917) |
| **TOTAL** | **($430,921,730)** | **($81,533,386)** | **($34,853,959)** | **$0** | **($314,534,385)** |
| % Change *from Nov Forecast* | -3.1% | -1.9% | -2.4% | 0.0% | -3.8% |
| | | | | | |
| **FY 24-25** | | | | | |
| Medical Services Premiums | (522,488,237) | (15,786,694) | (48,443,744) | (15,098,476) | (443,159,323) |
| Behavioral Health | (178,813,516) | (22,998,771) | (13,049,881) | 0 | (142,764,864) |
| Children's Basic Health Plan | 56,574,535 | 6,128,850 | 13,672,237 | 0 | 36,773,448 |
| Medicare Modernization Act | (9,385,536) | (9,385,536) | 0 | 0 | 0 |
| Office of Community Living | (12,465,855) | (6,250,368) | 17,442 | 0 | (6,232,929) |
| **TOTAL** | **($666,578,609)** | **($48,292,519)** | **($47,803,946)** | **($15,098,476)** | **($555,383,668)** |
| % Change *from Nov Forecast* | -4.9% | -1.2% | -3.4% | -15.1% | -7.0% |
| | | | | | |
| **Cumulative Over Both Years** | | | | | |
| Medical Services Premiums | (855,368,562) | (69,322,911) | (83,620,544) | (15,098,476) | (687,326,631) |
| Behavioral Health | (287,666,060) | (42,207,766) | (19,323,600) | 0 | (226,134,694) |
| Children's Basic Health Plan | 85,453,790 | 9,457,625 | 20,249,047 | 0 | 55,747,118 |
| Medicare Modernization Act | (15,750,961) | (15,750,961) | 0 | 0 | 0 |
| Office of Community Living | (24,168,546) | (12,001,892) | 37,192 | 0 | (12,203,846) |
| **TOTAL** | **($1,097,500,339)** | **($129,825,905)** | **($82,657,905)** | **($15,098,476)** | **($869,918,053)** |
| % Change *from Nov Forecast* | -4.0% | -1.5% | -2.9% | -7.6% | -5.4% |



Cumulative over the two fiscal years the February 2024 forecast is down $1,097.5 million total funds and the General Fund is down $129.8 million. This is primarily due to the decline in enrollment due to the end of the public health emergency being steeper and deeper than the Department previously anticipated. When the Department submitted the November 2023 forecast it had only one month of disenrollment data to analyze. For the February 2024 forecast the Department had 7 months of actual disenrollment data. The decrease in the Medicaid forecast is a savings the Governor did not assume when presenting a balanced budget based on the November request and January supplementals and budget amendments.

## ➔ R1 Medical Services Premiums

**REQUEST**

The Department requests a change to the Medical Services Premiums appropriation for both FY 23-24 and FY 24-25 based on a new forecast of caseload and expenditures under current law and policy. Medical Services Premiums pays for physical health and most long-term services and supports[1] for people eligible for Medicaid.

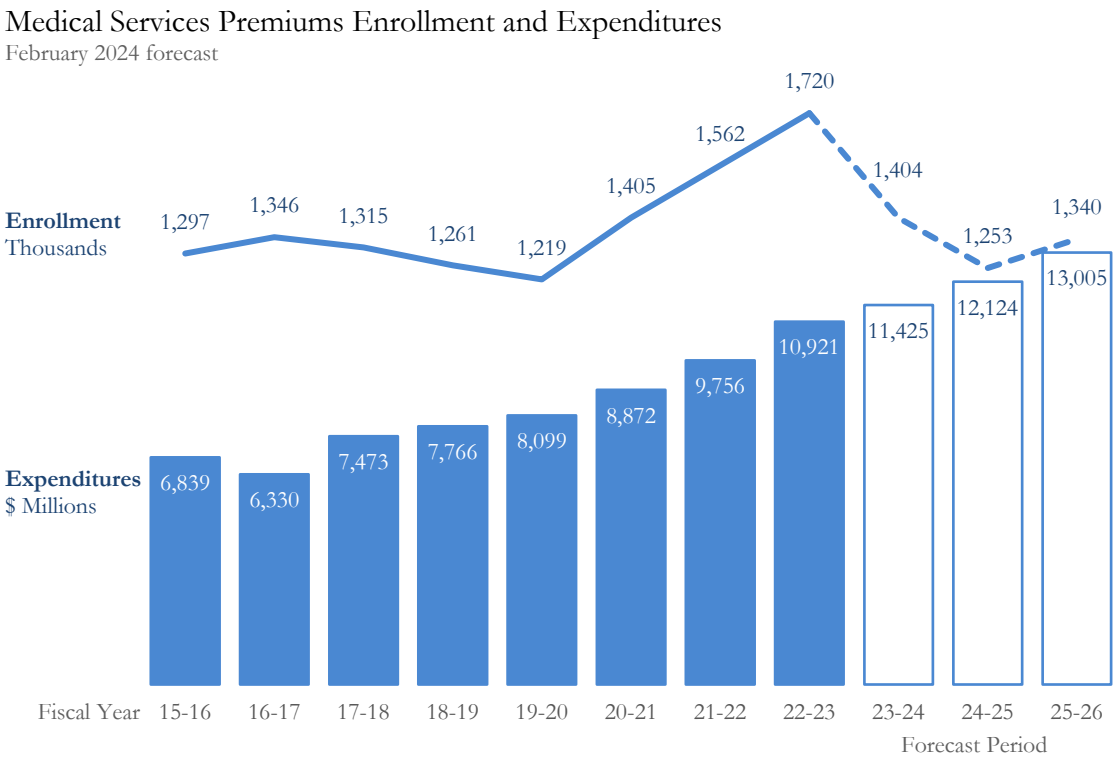
On February 15, 2024, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2024 forecast is lower than the forecast used for the Governor's request by $332.8 million total funds, including $53.5 million General Fund, in FY 23-24 and $522.5 million total funds, including $15.8 million General Fund, in FY 24-25. The cumulative General Fund difference over the two years is $69.3 million lower than the Governor's November request.

**RECOMMENDATION**

Staff recommends using the Department's February 2024 forecast of enrollment and expenditures to modify both the FY 23-24 and FY 24-25 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.

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




**FY 2023-24**

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

| FY 2023-24 Medical Services Premiums Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Other State | Federal Funds |
| FY 2023-24 Appropriation | $11,426,144,212 | 3,217,331,185 | 1,380,191,095 | 6,828,621,932 |
| Acute Care | | | | |
| Enrollment | (648,601,168) | (126,411,637) | (39,061,824) | (483,127,707) |
| Per capita | 405,428,585 | 79,355,599 | 29,395,550 | 296,677,436 |
| *Subtotal - Acute Care* | *(243,172,583)* | *(47,056,038)* | *(9,666,274)* | *(186,450,271)* |
| Long-term Care Programs | | | | |
| HCBS waivers | 32,290,865 | 15,822,524 | 0 | 16,468,341 |
| Long-Term Home Health/PDN/Hospice | (18,203,115) | (8,392,764) | (79,482) | (9,730,869) |
| Nursing homes | (16,549,289) | (8,068,518) | (4,471) | (8,476,300) |
| PACE | (9,742,604) | (4,773,876) | 0 | (4,968,728) |
| *Subtotal - Long-term Care Programs* | *(12,204,143)* | *(5,412,634)* | *(83,953)* | *(6,707,556)* |
| Medicare & private premiums | 3,003,634 | 3,594,264 | 0 | (590,630) |
| Service management | (35,477,787) | (8,827,365) | (4,252,933) | (22,397,489) |
| Recoveries | 0 | 9,365,094 | 0 | (9,365,094) |
| Hospital supplemental payments | (53,266,610) | 0 | (20,449,675) | (32,816,935) |
| EMT certified public expenditures | 8,879,386 | (1,119,923) | 4,379,697 | 5,619,611 |
| Other financing | (642,221) | (4,079,615) | (5,103,662) | 8,541,056 |
| **TOTAL** | **$11,093,263,888** | **$3,163,794,968** | **$1,345,014,295** | **$6,584,454,624** |
| | | | | |
| Increase/(Decrease) | (332,880,324) | (53,536,217) | (35,176,800) | (244,167,308) |
| Percentage Change | -2.9% | -1.7% | -2.5% | -3.6% |

*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 forecast is down 75,000 for ACA expansion populations, 40,000 for children, 26,000 for parents and pregnant women, and 3,400 for the elderly and people with disabilities.
- Per Capita – Actual expenditures per capita are running higher than expected for the first part of the year. Also, the disenrollments for the end of the public health emergency are low utilizers, so when they are removed from the calculation the average expenditure per enrollee increases.

*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. 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 decreased the forecast primarily due to decreased utilization of therapy 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 with the end of a moratorium on new enrollment for one of the major providers, InnovAge, but 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.

*MEDICARE & PRIVATE PREMIUMS*

The increase is primarily due to slightly higher Medicare premiums than forecasted. 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.

*RECOVERIES*

The Department decreased the projected share of recoveries that offset General Fund expenditures versus federal funds expenditures.

*HOSPITAL SUPPLEMENTAL PAYMENTS*

The Department is anticipating that some reconciliation payments will occur in FY 24-25 instead of the originally forecasted FY 23-24. These reconciliations typically happen on the cusp of the state fiscal year and adjustments to which state fiscal year they impact are not uncommon. To make the hospital supplemental payments, the Department collects money from the hospitals through the Healthcare Affordability and Sustainability Fee, matches the money with federal funds, and then sends the money back to the hospitals in proportion to the indigent clients served. The supplemental payments reduce shortages when Medicaid reimbursements are below costs and when hospitals provide care to patients who are uninsured or underinsured.

*EMT CERTIFIED PUBLIC EXPENDITURES*

The Department increased the forecast of expenditures by public emergency medical transportation (EMT) 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 $509.9 million total funds, including an increase of $325.0 million General Fund, from FY 2023-24 to FY 2024-25. The table below shows the major contributors to the General Fund change.

| FY 2024-25 Medical Services Premiums Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Other State | Federal Funds |
| FY 2024-25 Projection | $11,093,263,888 | 3,163,794,968 | 1,345,014,295 | 6,584,454,624 |
| Acute Care | | | | |
| Enrollment | (549,062,882) | (86,534,290) | (40,376,929) | (422,151,663) |
| Per capita | 602,719,373 | 159,957,381 | 23,231,710 | 419,530,281 |
| DACA recipients | 2,061,189 | 1,030,594 | 0 | 1,030,595 |
| *Subtotal - Acute Care* | *55,717,680* | *74,453,686* | *(17,145,219)* | *(1,590,787)* |
| Long-term Care Programs | | | | |
| HCBS waivers | 169,046,466 | 80,223,032 | 2,664,360 | 86,159,074 |
| Long-Term Home Health/PDN/Hospice | 66,774,828 | 33,387,414 | 0 | 33,387,414 |
| Nursing homes | 55,372,515 | 26,210,116 | (67,198) | 29,229,597 |
| PACE | 42,027,379 | 21,013,689 | 0 | 21,013,690 |
| *Subtotal - Long-term Care Programs* | *333,221,188* | *160,834,251* | *2,597,162* | *169,789,775* |
| Medicare & private premiums | 16,378,390 | 11,332,874 | 0 | 5,045,516 |
| Service management | (19,776,830) | (3,098,222) | (2,613,943) | (14,064,665) |

| FY 2024-25 Medical Services Premiums Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Other State | Federal Funds |
| One-time ARPA funding | 0 | 4,757,905 | (4,757,905) | 0 |
| Federal match | 0 | 83,858,736 | (12,382,001) | (71,476,735) |
| Supplemental payments | 133,067,434 | 0 | 62,287,010 | 70,780,424 |
| CUSOM payments | (20,099,946) | 0 | 0 | (20,099,946) |
| Other financing | 11,356,428 | (7,140,516) | 14,224,961 | 4,271,983 |
| **TOTAL** | **$11,603,128,232** | **$3,488,793,682** | **$1,387,224,360** | **$6,727,110,189** |
| | | | | |
| Increase/(Decrease) | 509,864,344 | 324,998,714 | 42,210,065 | 142,655,565 |
| Percentage Change | 4.6% | 10.3% | 3.1% | 2.2% |

*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 an 11 percent decrease in average enrollment in FY 2024-25, after an 18 percent decrease in FY 2023-24.
- 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 with notable increases for services to people with disabilities and foster care children.
- DACA Recipients -- The forecast assumes a new proposed federal regulation will be implemented in July 2024 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. 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 increased utilization and 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 2.2 percent increase in patient days and a 3.0 percent statutory minimum increase in per diem rates. The statutory minimum increase will decrease to 1.5 percent in FY 2025-26 and then thereafter there will be no minimum increase.
- PACE -- The Department projects continued strong growth in both enrollment (11.0 percent) and per capita costs (3.5 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 & PRIVATE 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 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 continued 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 some of the payments from FY 2023-24 bleeding into FY 2024-25.

*CUSOM PAYMENTS*

The Department's forecast assumes a decrease in federal funds to match expenditures by the University of Colorado School of Medicine (CUSOM) for Medicaid reimbursements to CUSOM providers due to the end of enhanced federal match. 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

**REQUEST**

The Department requests a change to the Child Health Plan Plus (CHP+) for both FY 23-24 and FY 24-25 based on a new forecast of caseload and expenditures under current law and policy. The CHP+ pays for physical health services for eligible children and pregnant women and for dental services for children.

On February 15, 2024, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2024 forecast is higher than the forecast used for the Governor's request by $28.9 million total funds, including $3.3 million General Fund, in FY 23-24 and $56.6 million total funds, including $6.1 million General Fund, in FY 24-25. The cumulative General Fund difference over the two years is $9.5 million higher than the Governor's November request.

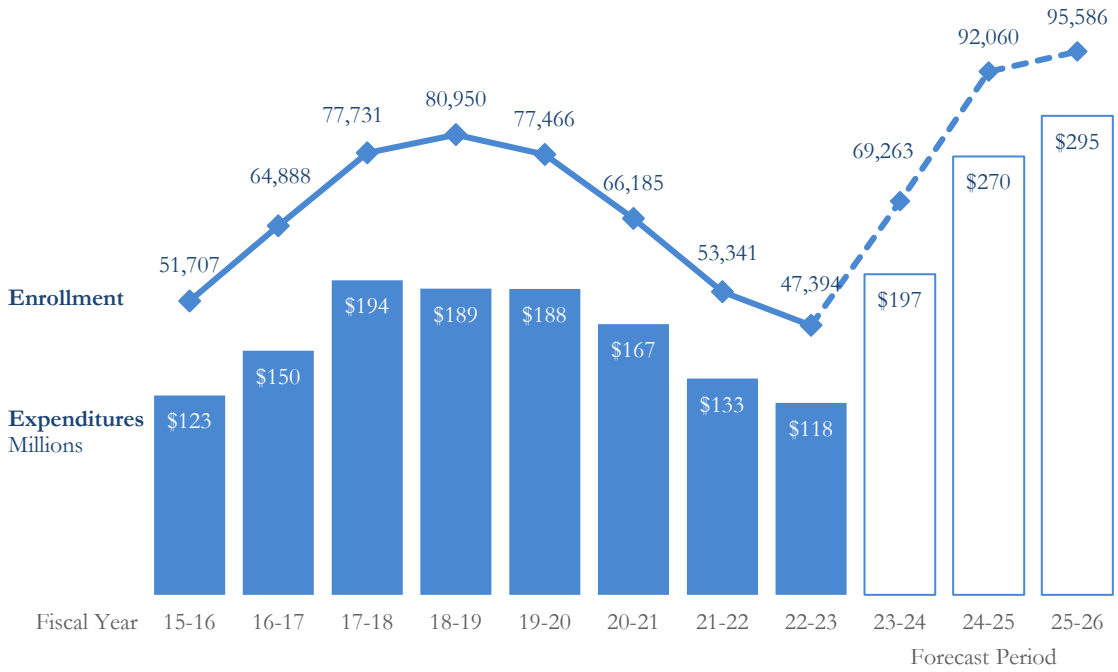
**RECOMMENDATION**

Staff recommends using the Department's February 2024 forecast of enrollment and expenditures to modify both the FY 23-24 and FY 24-25 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.

Children's Basic Health Plan (CHP+) Enrollment and Expenditures

February 2024 forecast, without reconciliations



*FY 2023-24*

The table below shows the most significant factors driving the change in the Department's forecast for FY 2023-24. Note that this table displays changes from the appropriation and not changes from FY 2022-23. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

| FY 2023-24 Children's Basic Health Plan Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2023-24 Appropriation | $168,474,027 | $24,314,949 | $34,299,762 | $109,859,316 |
| Enrollment | 23,372,946 | 2,243,498 | 5,322,832 | 15,806,616 |
| Per capita | 5,506,309 | 1,085,277 | 1,253,978 | 3,167,054 |
| Tobacco forecast | 0 | 0 | 0 | 0 |
| **TOTAL** | **$197,353,282** | **$27,643,724** | **$40,876,572** | **$128,832,986** |
| | | | | |
| Increase/(Decrease) | 28,879,255 | 3,328,775 | 6,576,810 | 18,973,670 |
| Percentage Change | 17.1% | 13.7% | 19.2% | 17.3% |

As the Department decreased the projected Medicaid enrollment, it increased the projected CHP+ 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. The Department made small changes to per capita assumptions.

*FY 2024-25*

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2023-24 to FY 2024-25. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

| FY 2024-25 Children's Basic Health Plan Enrollment/Utilization Trends | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | OTHER STATE | FEDERAL FUNDS |
| FY 2023-24 Projection | $197,353,282 | $27,643,724 | $40,876,572 | $128,832,986 |
| Enrollment | 59,879,935 | 13,089,067 | 7,868,911 | 38,921,958 |
| Per capita | 12,747,569 | 1,771,321 | 1,927,207 | 9,049,040 |
| Federal match | 0 | 1,381,473 | 0 | (1,381,473) |
| **TOTAL** | **$269,980,786** | **$43,885,585** | **$50,672,690** | **$175,422,511** |
| | | | | |
| Increase/(Decrease) | 72,627,504 | 16,241,861 | 9,796,118 | 46,589,525 |
| Percentage Change | 36.8% | 58.8% | 24.0% | 36.2% |

The projected increase in total funds for FY 2024-25 is primarily driven by an expected significant jump in enrollment with the end of the continuous eligibility requirement. The Department is required by federal statute to annually adjust capitated payments for managed care plans to ensure the rates are actuarially sound. 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

**REQUEST**

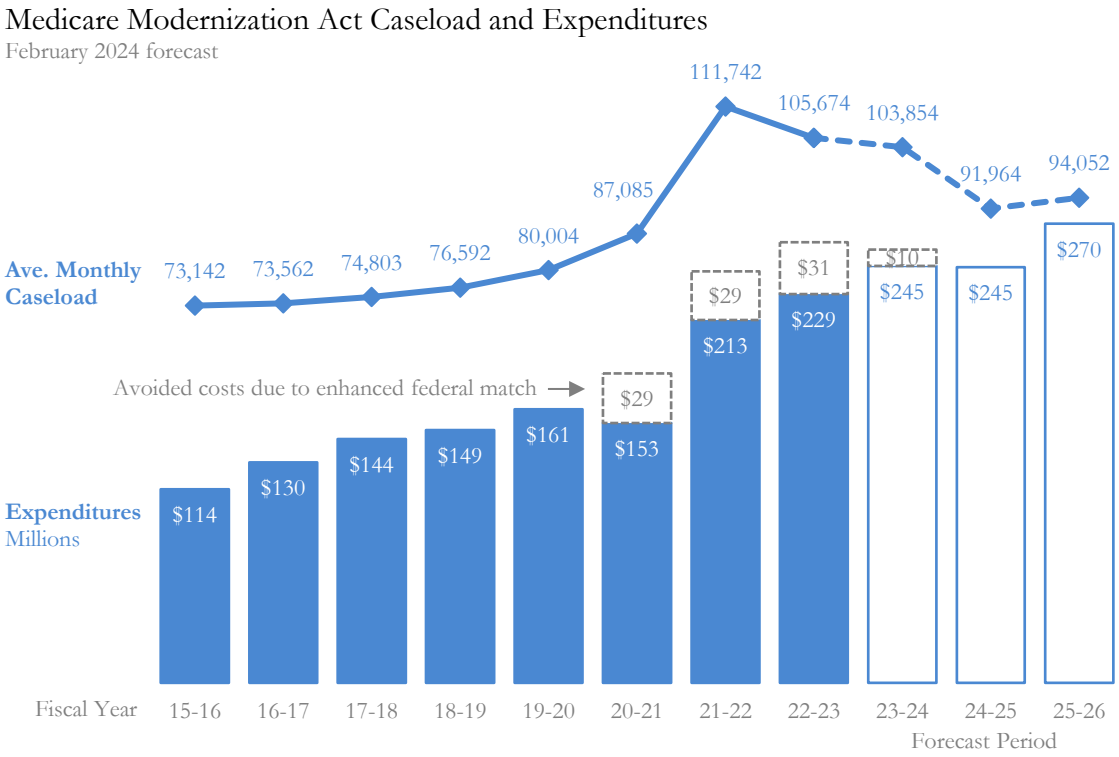
The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible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

On February 15, 2024, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2024 forecast is lower than the forecast used for the Governor's request by $6.4 million General Fund in FY 2023-24 and $9.4 million General Fund in FY 2024-25. The cumulative General Fund difference over the two years is $15.8 million higher than the Governor's November request.

**RECOMMENDATION**

Staff recommends using the Department's February 2024 forecast of enrollment and expenditures to modify both the FY 2023-24 and FY 2024-25 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast. The enhanced federal match through the federal Families First Coronavirus Response Act reduced the state obligation under the Medicare Modernization Act.




*FY 2023-24*

The table below shows the most significant factors driving the change in the Department's forecast for FY 2023-24. Note that this table displays changes from the appropriation and not changes from FY 2022-23. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

| FY 2023-24 Medicare Modernization Act | |
|---|---|
| | General Fund |
| FY 2023-24 Appropriation | $251,754,405 |
| Enrollment | (7,857,546) |
| Per capita | 1,492,121 |
| **TOTAL** | **$245,388,980** |
| | |
| Increase/(Decrease) | (6,365,425) |
| Percentage Change | -2.5% |

The Department brought down the enrollment forecast consistent with the Medicaid enrollment forecast and increased the projected per capita expenditures based on the way the federal formula tries to account for pharmaceutical inflation.

*FY 2024-25*

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2023-24 to FY 2024-25. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

| FY 2024-25 Medicare Modernization Act | |
|---|---|
| | GENERAL FUND |
| FY 2023-24 Projection | $245,388,980 |
| Enrollment | (28,094,552) |
| Per capita | 22,252,612 |
| Federal match for public health emergency | 5,112,572 |
| **TOTAL** | **$244,659,612** |
| | |
| Increase/(Decrease) | (729,368) |
| Percentage Change | -0.3% |

The Department brought down the enrollment forecast consistent with the Medicaid enrollment forecast and increased the projected per capita expenditures based on the way the federal formula tries to account for pharmaceutical inflation. The projection also increases the estimated required General Fund for the phase out of the enhanced federal match.

## ➔ BA9 Public School Health Services

**REQUEST**

The Department requests a net increase of $9.7 million total funds for public school health services based on an updated projection of certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

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

**RECOMMENDATION**

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

Department. The Department needs the increase in spending authority to distribute the federal funds to the school districts.

## BENEFITS/ELIGIBILITY ADJUSTMENTS

### ➔ R9 Access to benefits [potential legislation]

**REQUEST**

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[2] on covering these treatments in CHP+.

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.

| 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** |

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.

**RECOMMENDATION**

The staff recommendation is summarized in the table below with each component discussed in more detail following the table.

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

| R9 Access to Benefits | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| **Proposed legislation** | | | | | |
| Autism spectrum disorder treatment in CHP+ | $18,628,834 | $3,925,923 | $2,594,169 | $12,108,742 | 0.0 |
| | | | | | |
| **Changes in Long Bill** | | | | | |
| Pain management | 308,000 | 153,999 | 0 | 154,001 | 0.9 |
| *Provider training & consults* | *250,000* | *125,000* | *0* | *125,000* | *0.0* |
| *Referral coordinator* | *58,000* | *28,999* | *0* | *29,001* | *0.9* |
| Plan for transplant nurse navigator program | 0 | 0 | 0 | 0 | 0.0 |
| Subtotal - Changes in Long Bill | $308,000 | $153,999 | $0 | $154,001 | 0.9 |
| | | | | | |
| **TOTAL - All Changes** | **$18,936,834** | **$4,079,922** | **$2,594,169** | **$12,262,743** | **0.9** |

*AUTISM SPECTRUM DISORDER TREATMENT IN CHP+*

**Staff recommends the requested legislation to add autism spectrum disorder treatments as a benefit in CHP+.** The change would make the CHP+ coverage more consistent with Medicaid and typical medical practice. It would ensure that people who transition from Medicaid to CHP+ do not have an interruption in coverage. The JBC staff cannot find a policy reason for the current statutory prohibition on CHP+ coverage. The Department's explanation is that the statutory prohibition was added as a budget consideration.

Based on the JBC's supplemental action to increase Medicaid rates for pediatric behavioral therapies, the JBC staff assumes the Department will need to set correspondingly higher rates for CHP+ services, increasing the estimated cost of the proposed new benefit to $18,628,834 total funds, including $3,925,923 General Fund. This is higher than the Department's request by $4,760,134 total funds, including $1,003,172 General Fund.

*PAIN MANAGEMENT CENTERS FOR EXCELLENCE*

The Department proposes continuing a pain management pilot program that was started with federal stimulus funds in the Home- and Community-Based Services Improvement Fund for another two years. The program is intended to address a perceived shortage of available Medicaid providers to treat members with chronic pain. It provides training to primary care medical providers, peer-to-peer consultations with pain specialists for primary care physicians, and a benefit specialist that helps coordinate appropriate referrals to mental health, substance use disorder, or chronic pain providers. Untreated chronic pain can result in depression, anxiety, suicidality, increased emergency department utilization, and use of illegal non-prescription drugs. Development and implementation of the pilot program was delayed due to contracting issues and the Department says the pilot program is just beginning to collect evidence. The Department believes the program would benefit from another two years of funding to determine whether to continue the program and possibly expand it to all Medicaid members and not just those receiving Home- and Community-Based Services.

When asked for data on the provider shortage for chronic pain management, the Department responded that the assertion there is a shortage is based on stakeholder and advocate feedback. The Department provided anecdotes that there have been at least nine documented pain clinic closures in Colorado since 2023, many providers treating chronic pain are scheduling 3-6 months out, and one of the largest healthcare organizations has no appointments for pain management for Medicaid members until 2025.

There is no specific credential required for providers that treat pain management. There are providers, often with a background in anesthesiology, who build practices around treating complex chronic pain. The Department hopes to increase the number of primary care providers who are able and willing to treat Medicaid members with chronic pain through training and facilitating peer to peer consults that allow the primary care providers to consult a more experienced provider for advice on how to manage a patient's chronic pain.

**Staff recommends approval of the request** with modification to apply the JBC's common policies regarding new FTE and removing the Department's assumption that some of the FTE cost would be covered by the Healthcare Affordability and Sustainability (HAS) Fee. This is presented as a pilot The JBC staff probably would not have recommended creating the pilot program based on only anecdotal evidence of the need. Also, the JBC staff is conscious of the number of areas where the Department is getting involved in training providers and whether that fits the Department's core statutory mission. However, now that the pilot has begun with the help of federal stimulus funding, it makes sense to the JBC staff to provide enough additional funding to see if the pilot can generate evidence that the program is effective in expanding access to care and improving health outcomes.

The Department's request assumed that the state match for the contract services would come from the General Fund, since this program is serving Home- and Community-Based Services clients rather than expansion populations. However, the Department assumed 38 percent of the state match for the FTE costs would be covered by the Healthcare Affordability and Sustainability (HAS) Fee. To be consistent with the financing for the contract services, the JBC staff assumes the state match for the FTE will be all General Fund.

*PLAN FOR TRANSPLANT NURSE NAVIGATOR PROGRAM*

The Department would like to study the best way to implement a nurse navigator program for organ transplants. The research would look at how a transplant nurse navigator program could improve health outcomes and patient experience and save medical costs. The Department would look at the efficacy of hiring staff versus using the Regional Accountable Entities (RAEs) to provide benefit navigation. After the study is complete, the Department submit a budget request to implement the program.

The Department believes there are opportunities to improve the health outcomes associated with organ transplants for Medicaid clients. For example, the Department says a nurse navigator program could help ensure patients do not skip follow up appointments due to distance or lack of awareness about the availability of transportation assistance. A transplant nurse navigator could help clients and providers steer through the process for getting preemptive transplants. For patients with chronic kidney disease, research indicates that preemptive transplants from living donors prior to the need to start dialysis result in better patient outcomes and a longer life of the new kidney (12-20 years versus 8-12 years). It used to be that Medicare was the primary payer for kidney transplants for Medicaid members, but over the last 10+ years more kidney transplants are occurring prior to a patient going on dialysis and becoming eligible for Medicare. The Department's preliminary data indicates Medicaid is now the primary payer in approximately 50 percent of kidney transplants for Medicaid members.

**The JBC staff does not recommend the requested $100,000 total funds, including $50,000 General Fund for a study of how to implement a transplant nurse navigator program**. The recommendation is not about the merits of the study. If the Department believes a transplant nurse navigator program could improve health outcomes and reduce costs for more expensive care, then

the Department should pursue the study and present a plan to the General Assembly next year, but the JBC staff believes the cost of the preliminary study can be absorbed within existing resources.

The Department has a line item called General Professional Services and Special Projects. Most of the money in the line item is earmarked for specific projects approved by the General Assembly, but there is flexibility built into the line item for ad hoc studies and analysis the Department periodically needs. In addition, all of the appropriations for the line item are based on estimates of the contract costs. The actual bids can be higher or lower, resulting in varying degrees of flexibility in the line item each year. In FY 2022-23 the Department was appropriated $51.1 total funds, including $7.0 million General Fund, and reverted $3.2 million General Fund from the line item. In FY 2023-24 the Department was appropriated $77.8 million total funds, including $8.6 million General Fund, and reverted $1.5 million General Fund from the line item. The proposed study is one-time and a relatively small dollar amount compared to the appropriation for General Professional Services and Special Projects. This is not something the General Assembly is requiring the Department to do, so if FY 2024-25 is the year that every bid comes in higher than expected and the Department needs to put off the nurse navigator program study, it could do so.

## PROVIDER RATES

### ➔ R6a Provider rates

**REQUEST**
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 provider rate increase.

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 rates receiving annual adjustments based on state or federal policy include hospital and nursing home supplemental payments, managed care, nursing facilities, pharmacy, Medicare premiums for people dually eligible, Federally Qualified Health Centers and Rural Health Centers, and hospice.

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 Medicaid Provider Rate Review Advisory Committee (MPRRAC) process would be in lieu of, rather than in addition to, the common policy provider rate adjustment, since these are a rebase of the rates relative to a benchmark. For the four requested targeted rate increases outside of the MPRRAC process (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.

**RECOMMENDATION**

Staff recommends an increase of $182.0 million total funds, including $69.9 million General Fund, for an across-the-board increase of 2.5 percent, consistent with the JBC's common policy, applied to the same codes as the Department's request. The staff recommendation differs from the request due to applying the JBC's common policy for a 2.5 percent increase instead of the requested 1.0 percent increase and updating the estimated total costs and fund sources based on the Department's February 2024 forecast. The cost of the common policy provider rate adjustment increases to $198.3 million total funds, including $76.2 million General Fund, in FY 2025-26 when the state needs to pick up the 12th month of expenditures.

| R6a Provider rates | | | | |
|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| **FY 2024-25** | | | | |
| County Administration | $2,789,702 | $461,064 | $638,079 | $1,690,559 |
| Medical Services Premiums | 152,811,430 | 56,298,249 | 6,313,841 | 90,199,340 |
| Behavioral Health Fee-for-Service | 251,739 | 55,821 | 15,178 | 180,740 |
| Adult Comprehensive Services | 18,007,287 | 8,972,340 | 31,304 | 9,003,643 |
| Adult Supported Living Services | 2,165,775 | 893,856 | 189,032 | 1,082,887 |
| Children's Extensive Support Services | 1,920,640 | 941,560 | 18,760 | 960,320 |
| Children's Habitation/Rehabilitation Program | 376,854 | 186,912 | 1,515 | 188,427 |
| Case Management | 3,161,225 | 1,560,538 | 34,992 | 1,565,695 |
| Family Support Services | 253,203 | 253,203 | 0 | 0 |
| State Supported Living Services | 119,018 | 119,018 | 0 | 0 |
| State Supported Living Services Case Management | 115,982 | 115,982 | 0 | 0 |
| Preventive Dental Hygiene | 1,600 | 1,600 | 0 | 0 |
| **Total** | **$181,974,455** | **$69,860,143** | **$7,242,701** | **$104,871,611** |
| | | | | |
| **FY 2025-26** | | | | |
| County Administration | $2,789,702 | $461,064 | $638,079 | $1,690,559 |
| Medical Services Premiums | 166,703,377 | 61,416,271 | 6,887,827 | 98,399,279 |
| Behavioral Health Fee-for-Service | 274,624 | 60,895 | 16,558 | 197,171 |
| Adult Comprehensive Services | 19,644,313 | 9,788,007 | 34,150 | 9,822,156 |
| Adult Supported Living Services | 2,362,663 | 975,115 | 206,216 | 1,181,332 |
| Children's Extensive Support Services | 2,095,244 | 1,027,157 | 20,465 | 1,047,622 |
| Children's Habitation/Rehabilitation Program | 411,113 | 203,904 | 1,652 | 205,557 |
| Case Management | 3,448,609 | 1,702,405 | 38,173 | 1,708,031 |
| Family Support Services | 276,221 | 276,221 | 0 | 0 |
| State Supported Living Services | 129,838 | 129,838 | 0 | 0 |
| State Supported Living Services Case Management | 126,526 | 126,526 | 0 | 0 |
| Preventive Dental Hygiene | 1,746 | 1,746 | 0 | 0 |
| **Total** | **$198,263,976** | **$76,169,149** | **$7,843,120** | **$114,251,707** |

Each 0.5 percent change in the common policy would adjust the estimated FY 2024-25 cost by $36.4 million total funds, including $14.0 million General Fund.

## ➔ R6b Targeted rates [potential legislation]

**REQUEST**

The Department requests $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 wages for Home- and Community-Based Services (HCBS). The Department divided the request into adjustments based on the annual rate review by the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and other targeted rate adjustments.

R6b Targeted Provider Rates - Department Request

| Rate | Change | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
|---|---|---|---|---|---|
| **Adjustments based on the MPRRAC Rate Review** | | | | | |
| Dental | 15 preventive codes to 100%<br>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%<br>12 other rates to 80% | 7,786,537 | 3,893,269 | 0 | 3,893,268 |
| Surgeries | 70-100% most surgeries<br>100% preventive digestive & integumentary<br>70-125% cardiovascular to non-facility | 6,773,293 | 1,982,002 | 280,956 | 4,510,335 |
| Ambulatory surgery centers | At least 75% of benchmark | 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** |

**RECOMMENDATION**

Staff recommends $198.4 million total funds, including $57.1 million General Fund, for targeted provider rate increases. The recommendation is summarized in the table below. More detail about each component of the staff recommendation can be found in the subsections following the table.

| R6b Targeted Provider Rates - Staff Recommendation | | | | | |
|---|---|---|---|---|---|
| Rate | Change | Total Funds | General Fund | Cash Funds | Federal Funds |
| **Adjustments based on the MPRRAC Rate Review** | | | | | |
| Dental | 15 preventive codes to 100%<br>13 diagnostic codes 70% | $92,710,684 | $16,928,971 | $13,999,314 | $61,782,399 |
| Pediatric behavioral therapies | 100% of benchmark with NE | 34,281,532 | 17,140,766 | 0 | 17,140,766 |
| Maternity | 100% of the benchmark | 8,197,058 | 4,098,529 | 0 | 4,098,529 |
| Surgeries | 100% preventive digestive<br>80% digestive & musculoskeletal<br>80-100% all others | 792,128 | 231,793 | 32,857 | 527,478 |
| Ambulatory surgery centers | At least 80% of benchmark | 4,931,565 | 1,443,074 | 204,562 | 3,283,929 |
| Co-surgeries | Expand billable codes | 0 | 0 | 0 | 0 |
| 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** | | **$133,347,273** | **$37,941,872** | **$13,860,380** | **$81,545,021** |
| | | | | | |
| **Other targeted rate adjustments** | | | | | |
| Wages for HCBS | Minimum wage increase | $65,042,725 | $19,198,936 | $13,322,439 | $32,521,350 |
| Single Assessment Tool | Implementation cost | 0 | 0 | 0 | 0 |
| Primary Care Fund | Serve clients 201-250% of FPL | 0 | 0 | 0 | 0 |
| Regional Center transitions | 1-year enhanced rate for transitions | 0 | 0 | 0 | 0 |
| **Subtotal - Other** | | **$65,042,725** | **$19,198,936** | **$13,322,439** | **$32,521,350** |
| | | | | | |
| **TOTAL** | | **$198,389,998** | **$57,140,808** | **$27,182,819** | **$114,066,371** |

The costs for most of the recommended targeted rate adjustments are calculated based on 11 months in order to account for the cash basis accounting of claims processing. The exception is the pediatric behavioral therapies, because the JBC already approved a supplemental increase. The next table shows the projected FY 2025-26 fiscal impact of the staff recommendation with the extra month of expenditures. Note that there is also a $13.3 million General Fund increase for the Wages for HCBS because the Department is requesting and the JBC staff is recommending offsetting some of the cost in FY 2024-25 with money from the Home- and Community-Based Services Improvement Fund.

| R6b Targeted Provider Rates - FY 2025-26 Fiscal Impact | | | | | |
|---|---|---|---|---|---|
| Rate | Change | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| **Adjustments based on the MPRRAC Rate Review** | | | | | |
| Dental | 15 preventive codes to 100%<br>13 diagnostic codes 70% | $101,138,928 | $18,467,968 | $15,271,979 | $67,398,981 |
| Pediatric behavioral therapies | 100% of benchmark with NE | 34,281,532 | 17,140,766 | 0 | 17,140,766 |
| Maternity | 100% of the benchmark | 8,942,246 | 4,471,123 | 0 | 4,471,123 |
| Surgeries | 100% preventive digestive<br>80% digestive & musculoskeletal<br>80-100% all others | 864,139 | 252,865 | 35,844 | 575,430 |
| Ambulatory surgery centers | At least 80% of benchmark | 5,379,889 | 1,574,263 | 223,158 | 3,582,468 |
| Co-surgeries | Expand billable codes | 0 | 0 | 0 | 0 |
| Autism spectrum screening | Restore 2 codes to previous levels | 1,644,157 | 822,078 | 0 | 822,079 |
| Abortion | 100% of benchmark | 325 | 162 | 0 | 163 |
| Anesthesia | 100% of benchmark | (9,897,967) | (2,896,344) | (410,567) | (6,591,056) |
| **Subtotal - MPRRAC** | | **$142,353,249** | **$39,832,881** | **$15,120,414** | **$87,399,954** |
| | | | | | |
| **Other targeted rate adjustments** | | | | | |
| Wages for HCBS | Minimum wage increase | $70,955,698 | $35,477,856 | $0 | $35,477,842 |
| Single Assessment Tool | Implementation cost | 0 | 0 | 0 | 0 |
| Primary Care Fund | Serve clients 201-250% of FPL | 0 | 0 | 0 | 0 |
| Regional Center transitions | 1-year enhanced rate for transitions | 0 | 0 | 0 | 0 |
| **Subtotal - Other** | | **$70,955,698** | **$35,477,856** | **$0** | **$35,477,842** |
| | | | | | |
| **TOTAL** | | **$213,308,947** | **$75,310,737** | **$15,120,414** | **$122,877,796** |

The next table summarizes where and by how much the staff recommendation differs from the Department's request. The difference for dental is based on corrected information submitted by the Department after the November 1 request, the difference for pediatric behavioral therapies is based on the JBC's supplemental action, and the difference for the Single Assessment is due to implementation delays. The remaining differences are new substantive policy differences.

| R6b Targeted Provider Rates - JBC Staff Higher/(Lower) than Request | | | | | |
|---|---|---|---|---|---|
| Rate | Change | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| **Adjustments based on the MPRRAC Rate Review** | | | | | |
| Dental | 15 preventive codes to 100%<br>13 diagnostic codes 70% | $14,225,663 | $2,597,605 | $2,148,076 | $9,479,982 |
| Pediatric behavioral therapies | 100% of benchmark with NE | 22,347,095 | 11,173,547 | 0 | 11,173,548 |
| Maternity | 100% of the benchmark | 410,521 | 205,260 | 0 | 205,261 |
| Surgeries | 100% preventive digestive<br>80% digestive & musculoskeletal<br>80-100% all others | (5,981,165) | (1,750,209) | (248,099) | (3,982,857) |
| Ambulatory surgery centers | At least 80% of benchmark | 928,817 | 271,790 | 38,528 | 618,499 |
| Co-surgeries | Expand billable codes | (1,613,031) | (472,005) | (66,908) | (1,074,118) |
| Autism spectrum screening | Restore 2 codes to previous levels | 0 | 0 | 0 | 0 |
| Abortion | 100% of benchmark | 0 | 0 | 0 | 0 |
| Anesthesia | 100% of benchmark | 0 | 0 | 0 | 0 |
| **Subtotal - MPRRAC** | | **$30,317,900** | **$12,025,988** | **$1,871,597** | **$16,420,315** |

| R6b Targeted Provider Rates - JBC Staff Higher/(Lower) than Request | | | | | |
|---|---|---|---|---|---|
| Rate | Change | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS |
| **Other targeted rate adjustments** | | | | | |
| Wages for HCBS | Minimum wage increase | $11,185,974 | $5,592,987 | $0 | $5,592,987 |
| 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** | | **$6,567,667** | **$3,283,835** | **$0** | **$3,283,832** |
| | | | | | |
| **TOTAL** | | **$36,885,567** | **$15,309,823** | **$1,871,597** | **$19,704,147** |

**ADJUSTMENTS BASED ON THE MPRRAC RATE REVIEW**

*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 preventive 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 preventive, 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.

Subsequent to the November request, the Department discovered that it made an error in calculating the cost of the proposed policy changes. The Department used the American Dental Association (ADA) 2020 survey for the benchmark, rather than the ADA 2022 survey. Using the ADA 2022 survey for the benchmark increases the estimated cost of implementing the Department's proposed rates to $92.7 million total funds, including $16.9 million General Fund. This is $2.6 million General Fund more than the original November request.

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 the 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.

The Department's request is lower than the MPRRAC recommendation to increase the 24 dental codes recommended by the Colorado Dental Association to 100 percent of the benchmark with no distinction between preventive and diagnostic codes.

**Staff recommends the Department's request, corrected for using the ADA 2022 survey.** The MPRRAC recommendation would raise the 24 dental codes identified by the Colorado Dental Association to 100 percent of a benchmark that the JBC staff has reservations about. The ADA survey 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.

The Department's request increases only preventive codes where the Department wants to incentivize utilization to 100 percent of the benchmark. The Department's request would increase the remaining diagnostic codes to a more conservative 70 percent of the benchmark. The Department promises a "full" review of dental rates in 2024 that will include comparisons to other state Medicaid programs. With the JBC staff's concerns about the ADA survey and the promise of a more complete rate review in 2024, the JBC staff favors the Department's request over the MPRRAC recommendation.

The Department has to present a balanced budget and the MPRRAC does not, but when the Department decided to request increases for 4 codes that were not reviewed by the MPRRAC it was adding money, rather than subtracting money. The Department says the lack of MPRRAC analysis on the 4 codes was due to timing issues. If that is the case, then the Department needs to improve its scheduling. Whether the MPRRAC would have supported the proposed increases for the other 4 codes or raised issues about them is unknown. The JBC is missing potentially valuable feedback from the MPRRAC and stakeholders to inform decision making.

*PEDIATRIC BEHAVIORAL THERAPIES*

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

The MPRRAC recommended increasing rates to 100 percent of the benchmark with Nebraska.

**Staff recommends $34.3 million total funds, including $17.1 million General Fund, to increase the rates to 100 percent of the benchmark including Nebraska.** The staff recommendation is based on the JBC's supplemental action to implement rate increases based on the MPRRAC recommendation beginning in FY 2023-24. The table above reflects the full fiscal year cost or consistency with the way the other targeted rate increases are presented, but the supplemental already provided $10.4 million total funds, including $5.2 million General Fund, in FY 2023-24, so the incremental increase needed over the FY 2023-24 budget is $23.9 million, including $11.9 million General Fund.

*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.

The MPRRAC recommended increasing maternity codes to 100 percent of the benchmark.

**Staff recommends $8.9 million total funds, including $4.5 million General Fund, to increase maternity codes to 100 percent of the benchmark, consistent with the MPRRAC recommendation**. The FY 2024-25 incremental difference between the MPRRAC recommendation and Department request is only $205,260, so the JBC staff is inclined to follow the recommendation of the MPRRAC.

*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 preventive 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 preventive digestive and integumentary surgeries is intended to incentivize preventive procedures that can improve health outcomes and reduce the utilization of more expensive care.

The Department says the wider range for cardiovascular surgery 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 are not provided in that setting.

The MPRRAC recommended rebalancing rates to within 80-100 percent of the benchmark with the following exceptions:

- Increase preventive digestive surgery codes to 100 percent of the benchmark
- Rebalance all other digestive surgery codes to 80 percent of the benchmark
- Rebalance musculoskeletal surgeries to 80 percent of the benchmark

**Staff recommends $792,128 total funds, including $291,793 General Fund, based on the MPRRAC recommendation.** Overall, the Department says it made modifications to the MPRRAC recommendations primarily for budget balancing reasons, but for surgeries the Department added money. For the surgery category, the Department added an additional explanation for why it changed the MPRRAC recommendation by raising access to care concerns. The Department's report indicates 40 percent of cardiovascular service providers serve Medicaid patients and 46 percent of digestive surgery providers serve Medicaid patients. For all other surgery categories, the percent of providers serving Medicaid patients is above 50 percent.

The Department tweaked every MPRRAC recommendation on surgeries. For example, for digestive surgeries the MPRRAC recommended rebalancing preventive codes to 100 percent of the benchmark versus the Department's request to increase preventive codes to 100 percent of the benchmark and leave codes with rates already above 100 percent of the benchmark unchanged. For integumentary procedures, the MPRRAC recommended rebalancing rates to within 80-100 percent of the benchmark while the Department recommended increasing 1 preventive code to 100 percent of the benchmark and rebalancing all other codes to within 70-100 percent of the benchmark.

The changes the Department made increased the projected expenditures for cardiovascular surgeries and digestive surgeries and decreased the projected expenditures for every other category. The Department moved money around within the surgery category as well as increasing the overall projected expenditures.

| Surgeries | | | | |
|---|---|---|---|---|
| | | | HCPF higher/(lower) | |
| | MPRRAC | HCPF | Total Funds | General Fund |
| Digestive | Preventive to 100%<br>Rebalance to 80% | Preventive to 100% +<br>Rebalance to 70-100% | $281,884 | $82,485 |
| Musculoskeletal | Rebalance to 80% | Rebalance to 70-100% | (1,270,987) | (371,917) |
| Cardiovascular | Rebalance to 80-100% | Rebalance to 70-125% using non-facility benchmark | 10,565,627 | 3,091,715 |
| Respiratory | Rebalance to 80-100% | Rebalance to 70-100% | (404,788) | (118,449) |
| Integumentary | Rebalance to 80-100% | 1 preventive code to 100%<br>Rebalance to 70-100% | (1,135,173) | (332,174) |
| Eye & Auditory | Rebalance to 80-100% | Rebalance to 70-100% | (207,364) | (60,679) |
| Other | Rebalance to 80-100% | Rebalance to 70-100% | (1,304,291) | (381,662) |
| **TOTAL** | | | **$6,524,908** | **$1,909,319** |

The most significant and troubling change was the Department's decision to use the higher non-facility rates as the benchmark for cardiovascular surgeries. Medicare pays the non-facility rate for services provided outside of a hospital, ambulatory surgery center, or skilled nursing facility. By using the higher Medicare non-facility rates as the benchmark for Medicaid services in a facility setting, the Department artificially raised the benchmark. 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 could still argue for paying above the benchmark because the provider participation rate is low, or to encourage utilization of preventive services, but that is a different argument than saying the rates are below the benchmark. What the Department did obscures how generous the Department's proposed rates for cardiovascular surgeries are compared to other payers. The MPRRAC recommendation to rebalance cardiovascular surgeries to within 80-100 percent of the benchmark would reduce projected expenditures by $7.7 million total funds while the Department's request would increase payments by $2.8 million total funds.

It is one thing for the Department to say that the MPRRAC didn't get a chance to review a change that was made for budget balancing reasons. It is another thing for the Department to rewrite every MPRRAC recommendation and increase the total projected expenditures without consulting the MPRRAC. One of the primary duties of the MPRRAC is to look at access to care issues. The MPRRAC is highly dependent on data from the Department to assess access to care. If the Department had concerns about access to care for cardiovascular and digestive surgeries and ideas for how to improve access to care, it should have presented this information to the MPRRAC so they could assess it and provide feedback. The MPRRAC was very clearly not on the same page as the Department with regard to whether there is an urgent need to increase cardiovascular surgery rates. The JBC staff does not know how the MPRRAC would have responded had the Department presented the same proposal to the MPRRAC as it presented to the JBC. For this subcategory, it appears from the outside that the Department's rate staff did not engage with the MPRRAC and just did what the Department thought was best. The JBC staff does not know why. The Department's explanation that this was a budget balancing change from the MPRRAC recommendation does not make sense.

*AMBULATORY SURGERY CENTERS*

The Department requests $4.0 million total funds, including $1.2 million General Fund, to increase rates to at least 75 percent of the benchmark. Also, the Department says it is exploring a change to the method for reimbursing ambulatory surgery centers that would be presented in a future request. The Department believes changing the reimbursement method would more accurately reimburse ambulatory surgery centers for services and resource utilization than simply raising rates to the benchmark in the current methodology. The Department did not expand further on what the potential future change to the payment methodology would mean for providers or how it would more accurately reimburse them.

The MPRRAC recommends increasing rates to at least 80 percent of the benchmark.

The Department estimates average reimbursement for ambulatory surgery centers is 53.5 percent of the benchmark. Ambulatory surgery centers are a lower cost alternative setting for many surgeries and the Department sees a benefit in encouraging greater utilization when that utilization reduces expenditures for higher cost options. The Department reports 43 percent of ambulatory surgery center providers serve Medicaid patients.

Staff recommends $4,931,565 total funds, including $1,443,074 General Fund, based on the MPRRAC recommendation. This is higher than the Department's request by $921,817 total funds, including $271,790 General Fund. In this area the Department's modification to the MPRRAC recommendation

was clearly a budget balancing decision. If the JBC needs money for balancing, this is a place where the JBC may want to consider the Department's request, especially with the Department's promise of a future budget proposal that would reform the payment methodology for ambulatory surgery centers. With current rates at 53.5 percent of the benchmark and a provider participation rate of 43 percent, the JBC staff decided to support the higher MPRRAC recommendation.

*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.

**Staff does not recommend the request**. The Department does not explain why it failed to 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. When the MPRRAC solicited stakeholder feedback on surgery rates it did not receive any testimony or concerns related to co-surgeries. It is not clear to the JBC staff if this is really a rate increase or a benefit expansion. Are the co-surgeries happening and the providers are just not getting paid the higher rate, or are co-surgeries not happening because the Department does not cover them? Will more Medicaid clients receive co-surgeries as a result of this request? If the Department is not going to follow the MPRRAC review process, then it needs to provide sufficient policy justification and explanation for an exception. That did not occur in this case. The JBC staff is open to the idea that this might be an important and valuable increase that the Department could justify in a comeback, but the JBC staff has insufficient information to support a recommendation for the request at this time.

*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 that the Department did not include in the budget request. The MPRRAC recommended adding a language translation modifier for native language speakers for testing codes and increasing rates to 100 percent of the benchmark for four psychology testing codes (96132, 96133, 96136, 96137).

**Staff recommends the Department's request**. The FY 2023-24 reductions in the autism screening and assessment rates were based on incomplete information and should be reversed. When the Department discovered the error, the JBC staff does not know why the Department did not just present this information to the MPRRAC as part of the rate review and get the MPRRAC's endorsement. After failing to inform the MPRRAC, the JBC staff is unsure why the Department characterized the rate change as attributable to the MPRRAC review. However, these frustrations with the Department's process do not change the staff recommendation on the best policy.

At the hearing the Department said it is doing further analysis on the cost of adding the language translation modifier proposed by MPRRAC. The codes MPRRAC recommended increasing are already at 97 percent of the benchmark. If the JBC wants to increase the codes to 100 percent of the benchmark, consistent with the MPRRAC recommendation, the Department estimates it would cost $319,452 total funds, including $159,726 General Fund. This was not part of the staff recommendation since the codes are already so close to the benchmark.

*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.

**Staff recommends approval of the request**. Due to the federal Hyde amendment, the circumstances when Medicaid would cover abortion services are very narrow, the number of abortions covered is very small, and the cost to implement the proposed rate increase is nominal.

*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.

The MPRRAC recommended the same adjustment as the Department's request but the MPRRAC also recommended adding a travel rate, which was intended to improve access to care in rural communities. For the hearing the Department responded that it does not have a way to differentiate services by traveling anesthesiologists from other anesthesia services or controls to ensure the

appropriate use of travel rates. The Department says it would need additional administrative resources to implement a travel rate. Also, the Department is doubtful that it could get federal approval from the Centers for Medicare and Medicaid Services (CMS). The Department is not aware of CMS approving any similar type of billing code. The Department notes that other types of specialists travel and do not receive additional Medicaid reimbursement.

**Staff recommends approval of the request, consistent with the recommendation with the MPRRAC**. However, it is worth noting that the JBC has a long history of denying requests to reduce anesthesia rates. The JBC denied requests to reduce anesthesia rates to 100 percent of the benchmark in FY 2018-19, FY 2020-21, and FY 2021-22. The Department did not submit a request to adjust anesthesia rates in FY 2023-24, but the Long Bill included footnote 21 to clarify that the appropriation was based on the assumption that anesthesia rates for services delivered by anesthesiologists and nurse anesthesiologists were not subject to rebalancing of any codes above 100 percent of Medicare and these codes were subject to the common policy community provider rate adjustment. The JBC compromised in FY 2019-20 and reduced anesthesia rates to 120 percent of the benchmark, rather than the requested 100 percent, but since then the Medicare benchmark rates have decreased. Colorado's rates are now on average 137.5 percent of the benchmark.

**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, and medication management. Many direct care workers are paid near minimum wage and providers compete with other industries for these workers.

For FY 2020-21 and thereafter, S.B. 19-238 established a statewide minimum wage for providers paid from Medicaid for personal care, homemaker, and in-home support services, which are the most commonly paid HCBS services. The minimum wage was part of a larger set of provisions in the bill designed to ensure that provider rate increases approved by the General Assembly that year were passed through to employees. At the time, the statutory minimum wage for personal care, homemaker, and in-home support services was above the statewide minimum wage. There is no statutory annual adjustment to the minimum wage requirement for these HCBS services.

To follow the spirit of S.B. 19-238, the Department started requiring in the contracts with HCBS providers that they pay a minimum base wage. The Department extended this requirement to all HCBS services and not just personal care, homemaker, and in-home support services, since they all employ similar direct care workers. Every year since FY 2020-21, the Department has proposed and the General Assembly has approved annual adjustments to the HCBS rates to try to keep pace with increases in the statewide minimum wage and the Denver minimum wage and the Department has increased the minimum base wage it requires providers to pay. This is not required by statute and the Department's minimum base wage is above the statewide minimum wage.

The Department is proposing to increase the HCBS minimum base wage by $0.80, which is slightly higher than the increase in the statewide minimum wage. Providers in Denver would need to pay the higher Denver minimum wage. Therefore, for providers in Denver the Department is proposing to increase the rates by $1.00. From calendar year 2023 to calendar year 2024 the statewide minimum wage increased $0.77 and the Denver minimum wage increased $1.00. The Department adjusts the HCBS minimum base wage on a fiscal year basis, rather than a calendar year basis.

| HCBS Minimum Base Wage | | | |
|---|---|---|---|
| | CY 2023 | CY 2024 | Increase |
| Statewide minimum wage | $13.65 | $14.42 | $0.77 |
| Denver minimum wage | $17.29 | $18.29 | $1.00 |
| | | | |
| | FY 23-24 | FY 24-25 | Increase |
| HCPF HCBS Minimum base wage | $15.75 | $16.55 | $0.80 |
| Increase in Denver provider rates | | | $1.00 |

In addition to the adjustment to keep pace with increases in the statewide and Denver minimum wages, the Department proposes that HCBS services get the across-the-board community provider rate increase. The Department notes that when direct care wages increase there are corresponding increases in benefit costs. Also, HCBS providers face inflationary pressures in components of the rates that are not related to direct care wages. Finally, the statewide and Denver minimum wages will adjust again in the middle of the state fiscal year and this could put pressure on providers for further wage increases to remain competitive.

The JBC staff has heard some providers complain that the state's approach to HCBS rates only considers the prior calendar year increase in the minimum wage and does not account for additional minimum wage increases that may occur in the next calendar year during the middle of the state fiscal year. That is not a fair or accurate criticism of the state's practice. First, the Department changes the HCBS minimum base wage on a fiscal year basis, rather than a calendar year basis, so the floor that providers must pay will not change in the middle of the fiscal year unless the provider is in Denver (or in the unlikely event that the statewide minimum wage increases by so much that it overtakes the Department's HCBS minimum base wage). Second, the Department is proposing an adjustment for the calendar year 2024 minimum wage increases PLUS the across-the-board community provider rate increase. The JBC approved a community provider rate increase of 2.5 percent, which provides significantly more than the expected cost of a mid-fiscal year increase in the statewide and Denver minimum wages.

We don't yet know what the calendar year 2025 adjustments will be for the statewide and Denver minimum wages but we can make projections. Assuming inflation of 4.5 percent, the statewide minimum wage would increase $0.65 and the Denver minimum wage would increase $0.82. The table below compares the 2.5 percent across-the-board increase with the projected cost of a 2025 4.5 percent increase in the statewide and Denver minimum wages. Again, the Department does not actually increase the HCBS minimum base wage on the calendar year like the statewide and Denver minimum wages, but this is the projected cost if the providers had to make commensurate increases.

| Projected 2025 Minimum Wage Increase Vs Community Provider Rate | | | |
|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | FEDERAL FUNDS |
| 2.5% Community provider rate increase for HCBS | $47,066,960 | $23,533,480 | $23,533,480 |
| 2025 Minimum wage increase (assuming 4.5% inflation) | $19,158,664 | $9,579,332 | $9,579,332 |

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 services 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 in other waivers.

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.

**Staff recommends an increase of $65,042,725 total funds, including $19,198,936 for a $1.00 increase for HCBS providers statewide.** The staff recommendation is higher than the Department's request by $11,185,974 total funds, including $5,592,987 General Fund, because the Department proposes differential increases of $1.00 in Denver and $0.80 statewide. 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 already pays different HCBS rates based on location. The Department's request would increase the existing differences between the Denver and non-Denver rates.

*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.

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.

**Staff does not recommend the request**. 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. The Department February forecast assumes the Single Assessment Tool will not be implemented until July 1, 2024. The February forecast includes funding for the necessary reassessments in the first year. The on-going costs included in this request will not be necessary until FY 2025-26. The JBC staff table projecting FY 2025-26 costs does not include anything for the Single Assessment Tool because the JBC staff assumes the Department will submit a new request next year.

*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.

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.

**Staff does not recommend the request**. 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. The providers receiving grants from the Primary Care Fund offer valuable safety net services, but this is a discretionary grant program that is designed to provide extra services. It is a much lower priority for the JBC staff than providing adequate funding for core sustaining provider rate increases. The primary recipients of the grants are FQHCs that get annual cost-based rate adjustments that are built into the Departments R1 forecast request.

As for the proposed legislation, the JBC staff agrees that the Colorado Indigent Care Program statutes would benefit from an update to reflect current practice. However, the Department is presenting this as a budget neutral change, so the JBC staff does not see a need for the JBC to carry the bill. Furthermore, associations representing the Federally Qualified Health Centers have raised concerns about the specifics of the Department's proposal, so this concept likely needs additional stakeholder engagement. The JBC staff suspects the JBC will have plenty of work with budget bills without taking on this policy sunset bill.

*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 of 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 from 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.

**The JBC staff does not recommend the request**. The request talks about trying to move clients from the regional centers to a community setting, but the Department then assumes that more clients will transition from community settings to the regional centers when space is available. Rather than paying an extra transition rate so that there can be a revolving door at the regional centers, maybe a better solution is to not transition clients from community settings to the regional centers in the first place. If the regional centers are at capacity, then providers won't be able to dump their problem clients on the state. The community providers will need to find a way to provide services and there will be a provider to submit a proposal for a Level 7 negotiated rate.

The JBC staff views paying the community providers sustainable rates as a higher priority than creating a new transition services rate. Toward this end, the JBC staff recommended a larger increase than the Department requested for the Wages for HCBS. If the JBC has extra money, the JBC staff would recommend going even higher on the Wages for HCBS, rather than implementing the requested new transition rate.

However, it should be noted that the Wages for HCBS benefits all HCBS providers while this request is more narrowly targeted to just providers serving clients with intellectual and developmental disabilities who are transitioning from a regional center to a community setting. If the JBC is wanting to target funding for that narrow and specific set of providers, then the JBC staff recommendation on Wages for HCBS spreads the money more broadly and may not accomplish that goal.

## ADMINISTRATION AND OTHER

### ➔ R8 Eligibility process compliance

**REQUEST**

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.

**RECOMMENDATION**

Staff recommends approval of the request with modification to apply the JBC's common policies. The JBC staff also assumed 38 percent of the FTE workload is attributable to expansion populations where

the state match is financed from the Healthcare Affordability and Sustainability (HAS) Fee. The table below summarizes the staff recommendation and each component is discussed in more detail following the table.

| R8 Eligibility Process Compliance | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| **FY 2024-25** | | | | | |
| 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 | 334,275 | 103,624 | 63,513 | 167,138 | 0.9 |
| *Contract resources* | *249,804* | *77,439* | *47,463* | *124,902* | *0.0* |
| *FTE* | *84,471* | *26,185* | *16,050* | *42,236* | *0.9* |
| Managing eligibility appeals | 108,486 | 33,629 | 20,613 | 54,244 | 0.9 |
| **TOTAL** | **$8,479,360** | **$788,878** | **$633,101** | **$7,057,381** | **1.8** |
| | | | | | |
| **FY 2025-26** | | | | | |
| 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 | 354,231 | 109,811 | 67,304 | 177,116 | 1.0 |
| *Contract resources* | *249,804* | *77,439* | *47,463* | *124,902* | *0.0* |
| *FTE* | *104,427* | *32,372* | *19,841* | *52,214* | *1.0* |
| Managing eligibility appeals | 133,082 | 41,256 | 25,285 | 66,541 | 1.0 |
| **TOTAL** | **$8,523,912** | **$802,692** | **$641,564** | **$7,079,656** | **2.0** |

*FEDERAL CHARGES FOR INCOME VERIFICATIONS*

The federal government notified states that beginning July 1, 2024, it will begin charging for access to a database that the Department uses to verify Medicaid client income and automatically process eligibility determinations without requiring further income documentation from the applicant. The Department's income verification process uses information from the federal database, a state Department of Labor database, and Equifax. The process is set up to prioritize the federal database as it is the most robust and it was previously free to access for state Medicaid programs. Each of the databases contains slightly different information and expands the pool of cases where the Department can verify applicant income automatically. The Department pays per query and the Department stops looking further as soon as one of the databases produces a useable match.

The Department proposes that the necessary funding be provided in a line item used to pay for commercial income verifications through Equifax. The line item is currently named "Work Number Verification". To reflect the expanded scope of the appropriation and use less jargony terminology, the Department proposes a new line item name of "Income Verification Programs".

**Staff recommends approval of the request**, including the renaming of the line item. Choosing not to pay for access to the federal database is not a practical option. The Department would need to redesign data systems and counties would need an increase in staff for a corresponding increase in cases where the applicants' income needs to be manually verified. There would be a negative impact on applicants, who would find the eligibility process more time consuming. It is reasonable to assume there would be a decrease in enrollment due to the increase in the administrative burden of applying for eligibility.

*FEDERAL MATCH FOR CREDIT BUREAU INCOME VERIFICATIONS*

Concurrent with the new requirement to pay for access to the federal database for income verifications, the Department learned that it can claim a 75 percent federal match, rather than a 50 percent federal match, for income verifications through Equifax. The Department requests an adjustment to the funds sources to reflect the new federal match rate.

**Staff recommends approval of the request**. Not adjusting the appropriation to reflect the change in the federal match rate would tie up General Fund in an appropriation where it is unneeded.

*MONITORING COUNTY ADMINISTRATION OF ELIGIBILITY*

The Department requests 1.0 FTE and contract funds to mitigate the risk of noncompliance with federal regulations and to ensure that funds awarded to counties are used appropriately. The Department is required by federal regulation to have controls on federal funds awarded to sub-recipients, in this case counties.

The Department currently has 1.0 FTE devoted to the fiscal oversight of county administration and this FTE has too many duties to perform one of the specifically required tasks in federal regulation of pre-approving significant county staffing or funding changes related to Medicaid.

Furthermore, federal regulation requires the Department to monitor the activities of the subrecipient "as necessary" to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. The Department is concerned that it is currently able to perform post-expenditure reviews on only 2 percent of reimbursements to counties annually.

The requested funding would add one FTE and contract resources so that the Department could implement a prior approval process for major changes in county administration and conduct post-expenditure reviews on an estimated 5 percent of reimbursements to counties annually.

**Staff recommends approval of the request for monitoring county administration of eligibility**, with modification to apply the JBC's common policies for new FTE. Since the counties are subdivisions of the State, the JBC staff asked if the State could just trust the counties to do things right and then bill the counties if there were federal audit findings. The Department believes it would be out compliance with 2 CFR Part 200 if it did not monitor county expenditures. From a policy perspective, the Department is concerned that billing counties for federal audit findings could be financially burdensome for some counties and might disrupt services to Medicaid applicants. The Department anticipates the increased state oversight will slightly increase the workload for county finance staff but emphasizes that it will not impact county eligibility technician workload.

The JBC staff asked the Department about how often the current fiscal oversight results in a negative finding. The Department reported that in the last two quarters the Department reviewed programmatic and fiscal compliance for 12 counties and the reviews resulted in 52 individual fiscal compliance findings with 22 related to unallowable costs. In response to a hearing question the Department elaborated that the 12 counties included small, medium, and large counties in frontier, urban, and rural settings with a wide range of resources. Per the Department, "While some of the findings are minor, many of the findings represent material deficiencies in fiscal internal controls which are required per 2 CFR Part 200, the Uniform Guidance. In these findings, the county was found to not have adequate processes to ensure accounting controls are in place; that the county did

not have controls over procurement cards and advance payments; or that the county did not meet contracting requirements to be eligible for federal and state funds. This is not an exhaustive list, but the findings represent state financial risk associated with inappropriate federal or state expenditures. The unallowable costs vary but represent several hundreds to several thousands of dollars."

The Department's responses were not compelling that there are major risks with county administration expenditures, but the JBC staff understands the Department's concerns that the current level of fiscal oversight may not meet the standards required in federal regulation. Also, in going from reviewing 2 percent of county expenditures to 5 percent of county expenditures annually the Department is still reviewing only a very small sample. The JBC staff's conclusion is that the request represents a modest increase in the Department's fiscal oversight of counties that appears reasonable in light of the requirements in federal regulation.

*MANAGING ELIGIBILITY APPEALS*

The Department requests 1.0 FTE for an internal appeals officer to reduce the time it takes to issue Initial Agency Decisions and Final Agency Decisions after a hearing. The Department has had the same base level of staff to manage appeals for more than 20 years, since before the Medicaid expansion in 2013. The Department has one eligibility appeals specialist to manage cases going through hearings and one internal appeals officer to issue Final Agency Decisions. To help with the expected surge in appeals during the public health emergency unwind, the Department received funding for 11.6 temporary FTE through June 2024. In 2010 the Department issued 936 Final Agency Decisions and in 2020 it issued 2,072.

**Staff recommends approval of the request**, with modification to apply the JBC's common policies regarding new FTE. The Department has been out of compliance with federal regulations regarding the timely processing of appeals since before the public health emergency. During the public health emergency, the federal government has increased its scrutiny of whether states are processing appeals in a timely manner and has threatened to withhold Medicaid funding for states that are out of compliance. Before the public health emergency, the appeals and Medicaid enrollment had both more than doubled since the Department last had an increase in funding for the base appeals staff.

## ➔ R10 Assessments for skilled nursing

**REQUEST**

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 when the Department will add assessments for consumer directed Health Maintenance Activities and recertifications. By FY 2026-27 the costs are projectd to stabilize at approximately $6.5 million total funds, including $1.6 million General Fund, per year. 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 consumer directed Health Maintenance Activities. The assessments will be eligible for a 75 percent federal match. The Department indicates that funding is for the implementation of a theory-informed practice.

Prior Authorization Request (PAR) 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 responsibility 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. The final prototype of the assessment is due and will be presented to the public in September 2024. The request assumes implementation in January 2025 for Long Term Home Health and Private Duty Nursing and July 2025 for consumer directed Health Maintenance Activities. The start date for applying the assessment to Health Maintenance Activities aligns with the expected implementation of Community First Choice that will make consumer directed services part of the State Plan.

The request assumes every utilizer will need an initial assessment in the first year. Based on prior experience, the Department assumes that in subsequent years 12 percent of clients will receive an express review with no changes but the remaining 88 percent will need a recertification, with half of the recertifications in person and half remote.

**RECOMMENDATION**

Staff recommends approval of the request. These are high cost services per client and they are only provided to clients with high needs. Both the Department and clients would benefit from an objective, validated assessment tool administered by trained staff with nursing knowledge. The Department has concerns that current procedures create conflicts of interest by involving service providers in the needs assessments. Also, the Department identifies risks of over-authorization and duplication with different utilization reviews for consumer directed Health Maintenance Activities versus Long Term Home Health and Private Duty Nursing. A client would currently need to go through potentially three different assessments for Health Maintenance Activities, Long Term Home Health, and Private Duty Nursing versus the planned one assessment for all in-home skilled nursing.

The JBC staff is surprised at the aggressive implementation schedule the Department is pursuing. Assessment tools are inevitably controversial and typically require significant stakeholder engagement. The Department has still not implemented the Single Assessment Tool for Home- and Community-Based Services that was required by S.B. 16-192 and expected to be completed in FY 2019-20. The Department argues the scope of the assessment for skilled nursing is much narrower. Still, the JBC staff would not be surprised if there end up being delays and a slower implementation than anticipated in the request.

| R10 Assessments for skilled nursing | | | |
|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | FEDERAL FUNDS |
| FY 2024-25 | $1,938,600 | $484,650 | $1,453,950 |
| FY 2025-26 | $10,332,605 | $2,583,151 | $7,749,454 |
| FY 2026-27 | $6,540,771 | $1,635,193 | $4,905,578 |

| R10 Assessments for skilled nursing | | | | |
|---|---|---|---|---|
| | LTHH/PDN | | Health Maintenance Activities | |
| | New Reviews | Recertifications | New Reviews | Recertifications |
| FY 2024-25 | 3,231 | 0 | 0 | 0 |
| FY 2025-26 | 3,622 | 2,843 | 13,207 | 0 |
| FY 2026-27 | 391 | 1,186 | 1,679 | 11,622 |

## ➔ R11 Program support

**REQUEST**

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 preventive 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 management 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, make adjustments to the methodology post implementation, and provide on-going oversight. The contract would start in January 2025 when the Person-Centered Budget Algorithm is scheduled to go live.

The Department says that it is in the process of analyzing the effectiveness of the stimulus-funded initiatives and to date has identified these programs as among those with the greatest impact that warrant continuation and where the Department wants to avoid any potential interruption when the stimulus funding ends.

The Department indicates that funding for the Preventive 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.

**RECOMMENDATION**

The staff recommendation is summarized in the table below with each component discussed in more detail following the table.

| R11 Program Support | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| FY 2024-25 | | | | | |
| HCBS Systems support | $179,231 | $44,807 | $0 | $134,424 | 1.5 |
| Direct care workforce unit | 187,206 | 93,603 | 0 | 93,603 | 0.5 |
| Preventive care outreach analyst | 103,971 | 35,350 | 16,635 | 51,986 | 0.9 |
| Person-centered budget algorithm | 100,100 | 50,050 | 0 | 50,050 | 0.0 |
| **TOTAL - FY 2024-25** | **$570,508** | **$223,810** | **$16,635** | **$330,063** | **2.9** |
| | | | | | |
| FY 2025-26 | | | | | |
| HCBS Systems support | $383,086 | $95,771 | $0 | $287,315 | 3.0 |
| Direct care workforce unit | 261,882 | 130,941 | 0 | 130,941 | 1.0 |
| Preventative care outreach analyst | 127,695 | 43,415 | 20,432 | 63,848 | 1.0 |
| Person-centered budget algorithm | 100,100 | 50,050 | 0 | 50,050 | 0.0 |
| **TOTAL - FY 2025-26** | **$872,763** | **$320,177** | **$20,432** | **$532,154** | **5.0** |

*HCBS SYSTEMS SUPPORT*

The request is for 3 on-going positions to maintain system improvements being financed with money from the Home- and Community-Based Services (HCBS) Improvement Fund. The Department currently has 15 term-limited employees working on these system changes through December 2024. The proposed 3 on-going positions would begin in January 2025 and would be eligible for the 75 percent federal match for information technology systems maintenance.

**The JBC staff recommendation is lower than the request primarily due to assuming a start date of January 1, 2025, rather than July 1, 2024**. The Department has federal funding for the positions for the first six months of the fiscal year and made a technical error when requesting 12 months of funding. In addition, the JBC staff applied the JBC's common policies regarding new FTE.

The staff recommendation is based on the criticality of the systems being supported, a favorable federal match rate that makes the General Fund cost relatively low, and an assumption that the Department has properly scoped the request. However, the request is extremely vague with very little detail for the JBC staff to analyze and the Department's responses to JBC staff questions are confusing and contradictory. For example, the original request indicated that of the 63 projects initiated with money from the HCBS Improvement Fund, 35 have information technology system impacts that will need on-going maintenance and support for future system changes. The Department estimated it would require 2,400 business hours per month to support the 35 projects and using internal workforce metrics this would require 3.0 FTE. The Department referenced a 2020 study where the information technology team tracked their time in 15 minute increments for 8 months to help determine the support level needed for different system changes. Then, in response to JBC staff questions, the Department indicated there are now only 28 sub-projects with IT system impacts, due to changes in the scope of the projects financed with federal stimulus funds, but the Department did not change the, allegedly, precisely calculated 3.0 FTE required to support the now 28 projects rather than 35. When asked for a list of the information technology impacts that will be supported, the Department said they fit into 8 distinct projects and then listed only 7 projects, including one where the title did not correspond with the Department's federal stimulus spending plan (it was misnamed). While the

JBC staff appreciates the Department's efforts to summarize for a policy making audience, rather than overwhelm with technical details, this request missed the mark of providing a useful level of information for evaluation.

According to the Department, the workload will be primarily driven by the projects identified in the bullets below. The numbers correspond to the Department's ARPA spending plan. More information about the projects can be found in the Department's quarterly reports[3].

- 4.12 Community First Choice (CFC) – The initiative will make attendant care services, including consumer directed options, available to all Medicaid members, rather than just those qualifying for a waiver. Medicaid members must still have an assessed need for the services. Attendant care services provide assistance with activities like eating, dressing, bathing, shopping, keeping doctor appointments, and medication monitoring. Implementing CFC requires changes to the provider subsystem, financial subsystem, prior authorization subsystem, and care and case management product. The CFC is scheduled to launch July 1, 2025, after the federal stimulus funding. Also, some of the functionality for CFC is waiting for development of the Care and Case Management system. The Department anticipates that as the program goes live and members begin using the services there will be systems issues that need to be addressed and improved.
- 6.01 Home Health/Private Duty Nursing (PDN) Acuity Tool – The initiative is developing a new assessment tool to determine the level of home health or private duty nursing services that Medicaid clients need. The Department is developing the tool with federal stimulus money, but some of the integrations with other systems that would result in the most efficient and seamless use of the tool may need to occur after the federal stimulus funding. In particular, the tool will need to be integrated with the Care and Case Management system.
- 6.03 Member Facing Provider Finder Tool Improvement – The initiative will improve the Department's "Find A Doctor" search tool that helps Medicaid members identify providers. Some of the improvements include the ability to search by location, associations, specialties, and cultural competencies. The Department says some requested functionality and fields identified as a result of stakeholder feedback have been put on hold to complete the project within the federal funding timeline. Adding the already identified fields will drive additional work after the federal stimulus funding ends.
- 3.03 Community Transitions Support – This initiative will improve transition services for people moving from an institutional to community setting and support people staying in a community setting. The improvements include proactive, standardized counseling about community options for members living in nursing facilities; diversion and rapid reintegration activities during the nursing facility level of care screening; enhanced case management for members identified as at risk of institutionalization; additional units of transition coordination services; inflation adjustments to transition setup caps; a new eligibility escalation process for transitions services; and expanded housing navigation services for members at risk of institutionalization to help identify units and negotiate leases. The Department says these changes will help in responding to Department of Justice findings that the state is not doing enough to support community options for Medicaid clients. The Department was not specific about all aspects of the initiative driving the information technology workload. The Department did indicate that Medicaid clients participating in the federal Money Follows the Person program for people transitioning from an institutional to community setting must be identifiable, compliance will be monitored as part of

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

the agreement with the Department of Justice, and shortages of available services in the community that result in delayed transitions exceeding span limits may necessitate system changes to address.

Other projects the Department said will be supported by the request but the Department identified as driving less of the workload include:

- 6.08 Care and Case Management System
- 6.15 Trails System Communication Improvements
- 5.02 Improve & Expedite Long-term Care Eligibility Processes

Then, in a more recent response to JBC staff questions the Department said, "Several of the ARPA projects have been deprioritized so the team can focus on stabilizing the [Care and Case Management System] CCM for the case management agencies. The work will resume for the projects that were deprioritized once the system is stabilized, which will push the implementations for these projects after December 31, 2024. The FTE will be used to continue the enhancement projects that are needed well beyond 2024, and continue supporting the ongoing configurations and operations for these systems.".

It is clear to the JBC staff that the Department has a lot of information technology needs stemming from the federal stimulus projects. The Department's explanation of what is driving the request is all over the place and the JBC staff remains unsure how the Department determined that the need is for 3.0 FTE. The care and case management system by itself is critical to agency operations and member care and the effective implementation of many of the Department's other initiatives depend on the functionality of the system, including the Single Assessment Tool, Person-Centered Budget Algorithm, and Home Health/PDN Acuity tool, to name a few. Although the JBC staff is frustrated with the lack of useful detail in the request, the JBC staff is trusting that the Department has scoped the request appropriately.

*DIRECT CARE WORKFORCE UNIT*

The request is to maintain the direct care workforce unit that was started with money from the HCBS Improvement Fund that allowed the Department to hire five time-limited positions. The request would fund two positions on-going: a manager would serve on the Direct Care Workforce Stabilization Board, partner with other state agencies, manage contracts related to training, and gather and analyze workforce compensation data to shape strategies; an administrator would create recommendations on how to improve recruitment and retention of direct care workers and manage contracts related to the Direct Care Career Center and surveys of workers and employers. The Direct Care Career Center provides on-line standardized training modules, provides a resource and job hub, and outlines career pathways. The request also includes contract funds for the workforce surveys and Direct Care Career Center. All of the activities of the direct care workforce unit would be eligible for a 50 percent federal match.

**The staff recommendation is for only one position and the contract resources for the workforce surveys.** There are severe workforce shortages impacting Medicaid members' access to care and the JBC staff sees value in dedicated staff and contract resources at the Department to gather data and develop strategies to inform policy making. However, the JBC staff questions whether the on-line Direct Care Career Center training and job hub is an appropriate function of the Department

versus higher education, the Department of Labor, trade associations, or employers. Also, the JBC staff is concerned about how the Department would ever demonstrate the effectiveness of the Direct Care Career Center in isolation of other variables impacting the direct care workforce. The fundamental challenge in developing a robust direct care workforce is low wages. The training barriers to entry into the field are low. The cost of the Direct Care Career Center is low compared to increasing rates so providers can pay better wages, but the JBC staff sees the value added from the Direct Care Career Center as similarly low compared to the value in solving the workforce shortage of paying higher wages. The Department of Early Childhood has a similar type of workforce unit, but the training expectations of early childhood educators are different and the statutory role of the Department of Early Childhood to develop the workforce is more expansive than the role for the Department of Health Care Policy and Financing.

| Direct Care Workforce Unit<br>Staff Recommendation vs Request | | | | |
|---|---|---|---|---|
| | FY 2024-25 | | FY 2025-26 | |
| | Request[1] | Recom | Request[1] | Recom |
| Program Management II | $62,206 | $62,206 | $133,082 | $133,082 |
| Administrator V | 59,744 | 0 | 127,695 | 0 |
| Workforce surveys contracts | 125,000 | 125,000 | 128,800 | 128,800 |
| Direct Care Career Center contract | 199,600 | 0 | 205,600 | 0 |
| **Total Funds** | **$446,550** | **$187,206** | **$595,177** | **$261,882** |
| General Fund | 223,275 | 93,603 | 297,589 | 130,941 |
| Federal Funds | 223,275 | 93,603 | 297,588 | 130,941 |

[1] Adjusted for application of the JBC's common policies regarding new FTE

The Department argues that the direct care workforce shortage is severe and problematic with an aging population and needs to be a top priority for the state. While the JBC staff views low wages as the primary problem, the Department argues that this request will relieve a training burden from providers, allowing them to focus more energy on recruitment and retention efforts. The Department says that the current training of the direct care workforce is not standardized or portable, resulting in inconsistent care for clients and less mobility for workers. The Department, along with the Department of Public Health and Environment, is tasked with enforcing initial and on-going training requirements for direct care workers in Section 25.5-6-1604, C.R.S. The statute doesn't direct the Department to provide the training, but the Department says that making on-line content that could be widely available to workers was a recommendation that came out of the stakeholder process.

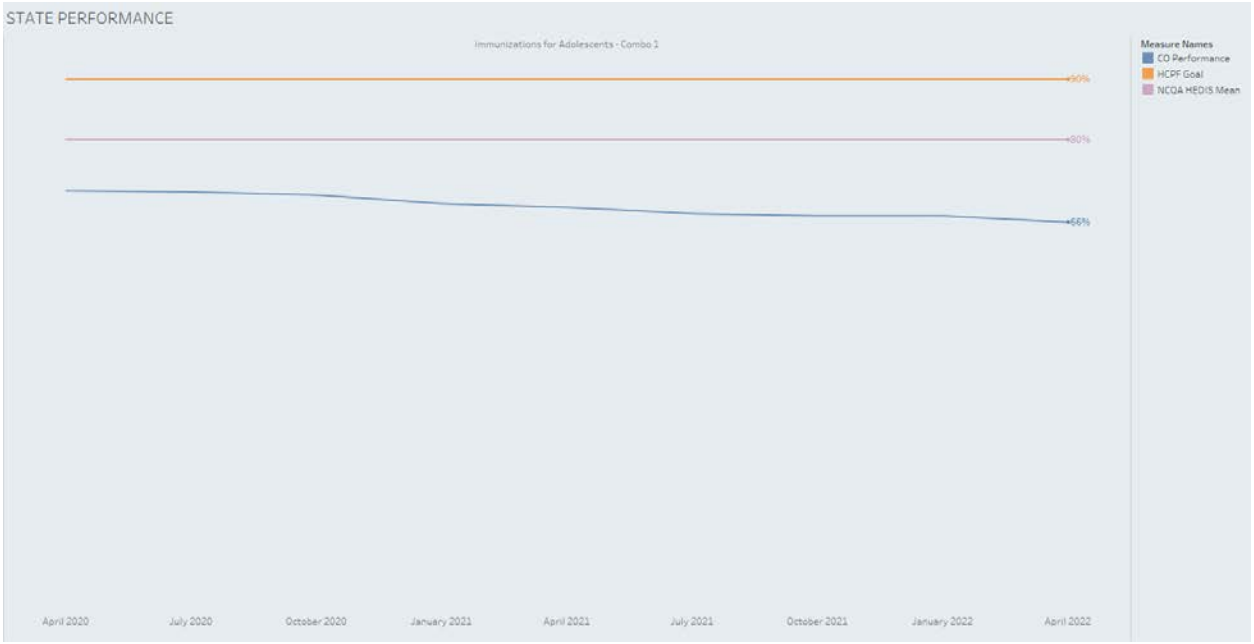
Without the requested funding for the Direct Care Career Center, the Department says there would be sunk costs for developed training content that the Department would struggle to make available and maintain within existing resources. The training content focuses on things like infection control, cleaning procedures, HIPAA and confidentiality, nutrition planning, and handling emergencies. There are modules to increase skills in helping clients with specialized needs such as dementia or low vision. The services the direct care workers provide are either non-medical or routine and repetitive health maintenance that does not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, dressing, and house cleaning. The training modules are in the final stages of development. The Department estimates there are 30,000 direct care workers serving Medicaid clients. Medicaid is the primary payer for these services. With the high turnover rates in the industry the Department believes 10,000 workers might access these training modules annually.

*PREVENTIVE CARE OUTREACH ANALYST*

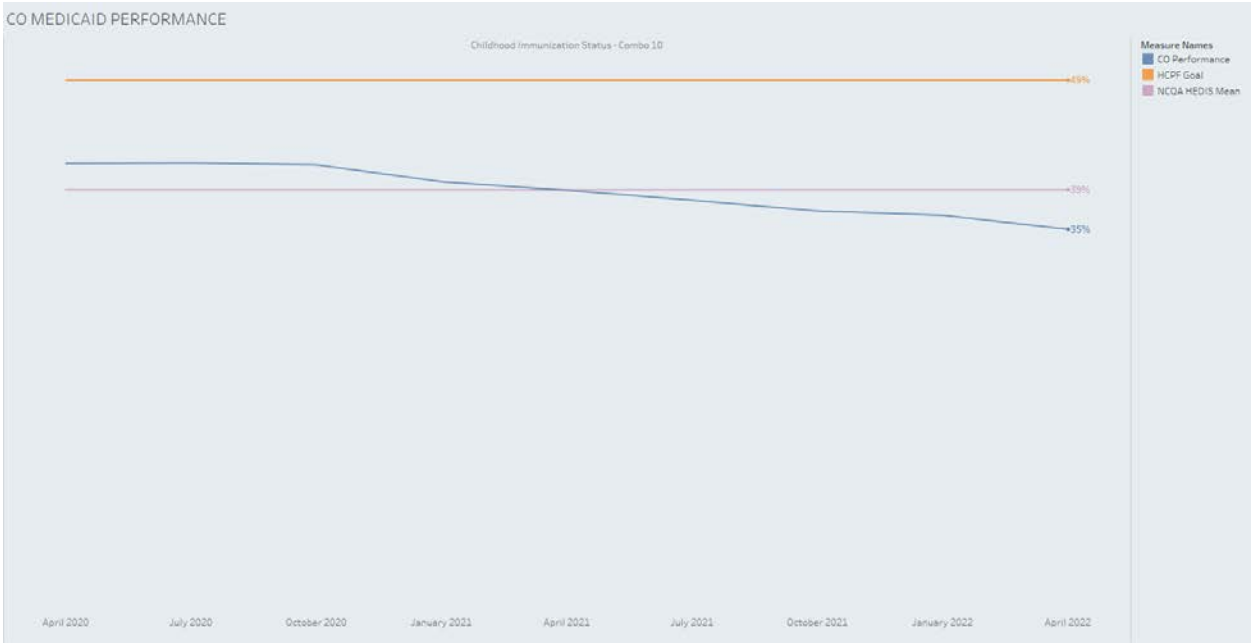
The request is to maintain one of two positions that were funded with temporary State and Local Fiscal Recovery Funds (SLFRF) made available through the American Rescue Plan Act (ARPA) to improve Medicaid client immunization rates for COVID. The Department proposes that the new position would have broader responsibilities that include analyzing and designing outreach strategies for a wider range of vaccines and for other types of preventive care. The Department says the analyst would work to improve the uptake of routine childhood immunizations and flu vaccines, determine how performance on health measures varies across communities, and identify the most significant opportunities for improvement. The Department estimates 32 percent of the work will be attributable to populations where the state match is financed from the Healthcare Affordability and Sustainability (HAS) Fee.

**Staff recommends approval of the request, with modification to apply the JBC's common policies regarding new FTE**, but in making this recommendation the JBC staff has some reservations. The data shows the value of the preventive measures the Department wants to improve and that the Medicaid utilization of these preventive measures lags the general population. These are potentially arguments that the Department should be doing more to increase utilization of preventive care. However, the JBC staff's confidence is low that an additional analyst to study the issues and coordinate initiatives will turn the tide.

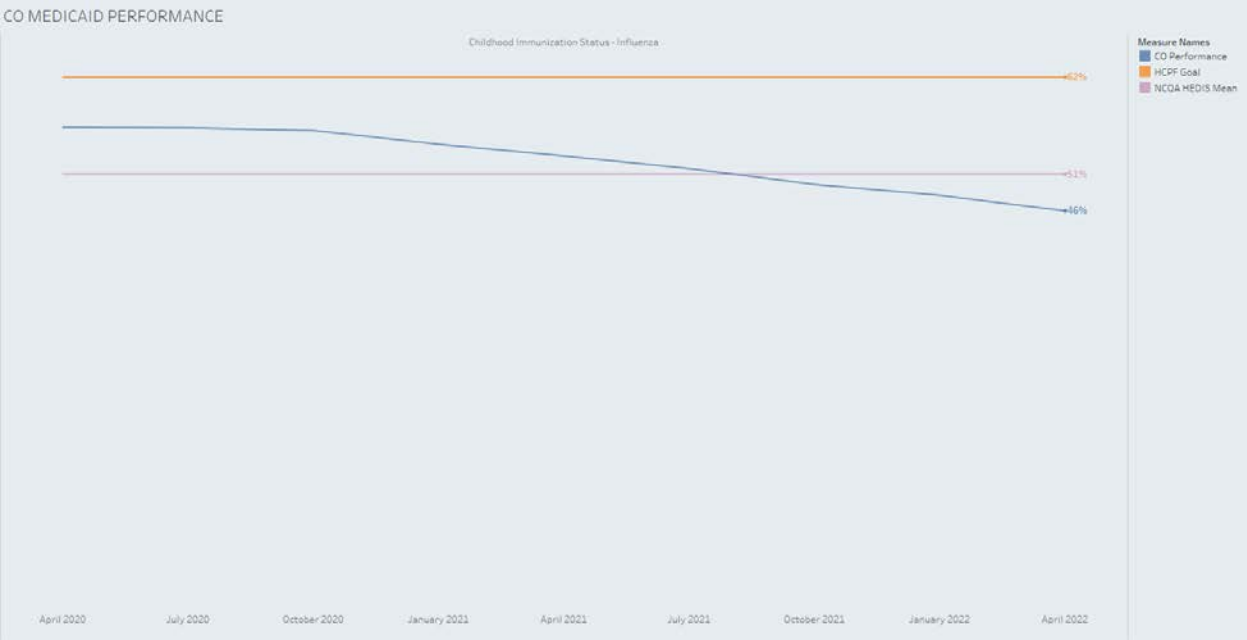
The problems are known and well researched. There is an entire Department of Public Health and Environment that is focused on developing and implementing strategies to improve population health, including the health of Medicaid members. That department has existing work groups and programs focused on improving childhood immunizations. In Health Care Policy and Financing, the flagship program to improve the utilization of preventive services, including childhood immunizations, is the Accountable Care Collaborative (ACC). Through the ACC, the Department pays Regional Accountable Entities (RAEs) to develop and implement population health strategies to improve Medicaid member health outcomes. The RAEs earn performance incentives if what they implement actually improves member health outcomes. Childhood immunization rates is one of the key performance measures used to determine the performance incentives paid to the RAEs. Despite these efforts, Medicaid's performance on measures of childhood immunizations is moving in the wrong direction.




The Immunizations for Adolescents—Combination 1 measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. This is measured as a combination rate. The blue line represents the Health First Colorado population compared with the national mean on this measure (purple) and our HCPF goal of 90% (orange).




The childhood immunization Combo 10 rate calculates the percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The blue line represents the Health First Colorado population compared with the national mean (purple) on this measure through the National Committee for Quality Assurance (NCQA) and our HCPF goal of 90% (orange).




The childhood immunization influenza rate calculates the percentage of children 2 years of age who are up to date on annual influenza vaccines by their second birthday. The blue line represents the Health First Colorado population compared with the national mean (purple) on this measure through the National Committee for Quality Assurance (NCQA) and our HCPF goal of 90% (orange).

The Department attributes the decrease in Medicaid performance to a decrease in pediatric immunizations during the COVID lockdown, but this does not explain why Medicaid performance decreased relative to the mean, and the Department says Medicaid pediatric vaccinations have rebounded.

The Department says that one of the initiatives the new staff would work on is increasing enrollment of pharmacies in the Vaccines for Children (VFC) program. During the public health emergency, the Department expanded vaccination coverage to allow adults to receive all routine vaccinations in pharmacies. The COVID vaccine was also available in the pharmacies. The pharmacy became the preferred location for adult flu vaccines and all COVID vaccines. To receive Medicaid reimbursement for providing childhood immunizations, a pharmacy needs to be enrolled in the VFC program. The proposed staff would do targeted outreach to pharmacies in underserved areas that already have large numbers of Medicaid clients to try to get them enrolled in the VFC program.

The Department says that during the public health emergency a large number of vaccine providers newly enrolled to serve Medicaid clients. Part of the duties of the proposed position would be to retain those newly enrolled providers and encourage them to provide routine childhood vaccinations for Medicaid members.

The position would also serve as a liaison between the Department's Benefits team and the RAEs specifically on preventive care, conduct analysis and research on preventive care utilization and access to inform policy, and be the Department's lead for the Immunization Coordination Team that meets weekly and includes representatives from Public Health and Environment, Human Services, the RAEs, the managed care organizations, and community based organizations.

It is hard for the JBC staff to recommend against the request in light of the data about Medicaid immunization rates relative to the general population, but it is frustrating and dismaying to the JBC staff that all of these things are not already happening with the efforts of the Department of Public Health and Environment to coordinate population health initiatives statewide and the efforts of the RAEs that are paid a base rate to improve Medicaid population health regionally plus performance incentives specifically tied to immunization rates.

*PERSON-CENTERED BUDGET ALGORITHM*

The request is to continue a contract with a vendor for the person-centered budget algorithm. The contract is currently scheduled to end in January 2025 and the Department wants to continue it indefinitely. The person-centered budget algorithm will take information from the single assessment tool for long-term services and supports and convert the assessment findings into a budget based on the identified needs, strengths, and preferences of the client. The goal is a more objective, transparent, and equitable resource allocation method.

**Staff recommends approval of the request.** The person-centered budget algorithm is a key companion to the Single Assessment Tool. The Single Assessment Tool and Person Centered Budget Algorithm are necessary to implement Community First Choice by July 1, 2025. Community First Choice will make attendant care services, including consumer directed options, available to all Medicaid members, rather than just those qualifying for a waiver. Medicaid members must still have an assessed need for the services. Attendant care services provide assistance with activities like eating, dressing, bathing, shopping, keeping doctor appointments, and medication monitoring. By implementing Community First Choice, Colorado will draw an additional 6.0 percent federal match for attendant care services that the Department anticipates will more than offset potential increased costs due to greater utilization.

## ➔ R12a Accessibility

**REQUEST**

The Department requests $374,355 total funds, including $141,039 General Fund, and 0.9 FTE to comply with provisions of H.B. 21-1110 that require public entities to make documents accessible to people with disabilities. The request includes $250,000 for contract services. The Department assumes a 50.0 percent federal match for administration and 34.0 percent of the state share will come the Healthcare Affordability and Sustainability (HAS) Fee, based on the portion of the total projected enrollment financed from the HAS Fee.

All documents produced by the Department must meet standards for accessibility. The Department received $2.9 million in one-time funding for FY 2023-24 to help address the accessibility of previously produced documents and to put processes in place so that newly produced documents will meet the accessibility standards. However, the Department continues to produce new documents that must be tested and remediated for accessibility and when there is turnover the Department must train new employees on procedures to ensure that newly created documents are accessible. Documents with tables, graphics, and information visuals require specialized knowledge and software to ensure they are accessible, beyond what program staff can do on their own.

**RECOMMENDATION**
Staff recommends approval of the request with modification to apply the JBC's common policies for new FTE. The Department has a clear and on-going need for dedicated staff and contract resources to ensure compliance with the accessibility standards in H.B. 21-1110.

The JBC staff is relying heavily on the Department's estimate of how much time is required for the on-going accessibility remediation. Based on the JBC staff's limited understanding of the work involved, the JBC staff has concerns that the Department may have underestimated the remediation costs. For comparison, the Executive Committee approved $1.2 million total funds, including 4.0 FTE, for accessibility compliance for the General Assembly.

| R12a Accessibility | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| FY 2024-25 | | | | | |
| FTE | $103,971 | $34,310 | $17,675 | $51,986 | 0.9 |
| Contract services | 250,000 | 82,500 | 42,500 | 125,000 | 0.0 |
| **Total - FY 2024-25** | **$353,971** | **$116,810** | **$60,175** | **$176,986** | **0.9** |
| | | | | | |
| FY 2025-26 | | | | | |
| FTE | $106,147 | $35,028 | $18,045 | $53,074 | 1.0 |
| Contract services | 250,000 | 82,500 | 42,500 | 125,000 | 0.0 |
| **Total - FY 2025-26** | **$356,147** | **$117,528** | **$60,545** | **$178,074** | **1.0** |

According to the Office of State Planning and Budgeting, no other department submitted a request for on-going funds for accessibility. This seems problematic, since every department must comply with the accessibility standards. In last year's funding request, four departments identified one-time needs that exceeded the Department of Health Care Policy and Financing's, including Labor and Employment, the Office of Information Technology, Personnel and Administration, and Public Health and Environment.

## ➔ R12b Senior dental administration

**REQUEST**
The Department requests $75,000 General Fund in FY 2024-25 and $150,000 General Fund in FY 2025-26 and on-going to contract with a third party to administer the Senior Dental Program. The request assumes the contract administrator would start in January 2025.

The Senior Dental Program provides grants to serve people over 60 with income at or below 250 percent of the federal poverty guidelines who do not have Medicaid or other dental coverage. Each grantee gets a total allocation that they then earn per procedure. The FY 2023-24 appropriation for grants is $3,990,358, which was the original amount for the program when it was transferred to the Department from the Department of Human Services, plus a $1.0 million increase approved by the JBC in FY 2019-20. In FY 2022-23 the grant program served 4,706 unduplicated seniors. Roughly half the expenditures are by Federally Qualified Health Centers (FQHCs).

The Department believes a contract administrator would reduce administrative burdens on providers and ensure grant funds reach the intended population. Eligibility determinations are currently performed by the grantees, requiring the providers to verify client income. In contrast, most other

dental payers let the provider know if the client is eligible. The contract administrator would perform eligibility determinations, relieving this administrative burden from grantees. There are currently no proactive controls to determine if clients are getting duplicate services or going over program limits by visiting multiple providers. The contract administrator would perform prior authorization reviews to ensure the limited grant funds reach the targeted population within program limits. The contract administrator would provide real-time reporting to grantees to reduce confusion or miscommunication about the remaining available grant funds.

The Department is required to submit an annual report on the performance of the Senior Dental Program[4], pursuant to Section 25.5-3-405, C.R.S. House Bill 19-1326 required that in the FY 2019-20 report the Department specifically recommend the most effective options for administering the program. One of the options presented in that report, based on recommendations from the Colorado Dental Association and the Public Consulting Group, Inc., was to contract with a third party administrator. However, due to the public health and fiscal emergencies, the Department did not submit a corresponding request for an increase in administrative funding until this year.

**RECOMMENDATION**

Staff recommends the requested $75,000 General Fund. A contract administrator would standardize and modernize the eligibility and reimbursement processes, making it easier for providers to participate and reducing the risk of inappropriate payments.

The Department currently has 1.0 FTE and roughly $83,000 for administration of the program. Much of the work of the proposed contract administrator would provide new functionality that is not currently part of the state-level administration of the grant program. However, some of contract administrator's work would reduce the time department staff have to spend on processing invoices and reporting and the department staff would see only a minimal increase in duties to monitor the contract administrator. The Department says the request would free up time for the in-house FTE to provide more technical support and program guidance to the grantees and do more audits. If the JBC would prefer to reduce the existing FTE, a decrease in the neighborhood of $25,000 General Fund and 0.3 FTE might be reasonable (half that amount in the first year).

## ➔ R13 Convert contractor resources to FTE

**REQUEST**

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 12.6 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.

[4] Senior Dental Program FY 2022-23 Annual Report.
https://hcpf.colorado.gov/sites/hcpf/files/Senior%20Dental%20Program%20FY22-23%20Annual%20Report.pdf

**RECOMMENDATION**

Staff recommends approval of the request with modification to apply the JBC's common policies regarding new FTE.

| R13 Convert Contracts to FTE | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| **FY 2024-25** | | | | | | |
| Payment Reform | | | | | | |
| FTE Costs | $179,104 | $55,521 | $34,030 | $0 | $89,553 | 1.8 |
| Contractor Cost Reductions | (250,000) | (77,500) | (47,500) | 0 | (125,000) | 0.0 |
| Subtotal - Payment Reform | ($70,896) | ($21,979) | ($13,470) | $0 | ($35,447) | 1.8 |
| SUD Benefit | | | | | | |
| FTE Costs | 156,842 | 48,620 | 29,800 | 0 | 78,422 | 1.8 |
| Contractor Cost Reductions | (250,000) | (77,500) | (47,500) | 0 | (125,000) | 0.0 |
| Subtotal - SUD Benefit | ($93,158) | ($28,880) | ($17,700) | $0 | ($46,578) | 1.8 |
| Call Center | | | | | | |
| FTE Costs | 565,437 | 79,956 | 49,420 | 307,417 | 128,644 | 9.0 |
| Contractor Cost Reductions | (267,660) | (82,942) | (51,266) | 0 | (133,452) | 0.0 |
| Subtotal - Call Center | $297,777 | ($2,986) | ($1,846) | $307,417 | ($4,808) | 9.0 |
| **TOTAL - HCPF** | **$133,723** | **($53,845)** | **($33,016)** | **$307,417** | **($86,833)** | **12.6** |
| | | | | | | |
| Other dept costs for Call Center | | | | | | |
| Human Services | ($10,472) | ($4,914) | $0 | $0 | ($5,558) | 0.0 |
| Public Health & Environment | (246) | 0 | 0 | 0 | (246) | 0.0 |
| Early Childhood | (765) | (383) | 0 | 0 | (382) | 0.0 |
| Office of the Governor (OIT) | (586,560) | 0 | 0 | (586,560) | 0 | 0.0 |
| **Total - Other depts Call Center** | **($598,043)** | **($5,297)** | **$0** | **($586,560)** | **($6,186)** | **0.0** |
| | | | | | | |
| **TOTAL - All Departments** | **($464,320)** | **($59,142)** | **($33,016)** | **($279,143)** | **($93,019)** | **12.6** |
| | | | | | | |
| **FY 2025-26** | | | | | | |
| Payment Reform | | | | | | |
| FTE Costs | $235,558 | $73,022 | $44,756 | $0 | $117,780 | 2.0 |
| Contractor Cost Reductions | (250,000) | (77,500) | (47,500) | 0 | (125,000) | 0.0 |
| Subtotal - Payment Reform | ($14,442) | ($4,478) | ($2,744) | $0 | ($7,220) | 2.0 |
| SUD Benefit | | | | | | |
| FTE Costs | 208,995 | 64,788 | 39,709 | 0 | 104,498 | 2.0 |
| Contractor Cost Reductions | (250,000) | (77,500) | (47,500) | 0 | (125,000) | 0.0 |
| Subtotal - SUD Benefit | ($41,005) | ($12,712) | ($7,791) | $0 | ($20,502) | 2.0 |
| Call Center | | | | | | |
| FTE Costs | 662,726 | 93,714 | 57,923 | 360,311 | 150,778 | 9.0 |
| Contractor Cost Reductions | (267,660) | (82,942) | (51,266) | 0 | (133,452) | 0.0 |
| Subtotal - Call Center | $395,066 | $10,772 | $6,657 | $360,311 | $17,326 | 9.0 |
| **TOTAL - HCPF** | **$339,619** | **($6,418)** | **($3,878)** | **$360,311** | **($10,396)** | **13.0** |
| | | | | | | |
| Other dept costs for Call Center | | | | | | |
| Human Services | $37,762 | $17,717 | $2 | $0 | $20,043 | 0.0 |
| Public Health & Environment | 886 | 0 | 0 | 0 | 886 | 0.0 |
| Early Childhood | 2,763 | 1,384 | 0 | 0 | 1,379 | 0.0 |
| Office of the Governor (OIT) | (586,560) | 0 | 0 | (586,560) | 0 | 0.0 |
| **Total - Other depts Call Center** | **($545,149)** | **$19,101** | **$2** | **($586,560)** | **$22,308** | **0.0** |
| | | | | | | |
| **TOTAL - All Departments** | **($205,530)** | **$12,683** | **($3,876)** | **($226,249)** | **$11,912** | **13.0** |

## ➔ R14 Contract true-up

**REQUEST**

The Department requests a net increase of $43,910 total funds, including an increase of $90,668 General Fund, to: (1) annualize a supplemental increase approved by the JBC for the centralized eligibility vendor; and (2) provide enrollment and inflationary increases for the host home inspections program.

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. Pursuant to the federal formula, the Department is currently underpaying the vendor for the services based on the vendor's actual allowable costs. Pursuant to statute, the source of the state match for the payment is the Healthcare Affordability and Sustainability Fee and there is no General Fund impact. Most of the population served is eligible for an enhanced federal match, so an estimated 73.6 percent of the total payment is coming from federal funds. Correcting the contract payment will reduce the amount of Denver Health's hospital and clinical revenue getting syphoned off for unrelated administrative activities.

For the host home inspections program, the Department sends money to the Department of Local Affairs that uses the money to perform health and safety inspections of homes serving 1-3 Medicaid clients with intellectual and developmental disabilities, to ensure compliance with state regulations. There are approximately 3,700 Medicaid clients receiving services in roughly 2,300 host homes. The Department describes examples of the regulatory requirements as ensuring that the home is maintained in good repair, adequate and comfortable furnishings are provided, sufficient spacing requirements exist for bedrooms, exits are accessible and unobstructed, smoke alarms and carbon monoxide detectors are properly installed and tested, etc. The original budget was set in FY 2019-20 and supported inspections of 1,700 host homes and a rate of $75 per inspection. The Department estimates that today it needs funding for 2,300 inspections and a rate of $120 per inspection. The request assumes inspections are performed once every two years, 35 percent of the inspections result in a finding that requires follow-up, and half of the follow ups are in person while half are virtual at 50% of the cost per inspection. The federal match rate for the inspections is 50 percent.

**RECOMMENDATION**

Staff recommends approval of the request. These are caseload and inflation driven adjustments to long-standing contracts. The General Fund cost is entirely driven by the increase for the host home inspections.

| R14 Contract True-up | | | | |
|---|---|---|---|---|
| | Total Funds | General Fund | Cash Funds-HAS Fee | Federal Funds |
| FY 2023-24 previously approved supplemental | | | | |
| **Centralized eligibility vendor** | **$1,974,480** | **$0** | **$521,534** | **$1,452,946** |
| | | | | |
| FY 2024-25 | | | | |
| Centralized eligibility vendor | $1,837,055 | $0 | $473,690 | $1,363,365 |
| Host home inspections program | 181,335 | 90,668 | 0 | 90,667 |
| **Subtotal - FY 2024-25** | **$2,018,390** | **$90,668** | **$473,690** | **$1,454,032** |
| | | | | |
| Net Change | $43,910 | $90,668 | ($47,844) | $1,086 |

## ➔ R15 Denver Health

**REQUEST**

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.

At the hearing, the Department indicated that the payment to Denver Health is contingent on the hospital agreeing to use the money for the following purposes:

- Improvements and modernizations in information technology systems. This might include:
  - accessing the Health Information Exchange, which drives care delivery efficiency and quality outcomes
  - advancing eConsult technology, which improve specialty care access while avoiding ineffective specialty visits and driving quality outcomes and affordability,
- increasing funding for Denver Health's nurse advice line, which avoids inappropriate ER utilization and triages individuals to the appropriate care, and
- timely eligibility application processing.

The Department said the money is specifically not intended to assist with or finance any Denver Health service expansions in other parts of the state.

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).[5] Denver Health Hospital's debt-to-asset ratio appears in the range of other Colorado hospitals (one of several solvency measures).[6] 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.[7] 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

[5] 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.

[6] 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

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

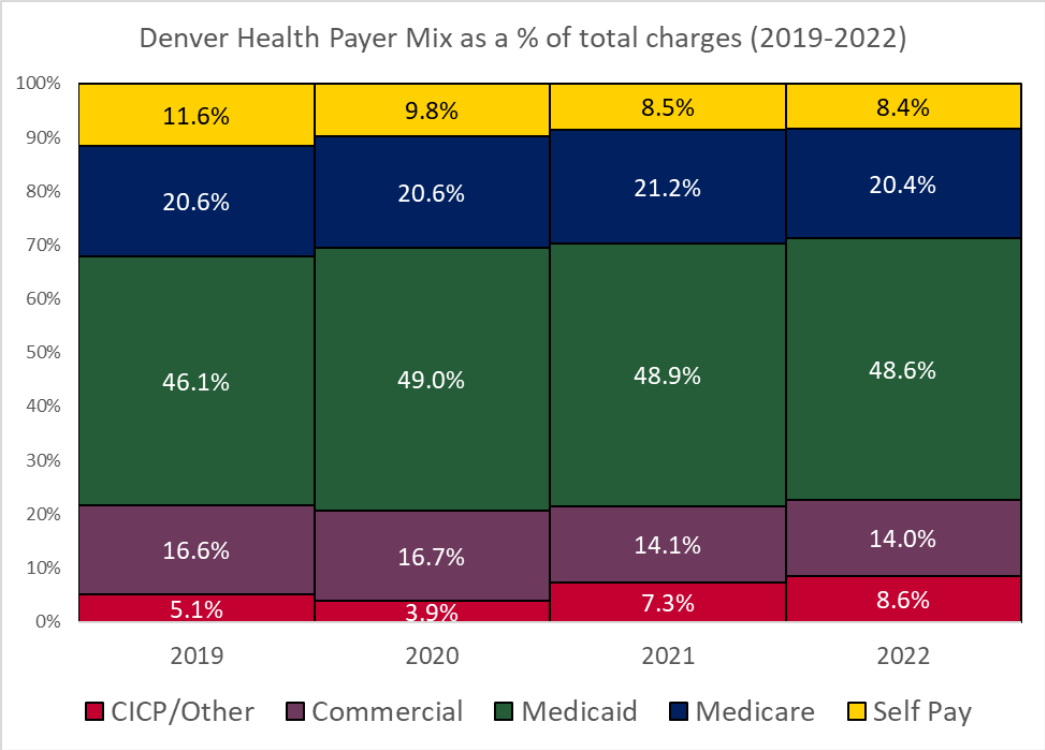
that the reduction of profitability for Denver Health Medical Center is what is driving the reduction in profits for the business as a whole. We can also determine that it is operating margins that are being eroded, and it is *not* solely non-operating aspects such as investments driving these reductions.[8]

3) Denver Health's payer mix is slowly eroding commercial care and adding additional government payers to an already higher-than-normal amount. 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.

[8] 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




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.[9, 10]

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.

**RECOMMENDATION**

Staff recommends denying the requested $5.0 million General Fund and authorizing legislation. The request is not sized appropriately to make a meaningful impact, is proposed as one-time funding for an on-going problem, and appears targeted more toward quality improvements than addressing Denver Health's financial sustainability. Denver Health is an important safety net provider and financial failure of the organization would have significant negative consequences regionally and statewide. The Department's argument that Denver Health is on an "unsustainable" financial path is compelling and concerning. At the same time, this was the Department's 15th and last priority in the November 1 budget request and it appears not fully formed. The request included very little in the

[9] 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%.

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

way of justification or explanation for the funding. Almost all of the available detail has been in response to JBC staff and member questions. To the extent the JBC staff can interpret a plan from what the Department has submitted, that plan appears to continue evolving with each subsequent question. The fundamental problem the Department describes is a long-term structural deficit for Denver Health. The JBC staff sees little value in rushing forward with a proposal that is not fully formed and sized and targeted appropriately to address the underlying issue. It is exceedingly unlikely that Denver Health will fail due to a lack of a one-time $5.0 million General Fund appropriation and the tone of urgency that accompanies the request comes across as hyperbole. While a case can be made that every little bit helps, the JBC staff would prefer to see the Department continue working with the Denver Health leadership and come back next year with a more fully formed and long range plan for setting the organization on a sustainable financial path.

The request is not sized appropriately to make a meaningful impact. One of the Department's primary arguments for the request is that Denver Health has insufficient reserves, measured in terms of days of operating cash on hand. The targeted reserve, according to the Department, is 210-240 days of operating cash and as of June 2023 Denver Health had only 81 days of operating cash. That is a deficit of 129–159 days of operating cash. Based on the data provided by the Department, the requested $5.0 million General Fund represents less than 2 days of operating cash for Denver Health[11].

The request is for one-time funding for on-going problems. The Department attributes Denver Health's financial instability to increasing costs, primarily for care provider compensation, and changes in the payer mix. Denver Health has seen a decrease in private pay clients who tend to pay rates that cover more than costs and increases in Medicaid and charity clients that pay less than costs.

The request appears targeted toward quality improvements with on-going costs to maintain, rather than toward improving Denver Health's financial stability. All the marketing around the request is about Denver Health's reserves, but the Department wants Denver Health to spend the money on (1) connections to the Health Information Exchange, (2) advancing eConsult technology for specialty care, (3) bolstering the nurse advice line, and (4) timely eligibility application processing. These are all things the General Assembly has supported in the past as likely to improve health outcomes for Medicaid clients. However, any connections between these initiatives and Denver Health's financial bottom line appear tenuous, modest, and many years in the future. With all of the intended uses of the funds being to advance quality of care priorities of the Department, this does not sound so much like a proposal for financial relief as a proposal to pay Denver Health to do more stuff. The Department describes the initiatives as "shared goals" with Denver Health, but it is not clear if Denver Health would otherwise prioritize the initiatives in a financial emergency. The Department's argument that this request will help Denver Health is puzzling to the JBC staff in the same way as the Department's argument that expanding autism treatment coverage without increasing rates would somehow financially help autism providers. In both cases, the Department is proposing to pay more but also asking the providers to deliver more.

There is nothing in the Department's request that estimates the cost of the four initiatives or compares those costs with the requested $5.0 million. It is not clear if the $5.0 million is covering all of the costs to Denver Health, or only a portion. The technology improvements would have front-loaded costs,

[11] In calendar year 2022 the Department reports that Denver Health had $302 million reserves and that represented 87 days of cash on hand. $302 M / 87 days = an operating cost of approximately $3.5 million per day.

but all of the initiatives will have some element of on-going costs to continue and maintain that will need to be absorbed by Denver Health.

Making the payment to Denver Health that is proposed in the request would require a bill. The Department's authority to make a General Fund payment to Denver Health without matching federal funds is based on a section of statute (25.5-4-427) that is scheduled to repeal on July 1, 2024. House Bill 24-1086 has already been introduced that would, among other provisions, remove the repeal date for the statute allowing General Fund payments to Denver Health. If the JBC wants to support the request, the JBC could consider adding an appropriations clause to that bill, rather than sponsoring a separate bill. However, there are provisions of that bill that go beyond just what was included in the Department's budget request and that might be a reason for the JBC to craft a narrower bill.

## ➔ BA6 Public health emergency unwind

**REQUEST**

The Department requests adjustments to short-duration appropriations for the surge in eligibility determinations associated with the end of the continuous coverage requirement during the federal public health emergency. The JBC already approved a supplemental for FY 2023-24. This budget amendment would continue and annualize the supplemental changes and add some new funding related to appeals and communications in FY 2024-25. All of the short-duration appropriations would go away in FY 2025-26.

For FY 2023-24, the approved supplemental reduced the County Administration line item that reimburses counties for eligibility determination services for Medicaid clients. The General Assembly had provided $21.0 million total funds in FY 2023-24 based on the expected increase in county workload. The actual workload increase is very similar to the projection used for the FY 2023-24 appropriation. However, counties have struggled to hire and maintain short-duration staff. As a result, the Department anticipates it will revert $10.3 million total funds from the County Administration line item, because the Department cannot push the money out to the counties under the current federally-approved funding formula unless the actual allowable expenditures by the counties justify the payments.

Of the $10.3 million total funds the Department does not expect to spend on County Administration, the approved supplemental reallocates $1.0 million total funds to a set of initiatives to address: (1) emerging issues around eligibility determinations for people receiving long-term care; (2) a backlog of eligibility determinations for people needing long-term care, which is accruing at least in part due to the inability of counties to fully staff; and (3) automated, or ex parte, eligibility determinations.

For FY 2024-25, the Department proposes giving the money cut from the counties in FY 2023-24 back to the counties to address the accumulating backlog of eligibility redeterminations, plus funding to continue the new initiatives begun with transferred funds in FY 2023-24, including:

- A long-term care outbound contact center that will do outreach to people losing Medicaid coverage who utilize long-term care
- Additional resources to eliminate backlogs in processing eligibility determinations for people who utilize long-term care
- A unit to resolve long-term care eligibility issues that are escalated to the Department
- Additional resources for appeals, primarily related to people who utilize long-term care

- Additional resources for communications related to eligibility redetermination procedures
- Information technology resources to make system changes necessary to comply with new federal guidance on how to process automated, or ex parte, eligibility determinations

The FY 2023-24 and FY 2024-25 appropriations are described in more detail following the staff recommendation.

**RECOMMENDATION**

The staff recommendation is summarized in the table below with additional detail about each component described in the subsections following the table.

| BA6 Public Health Emergency Unwind | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Total Funds | General Fund | Cash Funds (HAS Fee) | Cash Funds (HCBS ARPA) | Reapprop. Funds | Federal Funds | FTE |
| **FY 2023-24 Previously Approved Supplemental** | | | | | | | |
| County Administration | ($10,266,675) | ($2,520,970) | ($792,185) | $0 | $0 | ($6,953,520) | 0.0 |
| *Like purpose transfers* | *(1,038,292)* | *(328,042)* | *(201,057)* | *0* | *0* | *(509,193)* | *0.0* |
| *Remaining FY 23-24 underutilization* | *(9,228,383)* | *(2,192,928)* | *(591,128)* | *0* | *0* | *(6,444,327)* | *0.0* |
| Outbound contact center for LTC | 704,570 | 32,763 | 20,080 | 299,442 | 0 | 352,285 | 0.0 |
| Backlog processing for LTC eligibility | 432,085 | 20,092 | 12,314 | 183,636 | 0 | 216,043 | 1.7 |
| *Eligibility processing unit* | *142,085* | *6,607* | *4,049* | *60,386* | *0* | *71,043* | *1.7* |
| *Contract services* | *290,000* | *13,485* | *8,265* | *123,250* | *0* | *145,000* | *0.0* |
| Escalations resolution unit | 517,293 | 133,331 | 81,719 | 43,596 | 0 | 258,647 | 0.0 |
| Automated eligibility system update | 457,600 | 141,856 | 86,944 | 0 | 0 | 228,800 | 0.0 |
| Appeals | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| *HCPF* | *0* | *0* | *0* | *0* | *0* | *0* | *0.0* |
| *Office of Administrative Courts* | *0* | *0* | *0* | *0* | *0* | *0* | *0.0* |
| Communications | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Reallocate existing ARPA $s | (932,576) | 0 | 0 | (466,288) | 0 | (466,288) | 0.0 |
| **Subtotal - HCPF** | **($9,087,703)** | **($2,192,928)** | **($591,128)** | **$60,386** | **$0** | **($6,364,033)** | **1.7** |
| Personnel and Administration | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| **TOTAL - All Departments** | **($9,087,703)** | **($2,192,928)** | **($591,128)** | **$60,386** | **$0** | **($6,364,033)** | **1.7** |
| | | | | | | | |
| **FY 2024-25** | | | | | | | |
| County Administration | $9,228,383 | $2,192,928 | $591,128 | $0 | $0 | $6,444,327 | 0.0 |
| *Like purpose transfer* | *0* | *0* | *0* | *0* | *0* | *0* | *0.0* |
| *Remaining FY 23-24 underutilization* | *9,228,383* | *2,192,928* | *591,128* | *0* | *0* | *6,444,327* | *0.0* |
| Outbound contact center for LTC | 920,795 | 164,131 | 100,597 | 195,669 | 0 | 460,398 | 0.0 |
| Backlog processing for LTC eligibility | 564,444 | 72,941 | 44,708 | 164,571 | 0 | 282,224 | 4.0 |
| *Eligibility processing unit* | *354,444* | *63,176* | *38,723* | *75,321* | *0* | *177,224* | *4.0* |
| *Contract services* | *210,000* | *9,765* | *5,985* | *89,250* | *0* | *105,000* | *0.0* |
| Escalations resolution unit | 775,939 | 220,269 | 135,003 | 32,697 | 0 | 387,970 | 0.0 |
| Automated eligibility system update | 1,294,800 | 401,388 | 246,012 | 0 | 0 | 647,400 | 0.0 |
| Appeals | 268,412 | 83,207 | 50,998 | 0 | 0 | 134,207 | 0.9 |
| *HCPF* | *59,196* | *18,350* | *11,247* | *0* | *0* | *29,599* | *0.9* |
| *Office of Administrative Courts* | *209,216* | *64,857* | *39,751* | *0* | *0* | *104,608* | *0.0* |
| Communications | 165,000 | 51,150 | 31,350 | 0 | 0 | 82,500 | 0.0 |
| Reallocate existing ARPA $s | (635,232) | 0 | 0 | (317,616) | 0 | (317,616) | 0.0 |
| **Subtotal - HCPF** | **$12,582,541** | **$3,186,014** | **$1,199,796** | **$75,321** | **$0** | **$8,121,410** | **4.9** |
| Personnel and Administration | 209,216 | 0 | 0 | 0 | 209,216 | 0 | 2.7 |
| **TOTAL - All Departments** | **$12,791,757** | **$3,186,014** | **$1,199,796** | **$75,321** | **$209,216** | **$8,121,410** | **7.6** |

*COUNTY ADMINISTRATION*

Staff recommends the Department's proposal to take the expected unspent money from County Administration in FY 2023-24 and appropriate it again to the counties in FY 2024-25. The Department

describes anecdotal feedback from the counties that part of the barrier to hiring more staff is the time limit on the funding. Counties are calculating that by the time they hire and train new staff, they will get only a few months of service from those staff before the one-time funding runs out. The Department hopes that by extending a portion of the one-time funding into FY 2024-25, more counties will take advantage of the funding and increase staffing levels.

The JBC staff considered recommending that all or some portion of the FY 2024-25 funding be on-going. If the short duration of the one-time funding is the primary barrier to counties increasing staffing levels, then an even more effective solution than extending the funding might be to make a portion of the one-time funding on-going. However, the JBC staff decided not to go this route for several reasons:

1. The Department reports that where the eligibility backlogs are occurring does not correlate with whether a county is utilizing the one-time funding provided to manage the surge in eligibility redeterminations, suggesting there are more complicated factors than just money that are impacting the ability of counties to keep up with the increased workload.
2. The counties have expressed concerns about the increase in workload, but the increase was expected and funded, and it is truly a temporary increase.
3. The counties argue that the workload is increasing faster than eligibility, in part due to changes in federal regulations during the public health emergency that are permanent, but the Department's data indicates that counties are more efficient in processing eligibility redeterminations per worker than ever before. The Department attributes this productivity and performance increase to the culmination of several process and technology improvements in recent years.

For these reasons, the JBC staff fells a deeper analysis is warranted to determine if counties need an increase in funding. An outside entity procured by the Department of Human Services is scheduled to develop a new county administration funding model for FY 2025-26 by July 1, 2024, pursuant to S.B. 22-235 (sponsored by the JBC). The Department will submit the results of the funding model to the JBC by November 1, 2024. The JBC is supposed to consider the funding model in setting appropriations for FY 2025-26. The JBC staff recommends delaying action on making on-going increases in county administration until this report is available, in hopes that the report will make a more definitive case on whether and how much funding is actually needed.

*OUTBOUND CONTACT CENTER FOR LONG-TERM CARE (LTC)*

The approved supplemental provided $704,570 total funds, including $32,763 General Fund, out of the savings from County Administration for an outbound contact center for long-term care. The amount needed for the outbound contact center grows to $920,795 total funds, including $164,131 General Fund, in FY 2024-25. The outbound contact center talks to every member who utilizes long-term care services and is overdue for renewing eligibility. The goal is to reduce procedural denials where a client loses Medicaid eligibility due to a failure to submit required documentation in a timely manner or some other similar technical and procedural problem.

The Department is particularly concerned about people receiving long-term care due to the vulnerability of the population, the assumption that the eligibility status for people receiving long-term care does not frequently change, and the complexity of eligibility determinations for people receiving

long-term care. The eligibility determinations for people receiving long-term care include documentation and analysis of assets, in addition to just income, and functional assessments of the need for care.

*BACKLOG PROCESSING FOR LTC ELIGIBILITY*

The approved supplemental provided $432,085 total funds, including $20,092 General Fund, out of the savings from County Administration for 1.7 FTE and contract services for backlog processing for long-term care eligibility. The amount increases to $564,444 total funds, including $72,941 General Fund, and 4.0 FTE in FY 2024-25. As noted above, eligibility redeterminations for people receiving long-term care are more complicated than standard eligibility redeterminations. The Department is particularly concerned about a backlog of long-term care eligibility redeterminations due to the vulnerability of the population and the cost to the Department when eligibility is continued for a high-cost client because the Department is unable to process an eligibility redetermination in a timely manner. To reduce the existing backlog, the Department is contracting for outside help and staffing up four state positions.

*ESCALATIONS RESOLUTION UNIT*

The approved supplemental provided $517,293 total funds, including $133,331 General Fund, out of the savings from the County Administration for an escalations resolution unit. The amount increases to $775,939 total funds, including $220,269 General Fund in FY 2024-25. The Department is experiencing an unprecedented and unexpected increase in escalations. From March to October 2023, the Department saw a significant increase in LTC escalations from 17 to 161. Further, overall escalations increased during this time period from 87 to 369, with each of these cases taking approximately 2-3 hours to resolve. One organization submitted over 40 escalations and identified over 100 more that may need to be escalated. According to the Department, advocates are encouraging and teaching members how to appeal their cases.

The Department has contracted for: (1) an eligibility escalations coordinator that focuses on Home- and Community-Based Services and coordinates with stakeholders on both functional and financial eligibility escalations, gathers data related to eligibility escalations and root causes and trends, makes recommendations for improved customer service, and provides training and guidance; (2) complaints and escalations staff to respond to the high volume of complaints and escalations; and (3) additional staff for the Medicaid eligibility inbox to research and respond to eligibility worker policy and processing questions, which have increased dramatically due in part to the large number of new eligibility staff and in part to all the new state and federal guidance related to the public health emergency unwind.

*AUTOMATED ELIGIBILITY SYSTEM UPDATE*

The approved supplemental provided $457,600 total funds, including $141,856 General Fund, out of the savings from the County Administration for contract services to support system and policy changes needed to comply with new federal guidance on automated (ex parte) eligibility renewals. The amount needed in FY 2024-25 increases to $1,294,800 total funds, including $401,388 General Fund. Instead of sending renewal packets including all members of a household, the new federal guidance requires states to perform automated eligibility reviews on an individual basis.

The Department contracted for two project coordinators and two business analysts to facilitate eligibility system changes to comply with the new federal guidance and mitigate miscellaneous specific circumstances contributing to procedural denials. As an interim step, the Department is continuing to

send a renewal packet to all household members, but if a household does not respond, then any member of the household with eligibility by automated procedures is renewed manually. Once the system changes these contract staff are working on are implemented, any member with eligibility by automated procedures will be renewed immediately, resulting in approval up to 60 days sooner.

*APPEALS*

Staff recommends an extension of $268,412 total funds, including $83,207 General Fund, of one-time funding to manage appeals into FY 2024-25. The federal Centers for Medicare and Medicaid Services (CMS) is threatening to withhold federal financial participation from states not resolving appeals within 90 days. The Department was out of compliance with this standard prior to the pandemic. For the unwind of the public health emergency, the Department received additional resources to manage appeals, but these resources are scheduled to expire at the end of FY 2023-24. The Department now expects a backlog of appeals to continue into FY 2024-25. In August 2023 there were 413 appeals, or 51 percent of appeals, that were outside of the 90 day federal standard. To meet federal guidelines, the Department has implemented procedures to ensure clients waiting for appeals continue to receive coverage. The request includes $59,196 total funds for one position (0.9 FTE) in HCPF and $209,216 total funds for an administrator, an administrative law judge, and two technicians for the Office of Administrative Courts in the Department of Personnel. Separately, the Department submitted R8 Eligibility process compliance that includes funding for additional on-going staff to manage appeals to address pre-pandemic appeals compliance issues.

*COMMUNICATIONS*

Staff recommends an extension of $165,000 total funds, including $51,150 General Fund, of one-time funding into FY 2024-25 for contract services to coordinate stakeholder outreach, improve eligibility communications, and develop and publish member facing materials to support the unwind, such as toolkits and Frequently Asked Questions. The Department has used the FY 2023-24 funding to increase and improve communications with clients and eligibility partners. The Department anticipates that many of the materials produced to date will need further updates and revisions based on new guidance, process improvements, and the federal changes to ex parte renewals.

*REALLOCATE EXISTING ARPA FUNDS*

To help finance the changes discussed above, staff recommends the Department's request to reallocate a portion of existing appropriations from the Home- and Community-Based Services (HCBS) Improvement Fund. Pursuant to the American Rescue Plan Act (ARPA), the federal government provided a temporary 10 percent additional match on HCBS services. The additional federal funds were deposited in the HCBS Improvement Fund and must be used to improve or expand HCBS programs. Some of the initiatives funded from the HCBS Improvement Fund are using less resources than originally forecasted, freeing up funds that can be used for this supplemental.

## ➔ BA7 Transportation credentialing and reviews

**REQUEST**

The Department requests funding to annualize a supplemental that increased oversight of the non-emergent medical transportation (NEMT) benefit 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, and coordinate with law enforcement investigating the alleged fraud.

**RECOMMENDATION**
Staff recommends approval of the request with application of the JBC's common policies regarding new FTE, based on the General Assembly's previous approval of the supplemental request.

The table below summarizes the General Assembly's previous action.

| Provider Credentialing and Reviews | | | | | |
|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
| FY 2023-24 | | | | | |
| Statewide credentialing | $506,773 | $152,032 | $101,354 | $253,387 | 0.0 |
| Claims reviews | 750,000 | 225,000 | 150,000 | 375,000 | 0.0 |
| Outreach & oversight | 28,328 | 8,497 | 5,666 | 14,165 | 0.3 |
| **Total FY 2023-24** | **$1,285,101** | **$385,529** | **$257,020** | **$642,552** | **0.3** |
| | | | | | |
| FY 2024-25 | | | | | |
| Statewide credentialing | $0 | $0 | $0 | $0 | 0.0 |
| Claims reviews | 1,500,000 | 450,000 | 300,000 | 750,000 | 0.0 |
| Outreach & oversight | 64,634 | 19,390 | 12,927 | 32,317 | 1.0 |
| **Total FY 2024-25** | **$1,564,634** | **$469,390** | **$312,927** | **$782,317** | **1.0** |
| | | | | | |
| FY 2025-26 | | | | | |
| Statewide credentialing | $0 | $0 | $0 | $0 | 0.0 |
| Claims reviews | 0 | 0 | 0 | 0 | 0.0 |
| Outreach & oversight | 32,317 | 9,695 | 6,463 | 16,159 | 0.5 |
| **Total FY 2025-26** | **$32,317** | **$9,695** | **$6,463** | **$16,159** | **0.5** |

*STATEWIDE CREDENTIALING*
This is a contract for a vendor to perform in-person vehicle inspections, liability and insurance checks, driver qualification reviews (including license and fingerprint background checks), standard of service reviews, and accident protocol reviews. Currently, only providers in the nine-county metro area are required to be credentialed. The Department was already in the process of expanding credentialing requirements statewide for FY 2024-25. Costs for FY 20224-25 and beyond are absorbable within existing appropriations. The request is for one-time credentialing catch up work in FY 2023-24 for providers outside the nine-county metro area and to address the unexpected surge in provider enrollment.

*Claims reviews*
This is a contract for pre- and post-payment claims reviews to prevent overbilling. The expectation is that this will make it more difficult for providers to profit from operating in ways that put clients at risk, in addition to protecting the financial interests of the state. Without funding the Department would not be able to put the same level of protections in place and whatever protections the Department could implement would take longer, further slowing payments to legitimate providers. Currently the Department has put 400 providers on prepayment claims review and each review takes 6-8 weeks. The Department's analysis indicates that it needs to conduct post-payment claims reviews on approximately 25,000 claims to approximately 130 providers. The post-payment claims review typically takes 210 days to complete, or longer if there is litigation. In addition, the vendor would analyze utilization and billing habits and make recommendations for program improvements to

address existing vulnerabilities The Department anticipates the work would continue through FY 2024-25. The Department anticipates implementing automated screens and process changes so such intensive pre- and post-payment claims reviews are not necessary indefinitely and the Department has not requested any funding in FY 2025-26 and beyond.

*Outreach & oversight*
This would pay for one position that would be responsible for providing outreach and technical assistance to providers in navigating the more rigorous payment requirements. Also, the position would coordinate with law enforcement and manage the high volume of pre- and post-payment claims reviews. The Department anticipates most of the work will be needed in FY 2023-24 and FY 2024-25 and the position would have some wrap up work continuing through December 2025, after which the positon would no longer be needed.

## ➔ BA10 CO Benefits Management System

**REQUEST**
The Department requests continuation of a supplemental action that aligned reappropriated funds spending authority from the Department of Human Services with how the Colorado Benefits Management System is being operated by the Executive Branch.

**RECOMMENDATION**
Staff recommends approval of the request based on the General Assembly's action on the supplemental. The changes are already in the FY 2023-24 base and there is no additional incremental change to continue the policy into FY 2024-25. The table below summarizes how the appropriations changed in FY 2023-24.

S10 CBMS True-up

| | Current Appropriation | Supplemental Change | New Appropriation |
|---|---|---|---|
| **Office of Information Technology** | | | |
| OIT support for CBMS | $21,866,546 | $0 | $21,866,546 |
| from HCPF | 17,432,010 | 4,434,536 | 21,866,546 |
| from DHS | 4,434,536 | (4,434,536) | 0 |
| Vendor payments related to CBMS | 37,659,180 | (37,659,180) | 0 |
| from HCPF | 30,021,898 | (30,021,898) | 0 |
| from DHS | 7,637,282 | (7,637,282) | 0 |
| **TOTAL - OIT** | **$59,525,726** | **($37,659,180)** | **$21,866,546** |
| | | | |
| **Health Care Policy and Financing** | | | |
| OIT support for CBMS | $17,432,010 | $4,434,536 | $21,866,546 |
| from HCPF | 17,432,010 | 0 | 17,432,010 |
| from DHS | 0 | 4,434,536 | 4,434,536 |
| Vendor payments related to CBMS | 30,021,898 | 7,637,282 | 37,659,180 |
| from HCPF | 30,021,898 | 0 | 30,021,898 |
| from DHS | 0 | 7,637,282 | 7,637,282 |
| **TOTAL - HCPF** | **$47,453,908** | **$12,071,818** | **$59,525,726** |
| | | | |
| **Human Services** | | | |
| OIT support for CBMS | $4,434,536 | $0 | $4,434,536 |
| Vendor payments related to CBMS | 7,637,282 | 0 | 7,637,282 |
| **TOTAL - HUM** | **$12,071,818** | **$0** | **$12,071,818** |
| | | | |
| **TOTAL - Statewide** | **$119,051,452** | **($25,587,362)** | **$93,464,090** |

In FY 2022-23 and in response to H.B. 21-1236 State Information Technology (Titone & Baisley/Bridges & Priola), OIT started delegating day-to-day operations of several information technology systems, including CBMS, to departments with the necessary resources and skills where the program is a unique or mission-critical function of the state agency. OIT continues to maintain a supervisory, guidance, and support role for the delegated programs. This supplemental only changed the way CBMS money is moved between departments and did not change the original primary sources of funding for CBMS. The net result was a reduction in statewide reappropriated funds, because a step had been eliminated where money was transferred to OIT for vendor payments related to CBMS.

## ➔ BA11 ARPA HCBS adjustments

**REQUEST**

The Department requests $4,608,068 total funds, including $2,495,840 cash funds from the Home- and Community-Based Services (HCBS) Improvement Fund, and 29.0 FTE to extend the duration of term-limited positions that are implementing the Department's spending plan for the American Rescue Plan Act (ARPA) HCBS funds. The ARPA temporarily increased the federal match rate for HCBS by 10 percentage points from April 1, 2021 through March 31, 2022. It required that the state savings from the higher match be used to enhance, expand, or strengthen HCBS. The Department submitted a spending plan to the General Assembly and has received a series of appropriations to implement 63 projects identified in the plan. To administer the projects, the Department hired 58.5 term-limited FTE with start and end dates that vary according to the specific timelines originally forecasted for each project. In this request, the Department proposes extending the end dates for all of the term-limited FTE to at least December 31, 2024 and extending the end date for 15.0 positions that will be involved in the close out accounting and reporting to March 31, 2025.

The federal government extended the timeline for spending the ARPA money to March 31, 2025. The Department is taking advantage of the extension to make more progress on projects where the Department experienced start-up challenges with hiring staff, procuring contractors, and getting materials. Even for projects that remain on schedule, the Department has identified needs for ongoing monitoring, performance analysis, reporting, and close out work that would benefit from additional staff time. The Department is targeting conclusion of the projects by December 31, 2024, to allow a little time before the final federal deadline of March 31, 2025, for last minute adjustments.

The General Assembly already approved a related supplemental request that provided funding for the FTE extensions in FY 2023-24 and made other modifications to the HCBS ARPA spending plan that freed up money for appropriation in FY 2024-25.

| BA11 ARPA HCBS Adjustments | | | | | |
|---|---|---|---|---|---|
| | Total Funds | HCBS Improvement Fund | HAS Fee ARPA Account | Federal Funds | FTE |
| **Previously approved supplemental for FY 2023-24** | | | | | |
| Extend FTE | $1,805,524 | $1,370,599 | $0 | $434,925 | 15.6 |
| Federal match | 869,851 | 434,926 | 0 | 434,925 | 11.3 |
| State only | 935,673 | 935,673 | 0 | 0 | 4.3 |
| Project Reversions | (49,533,546) | (22,073,472) | 0 | (27,460,074) | 0.0 |
| Systems Infrastructure | 0 | (2,700,000) | 0 | 2,700,000 | 0.0 |
| Federal match | 3,000,000 | 300,000 | 0 | 2,700,000 | 0.0 |
| State only | (3,000,000) | (3,000,000) | 0 | 0 | 0.0 |
| Correct fund sources | 0 | (14,487,677) | 14,487,677 | 0 | 0.0 |
| **Total** | **($47,728,022)** | **($37,890,550)** | **$14,487,677** | **($24,325,149)** | **15.6** |
| | | | | | |
| **FY 2024-25** | | | | | |
| Extend FTE | $4,608,068 | $2,495,840 | $0 | $2,112,228 | 29.0 |
| Federal match | 4,199,438 | 2,087,210 | 0 | 2,112,228 | 22.8 |
| State only | 408,630 | 408,630 | 0 | 0 | 6.2 |
| **Total** | **$4,608,068** | **$2,495,840** | **$0** | **$2,112,228** | **29.0** |

The General Fund savings from the higher federal match for HCBS was deposited in the HCBS Improvement Fund and the cash fund savings to the Healthcare Affordability and Sustainability (HAS) Fee was deposited in a special ARPA account of the HAS Fee. The total amount deposited in the two funds to date is $304.3 million, but small reconciliation accounting adjustments are still possible. The table below summarizes the expenditures and authorized rollforwards through FY 2022-23 and all the changes proposed in the Department's supplemental and budget requests for FY 2023-24 and FY 2024-25.

| ARPA HCBS Spending Plan | | | |
|---|---|---|---|
| | Total Funds | HCBS Improvement Fund | HAS Fee ARPA Account |
| Total Available | $304,257,345 | $272,489,675 | 31,767,670 |
| | | | |
| FY 21-22 through FY 22-23 | | | |
| FY 21-22 Actual Expenditures | 34,345,059 | 33,479,301 | 865,758 |
| FY 22-23 Actual Expenditures | 91,219,390 | 89,386,623 | 1,832,767 |
| Authorized rollforwards | 99,542,506 | 85,209,341 | 14,333,165 |
| **Subtotal - FY 21-22 through FY 22-23** | **225,106,955** | **208,075,265** | **17,031,690** |
| | | | |
| FY 23-24 Appropriations | | | |
| FY 2023-24 Long Bill | 85,010,711 | 84,940,692 | 70,019 |
| S5 Office of Community Living | (11,923) | (11,923) | 0 |
| S6 Public health emergency unwind | 60,386 | 60,386 | 0 |
| S8 Community-based access to services | (908,021) | (908,021) | 0 |
| S11 ARPA HCBS Adjustments | (23,402,873) | (37,631,419) | 14,228,546 |
| Staff recommended technical correction to S11 | 0 | (437,415) | 437,415 |
| **Subtotal - FY 23-24 Appropriations** | **60,748,280** | **46,012,300** | **14,735,980** |
| | | | |
| FY 2024-25 Requests | | | |
| Continuation request to finish approved projects | 2,496,448 | 2,496,448 | 0 |
| R6 Provider rates - HCBS minimum wage | 13,330,549 | 13,330,549 | 0 |
| BA6 Public health emergency unwind | 79,273 | 79,273 | 0 |
| BA11 ARPA HCBS adjustments | 2,495,840 | 2,495,840 | 0 |
| **Subtotal - FY 24-25 Requests** | **$18,402,110** | **$18,402,110** | **0** |
| | | | |
| Remaining funds | 0 | 0 | 0 |

The big picture is that in S11 the Department identified FY 2023-24 savings from several projects and in R6 the Department is proposing to spend that savings in FY 2024-25 to offset the cost of a provider rate increase for HCBS providers to help them keep pace with minimum wage increases. The Department is also proposing to spend much smaller amounts of the savings in BA 11 to extend the duration of term-limited FTE administering the ARPA HCBS projects and in BA6 to improve the eligibility redetermination process for HCBS clients impacted by the unwind of the public health emergency.

The savings identified in S11 were due to a menagerie of factors that include lower than anticipated costs for things like training materials, supplies, and software licenses, lower than expected bids for contract work, delays in hiring staff and procuring contract services, lower than expected interest in grants, and lower than anticipated Medicaid enrollment resulting in lower costs for provider rate increases. The Department submits lengthy quarterly reports[12] to the JBC and the Centers for Medicare and Medicaid Services that provide more detail on the specific changes to the budgets for each project.

**RECOMMENDATION**

Staff recommends that the JBC:

- Approve BA11, consistent with the General Assembly's action on S11
- Correct a technical error in the FY 2023-24 appropriation for the State-only Payments for Home- and Community-Based Services line item to decrease the amount identified as from the HCBS Improvement Fund and increase the amount identified as from the ARPA Account of the HAS Fee by $437,415 with no change in the total appropriation
- Provide missing rollforward authority for FY 2023-24 appropriations from the ARPA funds to FY 2024-25 for the same purpose, consistent with the JBC's action during figure setting for the Office of Community Living last year

BA11 is just continuing the policy the General Assembly approved in the supplemental of extending the duration of all the term-limited FTE to at least December 31, 2024 and 15.0 of the FTE involved in close out accounting and reporting to March 31, 2025.

In the supplemental bill the JBC staff made a technical error in identifying the fund sources for the State-only Payments for Home- and Community-Based Services line item and this needs to be corrected to ensure the Department does not overspend the available funds.

Last year, the JBC approved a staff recommendation to provide rollforward authority for all appropriations from the HCBS Improvement Fund from FY 2023-24 to FY 2024-25.[13] Due to a communications breakdown, the approved rollforward authority was only provided in the Long Bill for line items in the Office of Community Living. The approved rollfoward authority was missing from the following appropriations:

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

[13] See page 24 of the JBC Staff figure setting for the Office of Community Living: https://leg.colorado.gov/sites/default/files/fy2023-24_hcpfig3.pdf

| FY 2023-24 Appropriations Missing Rollforward Authority | | | |
|---|---|---|---|
| Line Item | Total Funds | HCBS Improvement Fund | HAS Fee ARPA Account |
| General Administration | $15,541,411 | $15,541,411 | $0 |
| Medicaid Management Information System | 1,341,439 | 1,341,439 | 0 |
| CBMS Operating and Contract Expenses | 1,650,000 | 1,650,000 | 0 |
| Medical Services Premiums | 358,526 | 113,850 | 244,676 |
| Adult Comprehensive Services | 5,101,628 | 5,101,628 | 0 |
| Adult Supported Living Services | 192,738 | 0 | 192,738 |
| Children's Extensive Support Services | 978,522 | 978,522 | 0 |
| Children's Habilitation Residential Program | 127,133 | 127,133 | 0 |
| Case Management for People with IDD | 3,023,886 | 3,023,886 | 0 |
| ARPA State-Only | 32,424,528 | 18,125,962 | 14,298,566 |
| **Total** | **$60,739,811** | **$46,003,831** | **$14,735,980** |

## ➔ BA14 Legal services

**REQUEST**

The Department requests an increase of $237,200 total funds, including $71,160 General Fund, in FY 2024-25 and ongoing for legal services attributable to increases in fraud referrals, audit requirements, and appeals.

Fraud referrals have increased from 209 in FY 2021-22 to 503 in FY 2022-23. Audit requirements and appeals have also contributed to a 53.0 percent increase in billable hours for legal services unrelated to the public health emergency from 9,793 in FY 2020-21 to 14,979 in FY 2022-23.

**RECOMMENDATION**

Staff recommends approval of the request based on trends in the actual usage of legal services. With the funding, the legal services appropriation will increase from supporting 12,540 hours at the blended rate in FY 2023-24 to 14,390 hours in FY 2024-25.

However, it is important to note that the JBC denied a related supplemental request that would have increased the legal services beginning mid-year in FY 2023-24. The JBC's stated rationale was that (1) the Department could absorb the cost (the supplemental was only $79,50 total funds, including $23,850 General Fund) and (2) the JBC had concerns about how much of the workload was driven by the Recovery Audit Contractor (RAC) audits that hospitals and some other providers have described as excessive.

Initially, the JBC staff believed the RAC audits were a minor component of the increase in legal services utilization but promised the JBC additional research on what was driving the workload. Based on discussions with the Attorney General's Office, the Department indicates, "A variety of factors contributed to the increase in legal services utilization, including a significant increase in hours related to federal litigation matters in SFY 22-23. However, the majority of the increase in SFY 22-23 was due to Recovery Audit Contractor (RAC) provider appeals."

While the JBC staff understands the JBC's concerns about potentially inappropriate and excessive RAC audit recoveries, trying to deny the Department the ability to defend itself is not the JBC staff's recommended policy solution. If the strategy were successful, it would invite lawsuits from plaintiffs that think they can win simply by out spending the state on legal services. More likely, the Attorney General would do whatever was necessary to mount a reasonable legal defense, but the Attorney

General's Office would be short on funds because the General Assembly didn't provide the Department of Health Care Policy and Financing with enough money to pay HCPF's legal bills. In trying to reign in HCPF's RAC policies, the entity that would suffer is not HCPF but the Attorney General's Office.

Last year, the JBC sponsored H.B. 23-1295 with reforms intended to reduce RAC findings and make the RAC process more transparent. It also required the State Auditor to conduct an independent review of the RAC process. The bill called for a provider advisory group that has been selected and will hold its first meeting March 14, 2024. The State Auditor is proceeding with the independent review and is currently on schedule to present findings to the Legislative Audit Committee in June 2024.

The JBC staff recommendation is to see what comes out of the provider advisory group and independent review by the Legislative Audit Committee. If this does not go far enough for JBC members, then the JBC staff would recommend reducing the Department of Health Care Policy and Financing's appropriation for Personal Services. The Department has approximately nine state positions managing the RAC program. The JBC couldn't eliminate these positions, because the Department is required by federal law to have a RAC program, but the JBC could potentially reduce the positions, although there would be risk of noncompliance with federal law. The contractor is paid on a contingency basis from the recoveries before they arrive at the Department, so there is no line item where funding for the contractor appears in the budget.

## ➔ Staff Initiated: DACA Recipients

**REQUEST**

The Department's February forecast assumes a proposed new federal regulation would extend Medicaid coverage to children and pregnant people with Deferred Action for Childhood Arrivals (DACA) status who meet the income qualifications and includes $2,061,189 total funds, including $1,030,594 General Fund, for the increased cost. 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 estimates the regulation will extend coverage to approximately 237 DACA recipients. The Department has existing statutory authority to implement provisions of Medicaid that are necessary to comply with federal regulation.

**RECOMMENDATION**

Based on more recent communication from the federal Centers for Medicare and Medicaid Services (CMS), the Department no longer believes the proposed new federal regulation would be implemented in FY 20224-25. Therefore, staff recommends a modification to the Departments forecast to remove $2,061,189 total funds, including $1,030,594 General Fund.

## ➔ Staff Initiated: Autism report

**REQUEST**

The Department did not submit a request related to this issue.

**RECOMMENDATION**

Staff recommends a reduction of $62,000 total funds, including $31,000 General Fund, from the General Professional Services and Special Projects line item. The purpose of the funding was the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. Senate Bill 23-289 repealed the autism waiver and program evaluation.

## ➔ Staff Initiated: Temporary suspension eligibility requirements [potential legislation]

**REQUEST**

The Department did not submit an official request related to this issue, but the Department has asked informally if JBC members could carry a bill to further modify Medicaid and CHP+ eligibility statute changes that were implemented last year in S.B. 23-182, which was sponsored by the JBC. The federal government recently extended the time frames for several public health emergency waivers related to enrollment procedures through December 2024. The Department would like to align state statutes with the extended time frames for the federal waivers. The Department is also proposing more flexible statutory language that would allow the Department to implement these policies permanently, if the Department is able to secure a permanent federal waiver.

**RECOMMENDATION**

Staff recommends that the JBC grant permission to draft a bill to align state statute with the extended time frames for the federal waivers and permit the Department to seek federal waivers to implement the changes permanently. The table below summarizes the waivers.

| Strategy | Implemented | In Progress |
|---|---|---|
| Renew Medicaid eligibility based on financial findings from Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or other means-tested benefit programs | X | |
| Renew Medicaid eligibility for individuals with no income and no data returned on an ex parte basis ($0 income strategy) | X | |
| Extend the timeframe to take final administrative action on fair hearing requests within the maximum 90 days permitted under the regulations for fair hearing requests | X | |
| Delay procedural terminations for beneficiaries under long-term eligibility categories for up to 2 mo.s | X | |
| Permit acceptance of updated in-state enrollee contact information from the National Change of Address (NCOA) database and United States Postal Service (USPS) in-state forwarding address without additional confirmation from the individual to update beneficiary contact information | X | |
| Renew Medicaid eligibility for individuals with income at or below 100% FPL and no data returned on an ex parte basis (100% income strategy) | | X |

| | | |
|---|---|---|
| Permit designation of an authorized representative for the purposes of signing an application or renewal form via the telephone without a signed designation from the applicant or beneficiary | | X |
| Reinstate eligibility effective on individual's prior termination date for individuals disenrolled based on a procedural reason that are redetermined eligible for Medicaid during 90-day reconsideration period | | X |

Extending these waivers would simplify the eligibility process for applicants and counties. The waivers may increase enrollment by reducing administrative churn, but the Department projects minimal impact on expenditures. The Department assumes people who are eligible for Medicaid who leave due to administrative reasons will be back when they encounter a medical issue.

# (1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Healthcare Affordability and Sustainability Fee.

| EXECUTIVE DIRECTOR'S OFFICE | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| **FY 2023-24 Appropriation** | | | | | | |
| FY 2023-24 Appropriation | $597,688,004 | $141,395,201 | $91,523,675 | $17,291,566 | $347,477,562 | 757.7 |
| **TOTAL** | **$597,688,004** | **$141,395,201** | **$91,523,675** | **$17,291,566** | **$347,477,562** | **757.7** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $597,688,004 | $141,395,201 | $91,523,675 | $17,291,566 | $347,477,562 | 757.7 |
| R9 Access to benefits | 308,000 | 153,999 | 0 | 0 | 154,001 | 0.9 |
| R6a Provider rates | 2,789,702 | 461,064 | 638,079 | 0 | 1,690,559 | 0.0 |
| R7 Behavioral health continuum | 271,962 | 118,685 | 17,296 | 0 | 135,981 | 1.4 |
| R8 Eligibility process compliance | 8,479,360 | 788,878 | 633,101 | 0 | 7,057,381 | 1.8 |
| R10 Assessments for skilled nursing | 1,938,600 | 484,650 | 0 | 0 | 1,453,950 | 0.0 |
| R11 Program support | 570,508 | 223,810 | 16,635 | 0 | 330,063 | 2.9 |
| R12a Accessibility | 353,971 | 134,310 | 42,675 | 0 | 176,986 | 0.9 |
| R12b Senior dental administration | 75,000 | 75,000 | 0 | 0 | 0 | 0.0 |
| R13 Convert contracts to FTE | 133,723 | (53,845) | (33,016) | 307,417 | (86,833) | 12.6 |
| R14 Contract true up | 43,910 | 90,668 | (47,844) | 0 | 1,086 | 0.0 |
| BA6 Public health emergency unwind | 21,670,244 | 5,378,942 | 1,805,859 | 0 | 14,485,443 | 3.2 |
| BA7 Transportation credentialing and reviews | 279,533 | 83,861 | 55,907 | 0 | 139,765 | 0.7 |
| BA8 Community-based access to services | 1,232,590 | 768,530 | 133,000 | 0 | 331,060 | 0.0 |
| BA10 CO Benefits Management System | 0 | 0 | 0 | 0 | 0 | 0.0 |
| BA11 ARPA HCBS adjustments | 4,199,438 | 0 | 2,087,210 | 0 | 2,112,228 | 22.8 |
| BA14 Legal services | 237,200 | 71,160 | 47,440 | 0 | 118,600 | 0.0 |
| Autism report | (62,000) | (31,000) | 0 | 0 | (31,000) | 0.0 |
| Payments to OIT | 7,888,029 | 1,665,364 | 688,427 | 1,068,127 | 4,466,111 | 0.0 |
| Centrally appropriated items | 10,631,703 | 4,808,407 | 781,868 | 23,179 | 5,018,249 | 0.0 |
| Transfers to other departments | 745,851 | 352,690 | 0 | 0 | 393,161 | 0.0 |
| Indirect costs | 136,603 | (136,603) | 77,822 | 161,372 | 34,012 | 0.0 |
| Annualize prior year funding | (54,784,168) | (6,111,267) | (19,389,275) | (4,055) | (29,279,571) | (20.2) |
| **TOTAL** | **$604,827,763** | **$150,722,504** | **$79,078,859** | **$18,847,606** | **$356,178,794** | **784.7** |
| **INCREASE/(DECREASE)** | **$7,139,759** | **$9,327,303** | **($12,444,816)** | **$1,556,040** | **$8,701,232** | **27.0** |
| Percentage Change | 1.2% | 6.6% | (13.6%) | 9.0% | 2.5% | 3.6% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$604,034,597** | **$150,774,532** | **$78,799,532** | **$18,923,804** | **$355,536,729** | **786.5** |
| Request Above/(Below) Recommendation | ($793,166) | $52,028 | ($279,327) | $76,198 | ($642,065) | 1.8 |

# LINE ITEM DETAIL — EXECUTIVE DIRECTOR'S OFFICE

## (A) GENERAL ADMINISTRATION

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

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

### CENTRALLY APPROPRIATED LINE ITEMS SET BY JBC COMMON POLICY

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

*REQUEST:* The Department requests:

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

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

| |
|---|
| Health, Life, and Dental |
| Short-term Disability |
| Paid Family and Medical Leave Insurance |
| Amortization Equalization Disbursement |
| Supplemental Amortization Equalization Disbursement |
| Amortization Payments for PERA Unfunded Liability |
| PERA Direct Distribution |
| Salary Survey |
| Temporary Employees Related to Authorized Leave |
| Workers' Compensation |
| Legal Services |
| Administrative Law Judge Services |
| Payment to Risk Management and Property Funds |
| Payments to OIT |
| IT Accessibility |
| CORE Operations |
| DPA Administrative Services |
| Division of Human Resources State Agency Services |
| Division of Human Resources Training Services |
| Division of Human Resources Labor Relations Services |
| Financial Ops and Reporting Services |
| Procurement and Contracts Services |

## PERSONAL SERVICES

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

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

*REQUEST:* The Department requests:

- Funding associated with new FTE requested in R7, R8, R9, R11, R12a, R13, BA6, BA7, and BA11
- A common policy adjustment for the increase in statewide indirect cost recoveries
- Annualizations of prior year bills and budget actions

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

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, PERSONAL SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $69,129,372 | $25,247,967 | $7,833,119 | $2,673,050 | $33,375,236 | 754.7 |
| **TOTAL** | **$69,129,372** | **$25,247,967** | **$7,833,119** | **$2,673,050** | **$33,375,236** | **754.7** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $69,129,372 | $25,247,967 | $7,833,119 | $2,673,050 | $33,375,236 | 754.7 |
| BA11 ARPA HCBS adjustments | 3,262,109 | 0 | 1,618,557 | 0 | 1,643,552 | 22.8 |
| R13 Convert contracts to FTE | 798,459 | 164,255 | 101,035 | 268,517 | 264,652 | 12.6 |
| BA6 Public health emergency unwind | 425,437 | 124,688 | 88,030 | 0 | 212,719 | 3.2 |
| R11 Program support | 289,075 | 93,275 | 14,412 | 0 | 181,388 | 2.9 |
| R8 Eligibility process compliance | 165,171 | 51,202 | 31,383 | 0 | 82,586 | 1.8 |
| R7 Behavioral health continuum | 123,668 | 49,467 | 12,367 | 0 | 61,834 | 1.4 |

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, PERSONAL SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| R12a Accessibility | 90,078 | 29,726 | 15,313 | 0 | 45,039 | 0.9 |
| R9 Access to benefits | 50,157 | 25,078 | 0 | 0 | 25,079 | 0.9 |
| BA7 Transportation credentialing and reviews | 42,189 | 12,657 | 8,438 | 0 | 21,094 | 0.7 |
| Indirect costs | 0 | (136,603) | 0 | 136,603 | 0 | 0.0 |
| Annualize prior year funding | (1,009,239) | 1,071,564 | (1,693,529) | 73,519 | (460,793) | (20.2) |
| **TOTAL** | **$73,366,476** | **$26,733,276** | **$8,029,125** | **$3,151,689** | **$35,452,386** | **781.7** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$4,237,104** | **$1,485,309** | **$196,006** | **$478,639** | **$2,077,150** | **27.0** |
| Percentage Change | 6.1% | 5.9% | 2.5% | 17.9% | 6.2% | 3.6% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$73,739,734** | **$26,901,979** | **$8,071,335** | **$3,160,871** | **$35,605,549** | **783.5** |
| Request Above/(Below) Recommendation | $373,258 | $168,703 | $42,210 | $9,182 | $153,163 | 1.8 |

## OPERATING EXPENSES

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

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

*REQUEST:* The Department requests:

- Funding associated with new FTE requested in R7, R8, R9, R11, R12a, R13, BA6, BA7, and BA8
- Annualizations of prior year bills and budget actions

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

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,742,348 | $1,429,780 | $475,909 | $40,724 | $1,795,935 | 0.0 |
| **TOTAL** | **$3,742,348** | **$1,429,780** | **$475,909** | **$40,724** | **$1,795,935** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,742,348 | $1,429,780 | $475,909 | $40,724 | $1,795,935 | 0.0 |
| R13 Convert contracts to FTE | 102,924 | 19,842 | 12,215 | 38,900 | 31,967 | 0.0 |
| R11 Program support | 37,083 | 11,803 | 1,255 | 0 | 24,025 | 0.0 |
| R8 Eligibility process compliance | 15,686 | 4,862 | 2,980 | 0 | 7,844 | 0.0 |
| R7 Behavioral health continuum | 15,100 | 6,040 | 1,510 | 0 | 7,550 | 0.0 |
| R9 Access to benefits | 7,843 | 3,921 | 0 | 0 | 3,922 | 0.0 |
| R12a Accessibility | 7,843 | 2,588 | 1,333 | 0 | 3,922 | 0.0 |
| Annualize prior year funding | (780,559) | (193,217) | (222,591) | (18,209) | (346,542) | 0.0 |
| BA8 Community-based access to services | (86,500) | (43,250) | 0 | 0 | (43,250) | 0.0 |
| BA6 Public health emergency unwind | (14,608) | 2,624 | (9,928) | 0 | (7,304) | 0.0 |
| BA7 Transportation credentialing and reviews | (5,883) | (1,764) | (1,177) | 0 | (2,942) | 0.0 |
| **TOTAL** | **$3,041,277** | **$1,243,229** | **$261,506** | **$61,415** | **$1,475,127** | **0.0** |

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($701,071)** | **($186,551)** | **($214,403)** | **$20,691** | **($320,808)** | **0.0** |
| Percentage Change | (18.7%) | (13.0%) | (45.1%) | 50.8% | (17.9%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$3,061,738** | **$1,246,684** | **$268,491** | **$60,363** | **$1,486,200** | **0.0** |
| Request Above/(Below) Recommendation | $20,461 | $3,455 | $6,985 | ($1,052) | $11,073 | 0.0 |

## LEASE SPACE

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

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

*REQUEST:* The Department requests:

- Funding associated with new FTE requested in R7, R8, R9, R11, R12a, and BA7
- Annualizations of prior year bills and budget actions

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

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, LEASED SPACE | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,925,908 | $1,479,958 | $446,103 | $38,849 | $1,960,998 | 0.0 |
| **TOTAL** | **$3,925,908** | **$1,479,958** | **$446,103** | **$38,849** | **$1,960,998** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,925,908 | $1,479,958 | $446,103 | $38,849 | $1,960,998 | 0.0 |
| R11 Program support | 19,250 | 6,182 | 968 | 0 | 12,100 | 0.0 |
| R8 Eligibility process compliance | 12,100 | 3,750 | 2,300 | 0 | 6,050 | 0.0 |
| R7 Behavioral health continuum | 6,956 | 2,782 | 696 | 0 | 3,478 | 0.0 |
| R12a Accessibility | 6,050 | 1,996 | 1,029 | 0 | 3,025 | 0.0 |
| R9 Access to benefits | 0 | 0 | 0 | 0 | 0 | 0.0 |
| BA7 Transportation credentialing and reviews | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (214,100) | (6,775) | (99,598) | 0 | (107,727) | 0.0 |
| **TOTAL** | **$3,756,164** | **$1,487,893** | **$351,498** | **$38,849** | **$1,877,924** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($169,744)** | **$7,935** | **($94,605)** | **$0** | **($83,074)** | **0.0** |
| Percentage Change | (4.3%) | 0.5% | (21.2%) | 0.0% | (4.2%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$3,799,397** | **$1,496,428** | **$363,847** | **$38,849** | **$1,900,273** | **0.0** |
| Request Above/(Below) Recommendation | $43,233 | $8,535 | $12,349 | $0 | $22,349 | 0.0 |

## GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility

Fee, Nursing Home Penalties, and the IDD Services Cash Fund. The federal match rate varies based on the specific contracts.

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

*REQUEST:* The Department requests:

- Funding associated with R7, R8, R9, R11, R12a, R12b, R13, BA6, BA7, and BA8
- Annualizations of prior year bills and budget actions

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

| EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $56,494,533 | $14,635,034 | $15,321,318 | $81,000 | $26,457,181 | 0.0 |
| **TOTAL** | **$56,494,533** | **$14,635,034** | **$15,321,318** | **$81,000** | **$26,457,181** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $56,494,533 | $14,635,034 | $15,321,318 | $81,000 | $26,457,181 | 0.0 |
| BA6 Public health emergency unwind | 1,694,415 | 525,268 | 321,939 | 0 | 847,208 | 0.0 |
| R9 Access to benefits | 250,000 | 125,000 | 0 | 0 | 125,000 | 0.0 |
| R12a Accessibility | 250,000 | 100,000 | 25,000 | 0 | 125,000 | 0.0 |
| R8 Eligibility process compliance | 249,804 | 77,439 | 47,463 | 0 | 124,902 | 0.0 |
| BA7 Transportation credentialing and reviews | 243,227 | 72,968 | 48,646 | 0 | 121,613 | 0.0 |
| R11 Program support | 225,100 | 112,550 | 0 | 0 | 112,550 | 0.0 |
| BA8 Community-based access to services | 216,000 | (25,000) | 133,000 | 0 | 108,000 | 0.0 |
| R7 Behavioral health continuum | 99,000 | 49,500 | 0 | 0 | 49,500 | 0.0 |
| R12b Senior dental administration | 75,000 | 75,000 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (20,343,182) | (1,459,028) | (12,340,264) | 0 | (6,543,890) | 0.0 |
| R13 Convert contracts to FTE | (500,000) | (155,000) | (95,000) | 0 | (250,000) | 0.0 |
| Autism report | (62,000) | (31,000) | 0 | 0 | (31,000) | 0.0 |
| **TOTAL** | **$38,891,897** | **$14,102,731** | **$3,462,102** | **$81,000** | **$21,246,064** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($17,602,636)** | **($532,303)** | **($11,859,216)** | **$0** | **($5,211,117)** | **0.0** |
| Percentage Change | (31.2%) | (3.6%) | (77.4%) | 0.0% | (19.7%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$39,153,397** | **$14,233,481** | **$3,462,102** | **$81,000** | **$21,376,814** | **0.0** |
| Request Above/(Below) Recommendation | $261,500 | $130,750 | $0 | $0 | $130,750 | 0.0 |

# (B) TRANSFERS TO OTHER DEPARTMENTS

## EDUCATION

**PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION**

This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and Financing and the Department of Education. Pursuant to statute, up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are used to offset appropriations

in the Medical Services Premiums line item. In this line item the state match appears as General Fund. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

*STATUTORY AUTHORITY:* Section 25.5-5-318 (8)(b), C.R.S.

*REQUEST:* The Department requests continuation funding.

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

## EARLY CHILDHOOD

### EARLY INTERVENTION

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

*STATUTORY AUTHORITY:* Section 26.5-3-406, C.R.S.

*REQUEST:* The Department requests a true up to the request from the Department of Early Childhood and annualizations of prior year funding.

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

### NURSE HOME VISITOR PROGRAM

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

*STATUTORY AUTHORITY:* Section 26.5-3-504 through 26.5-3-508, C.R.S.

*REQUEST:* The Department requests continuation funding

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

## LOCAL AFFAIRS

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

*STATUTORY AUTHORITY:* Section 25.5-6-313(1), C.R.S.

*REQUEST:* The Department requests R14 for a contract true up.

*RECOMMENDATION:* Staff recommends the Department's request.

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

*STATUTORY AUTHORITY:* Section 25.5-6-307 (1)(d), C.R.S.

*REQUEST:* The Department requests continuation funding.

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

## PUBLIC HEALTH AND ENVIRONMENT

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

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

*STATUTORY AUTHORITY:* Section 25-1.5-103 (1), C.R.S.

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

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

**PRENATAL STATISTICAL INFORMATION**

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

*STATUTORY AUTHORITY:* Section 25.5-5-309, C.R.S.

*REQUEST:* The Department requests continuation funding.

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

## REGULATORY AGENCIES

**NURSE AIDE CERTIFICATION**

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

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

*REQUEST:* The Department requests continuation funding.

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

**REVIEWS**

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

*STATUTORY AUTHORITY:* Section 24-34-104 and 40-10.1-302 (1)(b)(II), C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### REVENUE

**HOSPITAL TAX EXEMPTIONS**
This line item pays the Department of Revenue to calculate the federal, state, and local tax exemptions received by each hospital.

*STATUTORY AUTHORITY:* Section 25.5-1-702 through 25.5-1-704, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

## (C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

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

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives a 65 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

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

*REQUEST:* The Department requests annualizations of prior year budget decisions and adjustments for R11 and BA8.

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

| EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $107,630,662 | $16,757,266 | $10,680,890 | $12,204 | $80,180,302 | 0.0 |
| **TOTAL** | **$107,630,662** | **$16,757,266** | **$10,680,890** | **$12,204** | **$80,180,302** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $107,630,662 | $16,757,266 | $10,680,890 | $12,204 | $80,180,302 | 0.0 |
| BA8 Community-based access to services | 355,080 | 88,770 | 0 | 0 | 266,310 | 0.0 |
| R11 Program support | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (3,420,331) | 959,108 | (1,319,616) | 0 | (3,059,823) | 0.0 |
| **TOTAL** | **$104,565,411** | **$17,805,144** | **$9,361,274** | **$12,204** | **$77,386,789** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($3,065,251)** | **$1,047,878** | **($1,319,616)** | **$0** | **($2,793,513)** | **0.0** |
| Percentage Change | (2.8%) | 6.3% | (12.4%) | 0.0% | (3.5%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$104,665,511** | **$17,855,194** | **$9,361,274** | **$12,204** | **$77,436,839** | **0.0** |
| Request Above/(Below) Recommendation | $100,100 | $50,050 | $0 | $0 | $50,050 | 0.0 |

## CBMS OPERATING AND CONTRACT EXPENSES

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

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

*REQUEST:* The Department requests annualizations of prior year budget decisions, adjustments for R13 and BA10, and a nonprioritized request for payments to the Office of Information Technology.

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

| EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $71,701,801 | $11,640,267 | $8,141,042 | $12,126,323 | $39,794,169 | 0.0 |
| **TOTAL** | **$71,701,801** | **$11,640,267** | **$8,141,042** | **$12,126,323** | **$39,794,169** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $71,701,801 | $11,640,267 | $8,141,042 | $12,126,323 | $39,794,169 | 0.0 |
| Payments to OIT | 5,314,065 | 644,530 | 425,110 | 1,068,127 | 3,176,298 | 0.0 |
| BA10 CO Benefits Management System | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (1,940,011) | 483,149 | (1,635,328) | 0 | (787,832) | 0.0 |
| R13 Convert contracts to FTE | (267,660) | (82,942) | (51,266) | 0 | (133,452) | 0.0 |
| **TOTAL** | **$74,808,195** | **$12,685,004** | **$6,879,558** | **$13,194,450** | **$42,049,183** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$3,106,394** | **$1,044,737** | **($1,261,484)** | **$1,068,127** | **$2,255,014** | **0.0** |
| Percentage Change | 4.3% | 9.0% | (15.5%) | 8.8% | 5.7% | 0.0% |

| EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2024-25 EXECUTIVE REQUEST** | **$74,808,195** | **$12,685,004** | **$6,879,558** | **$13,194,450** | **$42,049,183** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

### CBMS HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

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

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

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

*RECOMMENDATION:* Staff recommends the Department's request.

### OFFICE OF EHEALTH INNOVATIONS OPERATIONS

This line item pays for the operations of the Office of eHealth Innovations, created by Executive Order B 2015-008, to provide advice and guidance on advancing health information technology. The Department serves as the fiscal agent for procurement, contracting, accounting, and payments to vendors.

*STATUTORY AUTHORITY:* Section 25.5-1-205, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested funding.

### ALL-PAYER CLAIMS DATABASE

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

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

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

*RECOMMENDATION:* The JBC staff recommends the requested funding.

## (D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

### CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining

Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital. The sources of cash funds are the Hospital Provider Fee and Colorado Autism Treatment Cash Fund.

*STATUTORY AUTHORITY:* Sections 25.5-4-105, 25.5-6-104, 25.5-4-205, and 25.5-4-402.4 (3)(a), C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### COUNTY ADMINISTRATION

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

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

*REQUEST:* The Department requests annualizations of prior year budget actions, an adjustment related to BA6, and the common policy provider rate increase in R6a.

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

| EXECUTIVE DIRECTOR'S OFFICE, ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES, COUNTY ADMINISTRATION | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $121,943,046 | $20,478,568 | $26,174,302 | $0 | $75,290,176 | 0.0 |
| **TOTAL** | **$121,943,046** | **$20,478,568** | **$26,174,302** | **$0** | **$75,290,176** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $121,943,046 | $20,478,568 | $26,174,302 | $0 | $75,290,176 | 0.0 |
| BA6 Public health emergency unwind | 19,495,058 | 4,713,898 | 1,383,313 | 0 | 13,397,847 | 0.0 |
| R6a Provider rates | 2,789,702 | 461,064 | 638,079 | 0 | 1,690,559 | 0.0 |
| Annualize prior year funding | (20,621,636) | (4,556,968) | (1,443,328) | 0 | (14,621,340) | 0.0 |
| **TOTAL** | **$123,606,170** | **$21,096,562** | **$26,752,366** | **$0** | **$75,757,242** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$1,663,124** | **$617,994** | **$578,064** | **$0** | **$467,066** | **0.0** |
| Percentage Change | 1.4% | 3.0% | 2.2% | 0.0% | 0.6% | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$121,897,752** | **$20,815,372** | **$26,366,727** | **$0** | **$74,715,653** | **0.0** |
| Request Above/(Below) Recommendation | ($1,708,418) | ($281,190) | ($385,639) | $0 | ($1,041,589) | 0.0 |

### MEDICAL ASSISTANCE SITES

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

*STATUTORY AUTHORITY:* Section 25.5-1-120, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### ADMINISTRATIVE CASE MANAGEMENT

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

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

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### CUSTOMER OUTREACH

This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

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

*REQUEST:* The Department requests annualization of prior year actions.

*RECOMMENDATION:* Staff recommends the requested funding.

### CENTRALIZED ELIGIBILITY VENDOR CONTRACT

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

*STATUTORY AUTHORITY:* Section 25.5-4-102 and 402.4, C.R.S.

*REQUEST:* The Department requests an adjustment for R14.

*RECOMMENDATION:* Staff recommends the request.

| EXECUTIVE DIRECTOR'S OFFICE, ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES, CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $8,096,880 | $0 | $2,801,253 | $0 | $5,295,627 | 0.0 |
| **TOTAL** | **$8,096,880** | **$0** | **$2,801,253** | **$0** | **$5,295,627** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $8,096,880 | $0 | $2,801,253 | $0 | $5,295,627 | 0.0 |
| R14 Contract true up | (137,425) | 0 | (47,844) | 0 | (89,581) | 0.0 |
| **TOTAL** | **$7,959,455** | **$0** | **$2,753,409** | **$0** | **$5,206,046** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($137,425)** | **$0** | **($47,844)** | **$0** | **($89,581)** | **0.0** |
| Percentage Change | (1.7%) | 0.0% | (1.7%) | 0.0% | (1.7%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$7,959,455** | **$0** | **$2,753,409** | **$0** | **$5,206,046** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

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

*STATUTORY AUTHORITY:* Section 25.5-1-120, C.R.S.

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

*RECOMMENDATION:* Staff recommends the requested funding.

## ELIGIBILITY OVERFLOW PROCESSING CENTER

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

*STATUTORY AUTHORITY:* Section 25.5-1-120, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

## RETURNED MAIL PROCESSING

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

*STATUTORY AUTHORITY:* Section 25.5-1-120, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested funding.

### WORK NUMBER VERIFICATION

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

*STATUTORY AUTHORITY:* Section 25.5-4-205, C.R.S.

*REQUEST:* The Department requests an adjustment related to R8 and a line item name change to "Income Verification Programs".

*RECOMMENDATION:* Staff recommends the request.

EXECUTIVE DIRECTOR'S OFFICE, ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES, INCOME VERIFICATION PROGRAMS

| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
|---|---|---|---|---|---|---|
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,305,114 | $1,089,815 | $545,013 | $0 | $1,670,286 | 0.0 |
| **TOTAL** | **$3,305,114** | **$1,089,815** | **$545,013** | **$0** | **$1,670,286** | **0.0** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,305,114 | $1,089,815 | $545,013 | $0 | $1,670,286 | 0.0 |
| R8 Eligibility process compliance | 8,036,599 | 651,625 | 548,975 | 0 | 6,835,999 | 0.0 |
| **TOTAL** | **$11,341,713** | **$1,741,440** | **$1,093,988** | **$0** | **$8,506,285** | **0.0** |
| **INCREASE/(DECREASE)** | **$8,036,599** | **$651,625** | **$548,975** | **$0** | **$6,835,999** | **0.0** |
| Percentage Change | 243.2% | 59.8% | 100.7% | 0.0% | 409.3% | 0.0% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$11,341,713** | **$1,741,440** | **$1,093,988** | **$0** | **$8,506,285** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## (E) UTILIZATION AND QUALITY REVIEW CONTRACTS

### PROFESSIONAL SERVICES CONTRACTS

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

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

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

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

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

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

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

*REQUEST:* The Department requests annualizations of prior year budget actions and R10.

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

| EXECUTIVE DIRECTOR'S OFFICE, UTILIZATION AND QUALITY REVIEW CONTRACTS, PROFESSIONAL SERVICE CONTRACTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $27,236,877 | $7,301,755 | $2,112,987 | $0 | $17,822,135 | 0.0 |
| **TOTAL** | **$27,236,877** | **$7,301,755** | **$2,112,987** | **$0** | **$17,822,135** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $27,236,877 | $7,301,755 | $2,112,987 | $0 | $17,822,135 | 0.0 |
| R10 Assessments for skilled nursing | 1,938,600 | 484,650 | 0 | 0 | 1,453,950 | 0.0 |
| Annualize prior year funding | 69,348 | 0 | 34,674 | 0 | 34,674 | 0.0 |
| **TOTAL** | **$29,244,825** | **$7,786,405** | **$2,147,661** | **$0** | **$19,310,759** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$2,007,948** | **$484,650** | **$34,674** | **$0** | **$1,488,624** | **0.0** |
| Percentage Change | 7.4% | 6.6% | 1.6% | 0.0% | 8.4% | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$29,244,825** | **$7,786,405** | **$2,147,661** | **$0** | **$19,310,759** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## (F) PROVIDER AUDITS AND SERVICES

### PROFESSIONAL AUDIT CONTRACTS

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.

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

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

*STATUTORY AUTHORITY:* Sections 25.5-6-201 and 202, 25.5-6-204, 25.5-4-401 (1)(a), 25.5-4-402, 25.5-5-408 (1)(d), 25.5-6-106, 25.5-6-107, 25.5-4-105, and 25.5-4-402.4 (3)(a), C.R.S.

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

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

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS

| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
|---|---|---|---|---|---|---|
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $4,281,019 | $1,645,679 | $565,801 | $0 | $2,069,539 | 0.0 |
| **TOTAL** | **$4,281,019** | **$1,645,679** | **$565,801** | **$0** | **$2,069,539** | **0.0** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $4,281,019 | $1,645,679 | $565,801 | $0 | $2,069,539 | 0.0 |
| Annualize prior year funding | (145,100) | (47,050) | (25,500) | 0 | (72,550) | 0.0 |
| **TOTAL** | **$4,135,919** | **$1,598,629** | **$540,301** | **$0** | **$1,996,989** | **0.0** |
| **INCREASE/(DECREASE)** | **($145,100)** | **($47,050)** | **($25,500)** | **$0** | **($72,550)** | **0.0** |
| Percentage Change | (3.4%) | (2.9%) | (4.5%) | 0.0% | (3.5%) | 0.0% |

| EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| **FY 2024-25 EXECUTIVE REQUEST** | **$4,135,919** | **$1,598,629** | **$540,301** | **$0** | **$1,996,989** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## (G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

### ESTATE RECOVERY

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

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

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### THIRD-PARTY LIABILITY COST AVOIDANCE CONTRACT

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

*STATUTORY AUTHORITY:* Section 25.5-4-301 (4) through (6), C.R.S.

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

*RECOMMENDATION:* Staff recommends the requested funding.

## (H) INDIRECT COSTS

### STATEWIDE INDIRECT COST ASSESSMENT

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

*STATUTORY AUTHORITY:* Section 24-75-112, C.R.S.

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

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

# (2) MEDICAL SERVICES PREMIUMS

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

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

# LINE ITEM DETAIL

## MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

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

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

*REQUEST:* The Department requests annualizations of prior year budget decisions and adjustments for R1, R6a, R6b, and BA8.

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

MEDICAL SERVICES PREMIUMS, MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
|---|---|---|---|---|---|---|
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $11,426,144,212 | $3,217,331,185 | $1,280,422,281 | $99,768,814 | $6,828,621,932 | 0.0 |
| Long bill supplemental | (332,880,325) | (53,536,217) | (35,176,800) | 0 | (244,167,308) | 0.0 |
| **TOTAL** | **$11,093,263,887** | **$3,163,794,968** | **$1,245,245,481** | **$99,768,814** | **$6,584,454,624** | **0.0** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $11,093,263,887 | $3,163,794,968 | $1,245,245,481 | $99,768,814 | $6,584,454,624 | 0.0 |
| R1 Medical Services Premiums | 488,069,566 | 310,722,337 | 48,532,452 | 0 | 128,814,777 | 0.0 |
| R6b Targeted provider rates | 169,291,833 | 42,591,718 | 27,182,819 | 0 | 99,517,296 | 0.0 |
| R6a Provider rates | 152,811,429 | 56,298,249 | 6,313,841 | 0 | 90,199,339 | 0.0 |
| Annualize prior year funding | 20,420,053 | 7,322,623 | (68,075) | 0 | 13,165,505 | 0.0 |
| BA8 Community-based access to services | 1,229,580 | 728,640 | (113,850) | 0 | 614,790 | 0.0 |
| DACA Recipients | (2,061,189) | (1,030,594) | 0 | 0 | (1,030,595) | 0.0 |
| **TOTAL** | **$11,923,025,159** | **$3,580,427,941** | **$1,327,092,668** | **$99,768,814** | **$6,915,735,736** | **0.0** |
| **INCREASE/(DECREASE)** | **$829,761,272** | **$416,632,973** | **$81,847,187** | **$0** | **$331,281,112** | **0.0** |
| Percentage Change | 7.5% | 13.2% | 6.6% | 0.0% | 5.0% | 0.0% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$12,329,137,106** | **$3,549,807,942** | **$1,371,044,499** | **$114,867,290** | **$7,293,417,375** | **0.0** |
| Request Above/(Below) Recommendation | $406,111,947 | ($30,619,999) | $43,951,831 | $15,098,476 | $377,681,639 | 0.0 |

# (5) INDIGENT CARE PROGRAM

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

| INDIGENT CARE PROGRAM | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| **FY 2023-24 Appropriation** | | | | | | |
| FY 2023-24 Appropriation | $469,136,714 | $36,589,314 | $169,463,918 | $0 | $263,083,482 | 0.0 |
| Long bill supplemental | 28,879,255 | 3,328,775 | 6,576,810 | 0 | 18,973,670 | 0.0 |
| **TOTAL** | **$498,015,969** | **$39,918,089** | **$176,040,728** | **$0** | **$282,057,152** | **0.0** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $498,015,969 | $39,918,089 | $176,040,728 | $0 | $282,057,152 | 0.0 |
| R3 Child Health Plan Plus | 71,926,571 | 15,997,713 | 9,821,673 | 0 | 46,107,185 | 0.0 |
| R9 Access to benefits | 0 | 0 | 0 | 0 | 0 | 0.0 |
| R6b Targeted provider rates | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (13,700,553) | (6,648,212) | 2,267,599 | 0 | (9,319,940) | 0.0 |
| **TOTAL** | **$556,241,987** | **$49,267,590** | **$188,130,000** | **$0** | **$318,844,397** | **0.0** |
| **INCREASE/(DECREASE)** | **$58,226,018** | **$9,349,501** | **$12,089,272** | **$0** | **$36,787,245** | **0.0** |
| Percentage Change | 11.7% | 23.4% | 6.9% | 0.0% | 13.0% | 0.0% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$514,649,958** | **$46,618,393** | **$176,389,057** | **$0** | **$291,642,508** | **0.0** |
| Request Above/(Below) Recommendation | ($41,592,029) | ($2,649,197) | ($11,740,943) | $0 | ($27,201,889) | 0.0 |

## LINE ITEM DETAIL – INDIGENT CARE PROGRAM

### SAFETY NET PROVIDER PAYMENTS

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

The source of cash funds is the Healthcare Affordability and Sustainability Fee and the federal match rate is at the standard Medicaid FMAP. Colorado draws the federal funds for Safety Net Provider Payments through a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. Federal DSH allotments are required to decrease in aggregate with the implementation of the Affordable Care Act and the expected decrease in the uninsured population.

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

*STATUTORY AUTHORITY:* Sections 25.5-3-108 (1) through (5), 25.5-3-104, C.R.S.

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

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

| INDIGENT CARE PROGRAM, SAFETY NET PROVIDER PAYMENTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $226,610,307 | $0 | $111,039,051 | $0 | $115,571,256 | 0.0 |
| **TOTAL** | **$226,610,307** | **$0** | **$111,039,051** | **$0** | **$115,571,256** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $226,610,307 | $0 | $111,039,051 | $0 | $115,571,256 | 0.0 |
| Annualize prior year funding | 1 | 0 | 2,266,103 | 0 | (2,266,102) | 0.0 |
| **TOTAL** | **$226,610,308** | **$0** | **$113,305,154** | **$0** | **$113,305,154** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$1** | **$0** | **$2,266,103** | **$0** | **($2,266,102)** | **0.0** |
| Percentage Change | 0.0% | 0.0% | 2.0% | 0.0% | (2.0%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$226,610,308** | **$0** | **$113,305,154** | **$0** | **$113,305,154** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## PEDIATRIC SPECIALTY HOSPITAL

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

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

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

the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

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

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

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

| INDIGENT CARE PROGRAM, PEDIATRIC SPECIALTY HOSPITAL | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $10,764,010 | $5,274,365 | $0 | $0 | $5,489,645 | 0.0 |
| **TOTAL** | **$10,764,010** | **$5,274,365** | **$0** | **$0** | **$5,489,645** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $10,764,010 | $5,274,365 | $0 | $0 | $5,489,645 | 0.0 |
| Annualize prior year funding | 0 | 107,640 | 0 | 0 | (107,640) | 0.0 |
| **TOTAL** | **$10,764,010** | **$5,382,005** | **$0** | **$0** | **$5,382,005** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$0** | **$107,640** | **$0** | **$0** | **($107,640)** | **0.0** |
| Percentage Change | 0.0% | 2.0% | 0.0% | 0.0% | (2.0%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$10,764,010** | **$5,382,005** | **$0** | **$0** | **$5,382,005** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

## APPROPRIATION FROM TOBACCO TAX FUND TO GENERAL FUND

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

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

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff requests permission to adjust this line item based on the March revenue forecast selected by the JBC for budget balancing and permission to make the corresponding adjustment to fund sources in the Children's Basic Health Plan line item.

## PRIMARY CARE FUND

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

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;

- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

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

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

*REQUEST:* The Department requests annualizations of prior year budget actions and additional funds through R6b.

*RECOMMENDATION:* The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. Staff requests permission to adjust this line item based on the March revenue forecast selected by the JBC for budget balancing.

| INDIGENT CARE PROGRAM, PRIMARY CARE FUND | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $59,118,641 | $7,000,000 | $22,494,290 | $0 | $29,624,351 | 0.0 |
| **TOTAL** | **$59,118,641** | **$7,000,000** | **$22,494,290** | **$0** | **$29,624,351** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $59,118,641 | $7,000,000 | $22,494,290 | $0 | $29,624,351 | 0.0 |
| R6b Targeted provider rates | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (14,401,487) | (7,000,000) | 0 | 0 | (7,401,487) | 0.0 |
| **TOTAL** | **$44,717,154** | **$0** | **$22,494,290** | **$0** | **$22,222,864** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($14,401,487)** | **($7,000,000)** | **$0** | **$0** | **($7,401,487)** | **0.0** |
| Percentage Change | (24.4%) | (100.0%) | 0.0% | 0.0% | (25.0%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$45,830,960** | **$556,902** | **$22,494,290** | **$0** | **$22,779,768** | **0.0** |
| Request Above/(Below) Recommendation | $1,113,806 | $556,902 | $0 | $0 | $556,904 | 0.0 |

## CHILDREN'S BASIC HEALTH PLAN (CHP+) ADMINISTRATION

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

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

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

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

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

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

| INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,864,405 | $0 | $1,325,491 | $0 | $2,538,914 | 0.0 |
| **TOTAL** | **$3,864,405** | **$0** | **$1,325,491** | **$0** | **$2,538,914** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $3,864,405 | $0 | $1,325,491 | $0 | $2,538,914 | 0.0 |
| R3 Child Health Plan Plus | 0 | 0 | 27,051 | 0 | (27,051) | 0.0 |
| **TOTAL** | **$3,864,405** | **$0** | **$1,352,542** | **$0** | **$2,511,863** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$0** | **$0** | **$27,051** | **$0** | **($27,051)** | **0.0** |
| Percentage Change | 0.0% | 0.0% | 2.0% | 0.0% | (1.1%) | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$3,864,405** | **$0** | **$1,352,542** | **$0** | **$2,511,863** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

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

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

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

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The projected federal match for FY 2024-25 is 65 percent.

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

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

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

| INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $168,474,027 | $24,314,949 | $34,299,762 | $0 | $109,859,316 | 0.0 |
| Long bill supplemental | $28,879,255 | $3,328,775 | $6,576,810 | $0 | $18,973,670 | 0.0 |
| **TOTAL** | **$197,353,282** | **$27,643,724** | **$40,876,572** | **$0** | **$128,832,986** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $197,353,282 | $27,643,724 | $40,876,572 | $0 | $128,832,986 | 0.0 |
| R3 Child Health Plan Plus | 71,926,571 | 15,997,713 | 9,794,622 | 0 | 46,134,236 | 0.0 |
| Annualize prior year funding | 700,933 | 244,148 | 1,496 | 0 | 455,289 | 0.0 |
| R9 Access to benefits | 0 | 0 | 0 | 0 | 0 | 0.0 |
| **TOTAL** | **$269,980,786** | **$43,885,585** | **$50,672,690** | **$0** | **$175,422,511** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **$72,627,504** | **$16,241,861** | **$9,796,118** | **$0** | **$46,589,525** | **0.0** |
| Percentage Change | 36.8% | 58.8% | 24.0% | 0.0% | 36.2% | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$227,274,951** | **$40,679,486** | **$38,931,747** | **$0** | **$147,663,718** | **0.0** |
| Request Above/(Below) Recommendation | ($42,705,835) | ($3,206,099) | ($11,740,943) | $0 | ($27,758,793) | 0.0 |

# (6) OTHER MEDICAL SERVICES

This division contains the funding for:

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

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

| OTHER MEDICAL SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| **FY 2023-24 Appropriation** | | | | | | |
| FY 2023-24 Appropriation | $509,303,001 | $266,861,089 | $135,133,405 | $220,500 | $107,088,007 | 8.3 |
| Long bill supplemental | (6,365,425) | (6,365,425) | 0 | 0 | 0 | 0.0 |
| **TOTAL** | **$502,937,576** | **$260,495,664** | **$135,133,405** | **$220,500** | **$107,088,007** | **8.3** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $502,937,576 | $260,495,664 | $135,133,405 | $220,500 | $107,088,007 | 8.3 |
| R4 Medicare Modernization Act | (729,368) | (729,368) | 0 | 0 | 0 | 0.0 |
| BA9 Public school health services | 9,682,177 | 0 | 9,246,240 | 0 | 435,937 | 0.0 |
| R15 Denver Health | 0 | 0 | 0 | 0 | 0 | 0.0 |
| BA11 ARPA HCBS adjustments | 408,630 | 0 | 408,630 | 0 | 0 | 6.2 |
| Annualize prior year funding | (31,987,867) | 93,066 | (31,990,532) | 4,500 | (94,901) | (4.0) |
| **TOTAL** | **$480,311,148** | **$259,859,362** | **$112,797,743** | **$225,000** | **$107,429,043** | **10.5** |
| **INCREASE/(DECREASE)** | **($22,626,428)** | **($636,302)** | **($22,335,662)** | **$4,500** | **$341,036** | **2.2** |
| Percentage Change | (4.5%) | (0.2%) | (16.5%) | 2.0% | 0.3% | 26.5% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$494,696,684** | **$274,244,898** | **$112,797,743** | **$225,000** | **$107,429,043** | **6.2** |
| Request Above/(Below) Recommendation | $14,385,536 | $14,385,536 | $0 | $0 | $0 | (4.3) |

## LINE ITEM DETAIL – OTHER MEDICAL SERVICES

### OLD AGE PENSION STATE MEDICAL PROGRAM

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

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

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

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

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

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### SENIOR DENTAL PROGRAM

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

*STATUTORY AUTHORITY:* Section 25.5-3-401 through 406, C.R.S.

*Request:* The Department requests continuation funding.

*Recommendation:* Staff recommends the requested continuation funding.

### COMMISSION ON FAMILY MEDICINE

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

*STATUTORY AUTHORITY:* Section 25-1-902 (1) and 903 (1)(c), C.R.S.

*REQUEST:* The Department requests annualizations of prior year funding.

*RECOMMENDATION:* Staff recommends the Department's request.

### MEDICARE MODERNIZATION ACT

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the

costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

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

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

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

*RECOMMENDATION:* Staff recommends adjusting both the FY 23-24 and FY 24-25 appropriations based on the updated February 2024 forecast. See the recommendation on *R4 Medicare Modernization Act* for more detail.

| OTHER MEDICAL SERVICES, MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $251,754,405 | $251,754,405 | $0 | $0 | $0 | 0.0 |
| Long bill supplemental | (6,365,425) | (6,365,425) | 0 | 0 | 0 | 0.0 |
| **TOTAL** | **$245,388,980** | **$245,388,980** | **$0** | **$0** | **$0** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $245,388,980 | $245,388,980 | $0 | $0 | $0 | 0.0 |
| R4 Medicare Modernization Act | (729,368) | (729,368) | 0 | 0 | 0 | 0.0 |
| **TOTAL** | **$244,659,612** | **$244,659,612** | **$0** | **$0** | **$0** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($729,368)** | **($729,368)** | **$0** | **$0** | **$0** | **0.0** |
| Percentage Change | (0.3%) | (0.3%) | 0.0% | 0.0% | 0.0% | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$254,045,148** | **$254,045,148** | **$0** | **$0** | **$0** | **0.0** |
| Request Above/(Below) Recommendation | $9,385,536 | $9,385,536 | $0 | $0 | $0 | 0.0 |

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

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

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

C.R.S. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

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

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

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

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

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

| OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $192,429,050 | $0 | $91,181,029 | $0 | $101,248,021 | 0.0 |
| **TOTAL** | **$192,429,050** | **$0** | **$91,181,029** | **$0** | **$101,248,021** | **0.0** |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $192,429,050 | $0 | $91,181,029 | $0 | $101,248,021 | 0.0 |
| BA9 Public school health services | 9,682,177 | 0 | 9,246,240 | 0 | 435,937 | 0.0 |
| **TOTAL** | **$202,111,227** | **$0** | **$100,427,269** | **$0** | **$101,683,958** | **0.0** |
| **INCREASE/(DECREASE)** | **$9,682,177** | **$0** | **$9,246,240** | **$0** | **$435,937** | **0.0** |
| Percentage Change | 5.0% | 0.0% | 10.1% | 0.0% | 0.4% | 0.0% |
| **FY 2024-25 EXECUTIVE REQUEST** | **$202,111,227** | **$0** | **$100,427,269** | **$0** | **$101,683,958** | **0.0** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | 0.0 |

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

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

*STATUTORY AUTHORITY:* Sections 25.5-5-208, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### REPRODUCTIVE HEALTH CARE FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICAID

This line funds a program by which individuals can receive reproductive health care who are not eligible for coverage under Medicaid only because of their citizenship, or immigration status.

*STATUTORY AUTHORITY:* Sections 25.5-1-201, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

### PAYMENTS TO DENVER HEALTH AND HOSPITAL AUTHORITY

This line item provides funding to support the financial stability of Denver Health.

*STATUTORY AUTHORITY:* Sections 25.5-4-427, C.R.S.

*REQUEST:* The Department requests R15.

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

| OTHER MEDICAL SERVICES, DENVER HEALTH AND HOSPITAL AUTHORITY | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $1,000,000 | $1,000,000 | $0 | $0 | $0 | 0.0 |
| **TOTAL** | **$1,000,000** | **$1,000,000** | **$0** | **$0** | **$0** | **0.0** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $1,000,000 | $1,000,000 | $0 | $0 | $0 | 0.0 |
| R15 Denver Health | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Annualize prior year funding | (1,000,000) | (1,000,000) | 0 | 0 | 0 | 0.0 |
| **TOTAL** | **$0** | **$0** | **$0** | **$0** | **$0** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($1,000,000)** | **($1,000,000)** | **$0** | **$0** | **$0** | **0.0** |
| Percentage Change | (100.0%) | (100.0%) | 0.0% | 0.0% | 0.0% | 0.0% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$5,000,000** | **$5,000,000** | **$0** | **$0** | **$0** | **0.0** |
| Request Above/(Below) Recommendation | $5,000,000 | $5,000,000 | $0 | $0 | $0 | 0.0 |

### RURAL PROVIDER ACCESS AND AFFORDABILITY FUND

This funding is for qualified rural providers based on financial need or the ability to expand health-care access and is intended to improve health-care affordability and access in rural communities.

*STATUTORY AUTHORITY:* Sections 25.5-1-207 (6)(a), C.R.S.

*REQUEST:* The Department requests no funding based on the end of the statutory authorization for the program.

*RECOMMENDATION:* Staff recommends the request.

### STATE-ONLY PAYMENTS FOR HOME- AND COMMUNITY-BASED SERVICES

Spending authority for the state-only projects approved under the ARPA HCBS Spending Plan to implement initiatives to enhance, expand, and strengthen home and community-based services over a period of three years.

*STATUTORY AUTHORITY:* Sections 25.5-6-1803, C.R.S.

*REQUEST:* The Department requests annualizations of prior year budget actions and BA11.

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

| OTHER MEDICAL SERVICES, ARPA HCBS STATE-ONLY FUNDS | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| | | | | | | |
| FY 2023-24 APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $32,424,528 | $0 | $32,424,528 | $0 | $0 | 8.3 |
| Long bill supplemental | $0 | $0 | $0 | $0 | $0 | 0.0 |
| **TOTAL** | **$32,424,528** | **$0** | **$32,424,528** | **$0** | **$0** | **8.3** |
| | | | | | | |
| FY 2024-25 RECOMMENDED APPROPRIATION | | | | | | |
| FY 2023-24 Appropriation | $32,424,528 | $0 | $32,424,528 | $0 | $0 | 8.3 |
| BA11 ARPA HCBS adjustments | 408,630 | 0 | 408,630 | 0 | 0 | 6.2 |
| Annualize prior year funding | (31,990,532) | 0 | (31,990,532) | 0 | 0 | (4.0) |
| **TOTAL** | **$842,626** | **$0** | **$842,626** | **$0** | **$0** | **10.5** |
| | | | | | | |
| **INCREASE/(DECREASE)** | **($31,581,902)** | **$0** | **($31,581,902)** | **$0** | **$0** | **2.2** |
| Percentage Change | (97.4%) | 0.0% | (97.4%) | 0.0% | 0.0% | 26.5% |
| | | | | | | |
| **FY 2024-25 EXECUTIVE REQUEST** | **$842,626** | **$0** | **$842,626** | **$0** | **$0** | **6.2** |
| Request Above/(Below) Recommendation | $0 | $0 | $0 | $0 | $0 | (4.3) |

### DOULA SCHOLARSHIP PROGRAM

The doula scholarship program provides financial support to eligible individuals to pursue doula training and certification.

*STATUTORY AUTHORITY:* Sections 25.5-4-506, C.R.S.

*REQUEST:* The Department requests annualization of prior year budget actions.

*RECOMMENDATION:* Staff recommends the request.

### HEALTH BENEFITS FOR CHILDREN

This line item provides look-alike coverage to Medicaid and the Children's Basic Health Plan (CHP+) for low-income children regardless of immigration status.

*STATUTORY AUTHORITY:* Sections 25.5-2-104 and 105, C.R.S.

*REQUEST:* The Department requests continuation funding.

*RECOMMENDATION:* Staff recommends the requested continuation funding.

# LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

## LONG BILL FOOTNOTES

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

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

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~~ 2025-26 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. The reason for the flexibility is that the payments for contract information technology services in this line item often unexpectedly cross state fiscal years.

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.

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. Staff requests permission to update the amounts in the footnote based on the JBC's actions during figure setting for the Department of Higher Education.

Staff recommends **DISCONTINUING** the following footnotes:

17 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, 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. The footnote is no longer necessary.

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 provided 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. The footnote is no longer relevant.

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.

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 explained the General Assembly's assumptions regarding FY 2023-24 provider rates for anesthesia. The Department is in compliance with the footnote. The footnote is no longer relevant.

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 provided roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote. The appropriations are not continuing into FY 2024-25, so the footnote is no longer necessary.

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 provided roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote. The appropriations are not continuing into FY 2024-25, so the footnote is no longer necessary.

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 provided roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote. The appropriations are not continuing into FY 2024-25, so the footnote is no longer necessary.

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 provided roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote. The appropriations are not continuing into FY 2024-25, so the footnote is no longer necessary.

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 provided roll-forward authority for appropriations from the Home- and Community-Based Services Improvement Fund. The Department is complying with the footnote. The appropriations are not continuing into FY 2024-25, so the footnote is no longer necessary.

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 provided roll-forward authority for a specific portion of the FY 2023-24 appropriation related to financial closeout activities for Case Management Agencies and Single Entry Points. The Department is complying with the footnote. The footnote is no longer necessary.

## REQUESTS FOR INFORMATION

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

### REQUESTS AFFECTING MULTIPLE DEPARTMENTS

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 long-standing request for information provides some accountability for the significant benefit to the University of Colorado of the agreement between the Departments.

## DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

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

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

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

Staff recommends **DISONTINUING** the following requests for 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 one-time reports as requested.

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 one-time report as requested.

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 one-time report as requested.

## Appendix A: Numbers Pages

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**<br>**Kim Bimestefer, Executive Director** | | | | | | |
| **(1) EXECUTIVE DIRECTOR'S OFFICE** | | | | | | |
| Primary functions: Provides all of the administrative, audit and oversight functions for the Department. | | | | | | |
| **(A) General Administration** | | | | | | |
| Personal Services | 51,242,435 | 62,060,344 | 69,129,372 | 73,739,734 | 73,366,476 | * |
| FTE | 600.5 | 704.7 | 754.7 | 783.5 | 781.7 | |
| General Fund | 16,861,340 | 21,628,822 | 25,247,967 | 26,901,979 | 26,733,276 | |
| Cash Funds | 4,699,898 | 5,859,142 | 7,833,119 | 8,071,335 | 8,029,125 | |
| Reappropriated Funds | 1,772,301 | 1,388,133 | 2,673,050 | 3,160,871 | 3,151,689 | |
| Federal Funds | 27,908,896 | 33,184,247 | 33,375,236 | 35,605,549 | 35,452,386 | |
| Health, Life, and Dental | 7,071,991 | 9,139,400 | 10,639,237 | 13,342,069 | 13,058,517 | * |
| General Fund | 2,642,297 | 3,552,746 | 4,148,063 | 5,365,022 | 5,296,860 | |
| Cash Funds | 660,834 | 796,123 | 849,729 | 1,142,711 | 1,103,640 | |
| Reappropriated Funds | 166,554 | 229,292 | 221,797 | 275,782 | 221,797 | |
| Federal Funds | 3,602,306 | 4,561,239 | 5,419,648 | 6,558,554 | 6,436,220 | |
| Short-term Disability | 104,617 | 93,895 | 100,903 | 127,425 | 124,563 | * |
| General Fund | 50,803 | 35,944 | 38,739 | 51,390 | 50,642 | |
| Cash Funds | 10,843 | 7,760 | 8,239 | 10,050 | 9,682 | |
| Reappropriated Funds | 3,300 | 2,119 | 1,911 | 2,302 | 1,911 | |
| Federal Funds | 39,671 | 48,072 | 52,014 | 63,683 | 62,328 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Paid Family and Medical Leave Insurance | 0 | 0 | 0 | 372,398 | 364,348 | * |
| General Fund | 0 | 0 | 0 | 157,433 | 155,245 | |
| Cash Funds | 0 | 0 | 0 | 27,745 | 26,796 | |
| Reappropriated Funds | 0 | 0 | 0 | 1,101 | 0 | |
| Federal Funds | 0 | 0 | 0 | 186,119 | 182,307 | |
| S.B. 04-257 Amortization Equalization Disbursement | 2,428,087 | 2,935,436 | 3,356,675 | 4,233,861 | 4,144,429 | * |
| General Fund | 924,349 | 1,123,363 | 1,293,879 | 1,711,552 | 1,688,363 | |
| Cash Funds | 211,103 | 243,684 | 269,385 | 331,196 | 319,551 | |
| Reappropriated Funds | 52,920 | 66,241 | 62,817 | 75,048 | 62,817 | |
| Federal Funds | 1,239,715 | 1,502,148 | 1,730,594 | 2,116,065 | 2,073,698 | |
| S.B. 06-235 Supplemental Amortization Equalization Disbursement | 2,428,087 | 2,935,437 | 3,356,675 | 4,233,860 | 4,144,428 | * |
| General Fund | 924,349 | 1,123,363 | 1,293,878 | 1,711,552 | 1,688,362 | |
| Cash Funds | 211,103 | 243,684 | 269,386 | 331,197 | 319,552 | |
| Reappropriated Funds | 52,920 | 66,241 | 62,817 | 75,048 | 62,817 | |
| Federal Funds | 1,239,715 | 1,502,149 | 1,730,594 | 2,116,063 | 2,073,697 | |
| Salary Survey | 1,273,930 | 1,739,584 | 3,665,128 | 3,569,073 | 3,569,073 | |
| General Fund | 474,954 | 701,453 | 1,412,280 | 1,527,117 | 1,528,978 | |
| Cash Funds | 98,663 | 117,370 | 267,765 | 254,689 | 252,828 | |
| Reappropriated Funds | 29,439 | 32,730 | 53,934 | 0 | 0 | |
| Federal Funds | 670,874 | 888,031 | 1,931,149 | 1,787,267 | 1,787,267 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| PERA Direct Distribution | 1,077,010 | 667,352 | 187,621 | 1,459,499 | 1,459,499 | |
| General Fund | 430,205 | 0 | 73,919 | 620,495 | 620,590 | |
| Cash Funds | 83,411 | 74,345 | 13,659 | 105,849 | 105,754 | |
| Reappropriated Funds | 24,889 | 21,079 | 2,869 | 2,869 | 2,869 | |
| Federal Funds | 538,505 | 571,928 | 97,174 | 730,286 | 730,286 | |
| Temporary Employees Related to Authorized Leave | 0 | 0 | 5,978 | 5,978 | 5,978 | |
| General Fund | 0 | 0 | 2,414 | 2,411 | 2,414 | |
| Cash Funds | 0 | 0 | 400 | 403 | 400 | |
| Reappropriated Funds | 0 | 0 | 112 | 112 | 112 | |
| Federal Funds | 0 | 0 | 3,052 | 3,052 | 3,052 | |
| Worker's Compensation | 160,590 | 194,996 | 184,274 | 262,815 | 262,815 | |
| General Fund | 64,817 | 74,668 | 68,015 | 99,543 | 99,635 | |
| Cash Funds | 14,502 | 16,333 | 20,031 | 26,658 | 26,566 | |
| Reappropriated Funds | 976 | 6,497 | 7,224 | 9,117 | 9,117 | |
| Federal Funds | 80,295 | 97,498 | 89,004 | 127,497 | 127,497 | |
| Operating Expenses | 2,528,896 | 3,091,508 | 3,742,348 | 3,061,738 | 3,041,277 | * |
| General Fund | 1,209,995 | 1,398,738 | 1,429,780 | 1,246,684 | 1,243,229 | |
| Cash Funds | 233,675 | 339,880 | 475,909 | 268,491 | 261,506 | |
| Reappropriated Funds | 13,297 | 59,204 | 40,724 | 60,363 | 61,415 | |
| Federal Funds | 1,071,929 | 1,293,686 | 1,795,935 | 1,486,200 | 1,475,127 | |
| Legal Services | 1,172,759 | 956,323 | 2,323,074 | 4,154,297 | 4,154,297 | * |
| General Fund | 384,389 | 371,762 | 1,178,925 | 2,329,173 | 2,330,080 | |
| Cash Funds | 206,798 | 92,356 | 197,130 | 340,346 | 339,439 | |
| Reappropriated Funds | 0 | 21,289 | 71,089 | 71,089 | 71,089 | |
| Federal Funds | 581,572 | 470,916 | 875,930 | 1,413,689 | 1,413,689 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Administrative Law Judge Services | 807,180 | 890,066 | 544,650 | 876,047 | 876,047 | |
| General Fund | 330,731 | 249,650 | 201,032 | 334,180 | 334,452 | |
| Cash Funds | 70,687 | 77,698 | 59,203 | 87,048 | 86,776 | |
| Reappropriated Funds | 2,172 | 117,685 | 21,350 | 29,336 | 29,336 | |
| Federal Funds | 403,590 | 445,033 | 263,065 | 425,483 | 425,483 | |
| Payment to Risk Management and Property Funds | 173,686 | 383,340 | 567,472 | 159,111 | 474,303 | |
| General Fund | 68,525 | 126,297 | 204,895 | 55,481 | 167,385 | |
| Cash Funds | 16,390 | 45,201 | 60,341 | 19,797 | 52,589 | |
| Reappropriated Funds | 1,928 | 20,172 | 21,760 | 7,644 | 19,515 | |
| Federal Funds | 86,843 | 191,670 | 280,476 | 76,189 | 234,814 | |
| Leased Space | 1,363,822 | 2,339,116 | 3,925,908 | 3,799,397 | 3,756,164 | * |
| General Fund | 443,581 | 871,723 | 1,479,958 | 1,496,428 | 1,487,893 | |
| Cash Funds | 238,330 | 265,993 | 446,103 | 363,847 | 351,498 | |
| Reappropriated Funds | 0 | 31,842 | 38,849 | 38,849 | 38,849 | |
| Federal Funds | 681,911 | 1,169,558 | 1,960,998 | 1,900,273 | 1,877,924 | |
| Payments to OIT | 5,765,418 | 6,481,886 | 11,745,467 | 14,276,583 | 14,319,431 | |
| General Fund | 1,971,816 | 2,306,188 | 4,647,766 | 5,645,755 | 5,668,600 | |
| Cash Funds | 910,893 | 917,510 | 1,190,936 | 1,455,720 | 1,454,253 | |
| Reappropriated Funds | 0 | 16,751 | 41,739 | 41,739 | 41,739 | |
| Federal Funds | 2,882,709 | 3,241,437 | 5,865,026 | 7,133,369 | 7,154,839 | |
| IT Accessibility | 0 | 0 | 2,933,182 | 0 | 0 | |
| General Fund | 0 | 0 | 1,147,864 | 0 | 2,706 | |
| Cash Funds | 0 | 0 | 295,151 | 0 | (2,706) | |
| Reappropriated Funds | 0 | 0 | 5,431 | 0 | 0 | |
| Federal Funds | 0 | 0 | 1,484,736 | 0 | 0 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| CORE Operations | 112,780 | 168,766 | 134,190 | 54,478 | 54,478 | * |
| General Fund | 56,303 | 65,526 | 49,530 | 17,354 | 17,421 | |
| Cash Funds | 5,835 | 15,046 | 14,586 | 7,934 | 7,867 | |
| Reappropriated Funds | 0 | 6,740 | 5,261 | 3,379 | 3,379 | |
| Federal Funds | 50,642 | 81,454 | 64,813 | 25,811 | 25,811 | |
| General Professional Services and Special Projects | 15,288,124 | 24,920,490 | 56,494,533 | 39,153,397 | 38,891,897 | * |
| General Fund | 3,837,133 | 5,695,511 | 14,635,034 | 14,233,481 | 14,102,731 | |
| Cash Funds | 2,892,967 | 6,848,472 | 15,321,318 | 3,462,102 | 3,462,102 | |
| Reappropriated Funds | 69,000 | 60,500 | 81,000 | 81,000 | 81,000 | |
| Federal Funds | 8,489,024 | 12,316,007 | 26,457,181 | 21,376,814 | 21,246,064 | |
| DPA Administrative Services | 0 | 0 | 0 | 83,322 | 83,322 | * |
| General Fund | 0 | 0 | 0 | 33,329 | 33,329 | |
| Cash Funds | 0 | 0 | 0 | 5,831 | 5,831 | |
| Reappropriated Funds | 0 | 0 | 0 | 2,500 | 2,500 | |
| Federal Funds | 0 | 0 | 0 | 41,662 | 41,662 | |
| Division of Human Resources State Agency Services | 0 | 0 | 0 | 126,390 | 126,390 | * |
| General Fund | 0 | 0 | 0 | 50,556 | 50,556 | |
| Cash Funds | 0 | 0 | 0 | 8,845 | 8,845 | |
| Reappropriated Funds | 0 | 0 | 0 | 3,793 | 3,793 | |
| Federal Funds | 0 | 0 | 0 | 63,196 | 63,196 | |
| Division of Human Resources Training Services | 0 | 0 | 0 | 25,477 | 25,477 | * |
| General Fund | 0 | 0 | 0 | 10,191 | 10,191 | |
| Cash Funds | 0 | 0 | 0 | 1,783 | 1,783 | |
| Reappropriated Funds | 0 | 0 | 0 | 764 | 764 | |
| Federal Funds | 0 | 0 | 0 | 12,739 | 12,739 | |

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

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| Universal Contract for Behavioral Health Services | 0 | 1,019,520 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 1,019,520 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| Statewide training | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| Merit Pay | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| **SUBTOTAL - (A) General Administration** | 93,650,498 | 120,642,956 | 173,036,687 | 167,462,567 | 166,648,827 |
| *FTE* | 600.5 | 704.7 | 754.7 | 783.5 | 781.7 |
| General Fund | 30,942,224 | 39,601,481 | 58,553,938 | 63,739,352 | 63,451,184 |
| Cash Funds | 10,623,010 | 17,028,585 | 27,592,390 | 16,347,771 | 16,247,871 |
| Reappropriated Funds | 2,191,524 | 2,147,103 | 3,413,734 | 3,953,076 | 3,876,878 |
| Federal Funds | 49,893,740 | 61,865,787 | 83,476,625 | 83,422,368 | 83,072,894 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **(B) Transfers to Other Departments** | | | | | | |
| Public School Health Services Administration, Education | 182,668 | 186,850 | 202,194 | 202,194 | 202,194 | |
| General Fund | 91,334 | 93,425 | 101,097 | 101,097 | 101,097 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 91,334 | 93,425 | 101,097 | 101,097 | 101,097 | |
| Early Intervention, Early Childhood | 0 | 4,003,824 | 9,457,463 | 9,940,111 | 9,940,111 | * |
| General Fund | 0 | 1,769,044 | 4,634,158 | 4,970,056 | 4,970,056 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 2,234,780 | 4,823,305 | 4,970,055 | 4,970,055 | |
| Nurse Home Visitor Program, Early Childhood | 193,475 | 268,101 | 3,010,000 | 3,010,000 | 3,010,000 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 73,254 | 111,259 | 1,505,000 | 1,505,000 | 1,505,000 | |
| Federal Funds | 120,221 | 156,842 | 1,505,000 | 1,505,000 | 1,505,000 | |
| Host Home Regulation, Local Affairs | 89,070 | 95,760 | 136,096 | 317,431 | 317,431 | * |
| General Fund | 44,535 | 47,880 | 68,048 | 158,716 | 158,716 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 44,535 | 47,880 | 68,048 | 158,715 | 158,715 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs | 296,990 | 208,808 | 313,881 | 313,881 | 313,881 | |
| General Fund | 148,495 | 104,404 | 156,941 | 156,941 | 156,941 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 148,495 | 104,404 | 156,940 | 156,940 | 156,940 | |
| Facility Survey and Certification, Public Health and Environment | 7,065,278 | 7,073,798 | 8,477,125 | 8,881,826 | 8,881,826 | * |
| General Fund | 2,445,321 | 2,484,420 | 3,153,491 | 3,335,606 | 3,335,606 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 4,619,957 | 4,589,378 | 5,323,634 | 5,546,220 | 5,546,220 | |
| Prenatal Statistical Information, Public Health and Environment | 5,888 | 5,888 | 5,887 | 5,887 | 5,887 | |
| General Fund | 2,944 | 2,944 | 2,944 | 2,944 | 2,944 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 2,944 | 2,944 | 2,943 | 2,943 | 2,943 | |
| Nurse Aide Certification, Regulatory Agencies | 324,041 | 324,040 | 324,041 | 324,041 | 324,041 | |
| General Fund | 147,369 | 147,369 | 147,369 | 147,369 | 147,369 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 14,652 | 14,651 | 14,652 | 14,652 | 14,652 | |
| Federal Funds | 162,020 | 162,020 | 162,020 | 162,020 | 162,020 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| Reviews, Regulatory Agencies | 0 | 0 | 3,750 | 3,750 | 3,750 |
| General Fund | 0 | 0 | 1,875 | 1,875 | 1,875 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 1,875 | 1,875 | 1,875 |
| | | | | | |
| Hospital Tax Exemptions, Revenue | 0 | 0 | 100,000 | 100,000 | 100,000 |
| Cash Funds | 0 | 0 | 50,000 | 50,000 | 50,000 |
| Federal Funds | 0 | 0 | 50,000 | 50,000 | 50,000 |
| | | | | | |
| Local Public Health Agencies, Public Health and Environment | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Hospital Tax Exemptions, Revenue | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Regulation of Medicaid Transportation Providers, Regulatory Agencies | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **SUBTOTAL - (B) Transfers to Other Departments** | 8,157,410 | 12,167,069 | 22,030,437 | 23,099,121 | 23,099,121 | |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |
| General Fund | 2,879,998 | 4,649,486 | 8,265,923 | 8,874,604 | 8,874,604 | |
| Cash Funds | 0 | 0 | 50,000 | 50,000 | 50,000 | |
| Reappropriated Funds | 87,906 | 125,910 | 1,519,652 | 1,519,652 | 1,519,652 | |
| Federal Funds | 5,189,506 | 7,391,673 | 12,194,862 | 12,654,865 | 12,654,865 | |
| **(C) Information Technology Contracts and Projects** | | | | | | |
| Medicaid Management Information System Maintenance and Projects | 10,393,942 | 7,767,294 | 107,630,662 | 104,665,511 | 104,565,411 | * |
| General Fund | 0 | 16,340 | 16,757,266 | 17,855,194 | 17,805,144 | |
| Cash Funds | 1,135,444 | 1,495,618 | 10,680,890 | 9,361,274 | 9,361,274 | |
| Reappropriated Funds | 0 | 0 | 12,204 | 12,204 | 12,204 | |
| Federal Funds | 9,258,498 | 6,255,336 | 80,180,302 | 77,436,839 | 77,386,789 | |
| Colorado Benefits Management Systems, Operating and Contract Expenses | 41,290,899 | 52,741,144 | 71,701,801 | 74,808,195 | 74,808,195 | * |
| General Fund | 5,741,240 | 9,741,310 | 11,640,267 | 12,685,004 | 12,685,004 | |
| Cash Funds | 4,784,644 | 6,364,853 | 8,141,042 | 6,879,558 | 6,879,558 | |
| Reappropriated Funds | 147 | 1,556 | 12,126,323 | 13,194,450 | 13,194,450 | |
| Federal Funds | 30,764,868 | 36,633,425 | 39,794,169 | 42,049,183 | 42,049,183 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center | 1,893,968 | 1,635,740 | 2,142,862 | 2,172,998 | 2,172,998 |
| General Fund | 608,896 | 528,326 | 679,389 | 689,160 | 689,160 |
| Cash Funds | 328,882 | 283,227 | 377,956 | 383,151 | 383,151 |
| Reappropriated Funds | 6 | 19 | 73 | 73 | 73 |
| Federal Funds | 956,184 | 824,168 | 1,085,444 | 1,100,614 | 1,100,614 |
| Office of eHealth Innovations Operations | 4,385,240 | 5,096,812 | 6,465,845 | 6,465,845 | 6,465,845 |
| FTE | 0.0 | 0.0 | 3.0 | 3.0 | 3.0 |
| General Fund | 2,296,332 | 2,621,444 | 3,372,367 | 3,372,367 | 3,372,367 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 2,088,908 | 2,475,368 | 3,093,478 | 3,093,478 | 3,093,478 |
| All-Payer Claims Database | 4,733,994 | 7,406,357 | 5,562,903 | 5,435,778 | 5,435,778 |
| General Fund | 2,962,231 | 4,254,769 | 4,598,136 | 4,471,011 | 4,471,011 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 1,771,763 | 3,151,588 | 964,767 | 964,767 | 964,767 |
| Health Information Exchange Maintenance and Projects | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| State Innovation Model Operations | 0 | 0 | 0 | 0 | 0 |
| FTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| Connect for Health Colorado Systems | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| **SUBTOTAL - (C) Information Technology Contracts and Projects** | 62,698,043 | 74,647,347 | 193,504,073 | 193,548,327 | 193,448,227 |
| *FTE* | 0.0 | 0.0 | 3.0 | 3.0 | 3.0 |
| General Fund | 11,608,699 | 17,162,189 | 37,047,425 | 39,072,736 | 39,022,686 |
| Cash Funds | 6,248,970 | 8,143,698 | 19,199,888 | 16,623,983 | 16,623,983 |
| Reappropriated Funds | 153 | 1,575 | 12,138,600 | 13,206,727 | 13,206,727 |
| Federal Funds | 44,840,221 | 49,339,885 | 125,118,160 | 124,644,881 | 124,594,831 |

## (D) Eligibility Determinations and Client Services

| | | | | | |
|---|---|---|---|---|---|
| Contracts for Special Eligibility Determinations | 0 | 2,839,066 | 12,039,555 | 12,039,555 | 12,039,555 |
| General Fund | 0 | 718,427 | 1,134,071 | 1,129,071 | 1,134,071 |
| Cash Funds | 0 | 459,509 | 4,338,468 | 4,343,468 | 4,338,468 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 1,661,130 | 6,567,016 | 6,567,016 | 6,567,016 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| County Administration | 79,214,462 | 102,184,661 | 121,943,046 | 121,897,752 | 123,606,170 | * |
| General Fund | 14,337,301 | 19,193,620 | 20,478,568 | 20,815,372 | 21,096,562 | |
| Cash Funds | 14,734,326 | 25,643,473 | 26,174,302 | 26,366,727 | 26,752,366 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 50,142,835 | 57,347,568 | 75,290,176 | 74,715,653 | 75,757,242 | |
| Medical Assistance Sites | 825,542 | 805,753 | 1,531,968 | 1,531,968 | 1,531,968 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 402,419 | 402,984 | 402,984 | 402,984 | 402,984 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 423,123 | 402,769 | 1,128,984 | 1,128,984 | 1,128,984 | |
| Administrative Case Management | 1,752,340 | 2,603,944 | 869,744 | 869,744 | 869,744 | |
| General Fund | 876,170 | 1,301,972 | 434,872 | 434,872 | 434,872 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 876,170 | 1,301,972 | 434,872 | 434,872 | 434,872 | |
| Customer Outreach | 2,623,526 | 2,596,573 | 3,461,519 | 3,461,519 | 3,461,519 | |
| General Fund | 992,812 | 979,335 | 1,394,139 | 1,394,139 | 1,394,139 | |
| Cash Funds | 318,951 | 318,951 | 336,621 | 336,621 | 336,621 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 1,311,763 | 1,298,287 | 1,730,759 | 1,730,759 | 1,730,759 | |
| Centralized Eligibility Vendor Contract Project | 6,731,692 | 6,777,665 | 8,096,880 | 7,959,455 | 7,959,455 | * |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 2,347,766 | 2,279,719 | 2,801,253 | 2,753,409 | 2,753,409 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 4,383,926 | 4,497,946 | 5,295,627 | 5,206,046 | 5,206,046 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Connect for Health Colorado Eligibility Determination | 10,220,546 | 8,680,778 | 10,642,710 | 11,174,846 | 11,174,846 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 5,343,099 | 4,504,089 | 4,757,291 | 4,995,156 | 4,995,156 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 4,877,447 | 4,176,689 | 5,885,419 | 6,179,690 | 6,179,690 | |
| Eligibility Overflow Processing Center | 740,475 | 1,542,528 | 1,904,677 | 1,904,677 | 1,904,677 | |
| General Fund | 110,923 | 208,691 | 285,320 | 285,320 | 285,320 | |
| Cash Funds | 74,196 | 176,941 | 190,849 | 190,849 | 190,849 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 555,356 | 1,156,896 | 1,428,508 | 1,428,508 | 1,428,508 | |
| Returned Mail Processing | 1,337,726 | 1,936,317 | 3,298,808 | 3,298,808 | 3,298,808 | |
| General Fund | 418,000 | 598,008 | 985,808 | 985,808 | 985,808 | |
| Cash Funds | 100,758 | 138,267 | 244,919 | 244,919 | 244,919 | |
| Reappropriated Funds | 31,303 | 44,751 | 111,942 | 111,942 | 111,942 | |
| Federal Funds | 787,665 | 1,155,291 | 1,956,139 | 1,956,139 | 1,956,139 | |
| Work Number Verification | 1,500,105 | 1,896,699 | 3,305,114 | 11,341,713 | 11,341,713 | * |
| General Fund | 502,685 | 635,584 | 1,089,815 | 1,741,440 | 1,741,440 | |
| Cash Funds | 247,367 | 312,766 | 545,013 | 1,093,988 | 1,093,988 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 750,053 | 948,349 | 1,670,286 | 8,506,285 | 8,506,285 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Medical Identification Cards | 1,650,386 | 0 | 0 | 0 | 0 | |
| General Fund | 481,831 | 0 | 0 | 0 | 0 | |
| Cash Funds | 343,362 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 825,193 | 0 | 0 | 0 | 0 | |
| **SUBTOTAL - (D) Eligibility Determinations and Client Services** | 106,596,800 | 131,863,984 | 167,094,021 | 175,480,037 | 177,188,455 | |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |
| General Fund | 17,719,722 | 23,635,637 | 25,802,593 | 26,786,022 | 27,072,212 | |
| Cash Funds | 23,912,244 | 34,236,699 | 39,791,700 | 40,728,121 | 41,108,760 | |
| Reappropriated Funds | 31,303 | 44,751 | 111,942 | 111,942 | 111,942 | |
| Federal Funds | 64,933,531 | 73,946,897 | 101,387,786 | 107,853,952 | 108,895,541 | |
| **(E) Utilization and Quality Review Contracts** | | | | | | |
| Professional Service Contracts | 19,970,962 | 15,350,105 | 27,236,877 | 29,244,825 | 29,244,825 | * |
| General Fund | 6,803,020 | 6,750,711 | 7,301,755 | 7,786,405 | 7,786,405 | |
| Cash Funds | 995,697 | 1,292,227 | 2,112,987 | 2,147,661 | 2,147,661 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 12,172,245 | 7,307,167 | 17,822,135 | 19,310,759 | 19,310,759 | |
| **SUBTOTAL - (E) Utilization and Quality Review Contracts** | 19,970,962 | 15,350,105 | 27,236,877 | 29,244,825 | 29,244,825 | |
| *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 | 7,786,405 | |
| Cash Funds | 995,697 | 1,292,227 | 2,112,987 | 2,147,661 | 2,147,661 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 12,172,245 | 7,307,167 | 17,822,135 | 19,310,759 | 19,310,759 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **(F) Provider Audits and Services** | | | | | |
| Professional Audit Contracts | 3,507,957 | 3,151,518 | 4,281,019 | 4,135,919 | 4,135,919 |
| General Fund | 1,524,776 | 1,418,458 | 1,645,679 | 1,598,629 | 1,598,629 |
| Cash Funds | 346,850 | 157,301 | 565,801 | 540,301 | 540,301 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 1,636,331 | 1,575,759 | 2,069,539 | 1,996,989 | 1,996,989 |
| **SUBTOTAL - (F) Provider Audits and Services** | 3,507,957 | 3,151,518 | 4,281,019 | 4,135,919 | 4,135,919 |
| *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 | 1,598,629 |
| Cash Funds | 346,850 | 157,301 | 565,801 | 540,301 | 540,301 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 1,636,331 | 1,575,759 | 2,069,539 | 1,996,989 | 1,996,989 |
| **(G) Recoveries and Recoupment Contract Costs** | | | | | |
| Estate Recovery | 749,055 | 961,962 | 1,165,841 | 1,165,841 | 1,165,841 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 374,527 | 480,981 | 582,920 | 582,920 | 582,920 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 374,528 | 480,981 | 582,921 | 582,921 | 582,921 |
| Third-Party Liability Cost Avoidance Contract | 4,622,500 | 2,279,120 | 8,417,842 | 8,838,738 | 8,838,738 |
| General Fund | 1,465,509 | 763,341 | 2,777,888 | 2,916,784 | 2,916,784 |
| Cash Funds | 845,741 | 376,219 | 1,431,033 | 1,502,585 | 1,502,585 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 2,311,250 | 1,139,560 | 4,208,921 | 4,419,369 | 4,419,369 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **SUBTOTAL - (G) Recoveries and Recoupment** | | | | | |
| **Contract Costs** | 5,371,555 | 3,241,082 | 9,583,683 | 10,004,579 | 10,004,579 |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| General Fund | 1,465,509 | 763,341 | 2,777,888 | 2,916,784 | 2,916,784 |
| Cash Funds | 1,220,268 | 857,200 | 2,013,953 | 2,085,505 | 2,085,505 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 2,685,778 | 1,620,541 | 4,791,842 | 5,002,290 | 5,002,290 |
| **(H) Indirect Cost Assessment** | | | | | |
| Indirect Cost Assessment | 1,143,073 | 1,054,856 | 921,207 | 1,059,222 | 1,057,810 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 132,859 | 112,605 | 196,956 | 276,190 | 274,778 |
| Reappropriated Funds | 106,490 | 90,368 | 107,638 | 132,407 | 132,407 |
| Federal Funds | 903,724 | 851,883 | 616,613 | 650,625 | 650,625 |
| **SUBTOTAL - (H) Indirect Cost Assessment** | 1,143,073 | 1,054,856 | 921,207 | 1,059,222 | 1,057,810 |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 132,859 | 112,605 | 196,956 | 276,190 | 274,778 |
| Reappropriated Funds | 106,490 | 90,368 | 107,638 | 132,407 | 132,407 |
| Federal Funds | 903,724 | 851,883 | 616,613 | 650,625 | 650,625 |
| **TOTAL - (1) Executive Director's Office** | 301,096,298 | 362,118,917 | 597,688,004 | 604,034,597 | 604,827,763 |
| *FTE* | 600.5 | 704.7 | 757.7 | 786.5 | 784.7 |
| General Fund | 72,943,948 | 93,981,303 | 141,395,201 | 150,774,532 | 150,722,504 |
| Cash Funds | 43,479,898 | 61,828,315 | 91,523,675 | 78,799,532 | 79,078,859 |
| Reappropriated Funds | 2,417,376 | 2,409,707 | 17,291,566 | 18,923,804 | 18,847,606 |
| Federal Funds | 182,255,076 | 203,899,592 | 347,477,562 | 355,536,729 | 356,178,794 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **(2) MEDICAL SERVICES PREMIUMS** | | | | | | |
| Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid. | | | | | | |
| Medical and Long-Term Care Services for Medicaid Eligible Individuals | 9,756,293,144 | 10,921,010,282 | 11,093,263,887 | 12,329,137,106 | 11,923,025,159 | * |
| General Fund | 2,179,055,708 | 2,630,296,339 | 1,982,601,803 | 2,368,614,777 | 2,399,234,776 | |
| General Fund Exempt | 0 | 0 | 1,181,193,165 | 1,181,193,165 | 1,181,193,165 | |
| Cash Funds | 1,087,673,430 | 1,294,227,032 | 1,245,245,481 | 1,371,044,499 | 1,327,092,668 | |
| Reappropriated Funds | 82,610,308 | 90,000,798 | 99,768,814 | 114,867,290 | 99,768,814 | |
| Federal Funds | 6,406,953,698 | 6,906,486,113 | 6,584,454,624 | 7,293,417,375 | 6,915,735,736 | |
| **TOTAL - (2) Medical Services Premiums** | 9,756,293,144 | 10,921,010,282 | 11,093,263,887 | 12,329,137,106 | 11,923,025,159 | |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |
| General Fund | 2,179,055,708 | 2,630,296,339 | 1,982,601,803 | 2,368,614,777 | 2,399,234,776 | |
| General Fund Exempt | 0 | 0 | 1,181,193,165 | 1,181,193,165 | 1,181,193,165 | |
| Cash Funds | 1,087,673,430 | 1,294,227,032 | 1,245,245,481 | 1,371,044,499 | 1,327,092,668 | |
| Reappropriated Funds | 82,610,308 | 90,000,798 | 99,768,814 | 114,867,290 | 99,768,814 | |
| Federal Funds | 6,406,953,698 | 6,906,486,113 | 6,584,454,624 | 7,293,417,375 | 6,915,735,736 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS** | | | | | |
| Healthcare Affordability and Sustainability Cash Fund. | | | | | |
| **TOTAL - (3) Behavioral Health Community Programs** | 864,633,587 | 1,081,999,209 | 1,056,467,598 | 1,199,781,438 | 998,141,826 |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| General Fund | 2,280,953 | 217,512,762 | 258,885,000 | 292,850,305 | 277,109,083 |
| Cash Funds | 64,030,730 | 92,829,501 | 83,386,013 | 91,910,564 | 79,440,640 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 798,321,904 | 771,656,946 | 714,196,585 | 815,020,569 | 641,592,103 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **(4) OFFICE OF COMMUNITY LIVING** | | | | | |
| **(A) Division for Individuals with Intellectual and Developmental Disabilities** | | | | | |
| **TOTAL - (4) Office of Community Living** | 812,400,247 | 911,017,416 | 1,050,387,184 | 1,192,156,815 | 1,175,029,567 |
| *FTE* | 29.1 | 33.7 | 39.5 | 39.5 | 39.5 |
| General Fund | 282,016,139 | 389,487,029 | 511,265,372 | 595,568,902 | 595,150,933 |
| Cash Funds | 39,164,037 | 25,448,232 | 20,466,680 | 12,119,172 | 8,729,157 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 491,220,071 | 496,082,155 | 518,655,132 | 584,468,741 | 571,149,477 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **(4) INDIGENT CARE PROGRAM** | | | | | | |
| Safety Net Provider Payments | 254,743,330 | 259,498,036 | 226,610,307 | 226,610,308 | 226,610,308 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 110,819,422 | 122,721,974 | 111,039,051 | 113,305,154 | 113,305,154 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 143,923,908 | 136,776,062 | 115,571,256 | 113,305,154 | 113,305,154 | |
| Pediatric Specialty Hospital | 10,764,010 | 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 | 5,382,005 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 6,049,374 | 6,017,082 | 5,489,645 | 5,382,005 | 5,382,005 | |
| Appropriation from Tobacco Tax Fund to the General Fund | 364,131 | 339,124 | 305,324 | 305,324 | 305,324 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 364,131 | 339,124 | 305,324 | 305,324 | 305,324 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| Primary Care Fund | 51,647,973 | 47,449,654 | 59,118,641 | 45,830,960 | 44,717,154 | * |
| General Fund | 0 | 0 | 7,000,000 | 556,902 | 0 | |
| Cash Funds | 22,755,511 | 21,438,852 | 22,494,290 | 22,494,290 | 22,494,290 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 28,892,462 | 26,010,802 | 29,624,351 | 22,779,768 | 22,222,864 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| Children's Basic Health Plan Administration | 2,336,020 | 1,403,394 | 3,864,405 | 3,864,405 | 3,864,405 * |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 716,224 | 432,716 | 1,325,491 | 1,352,542 | 1,352,542 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 1,619,796 | 970,678 | 2,538,914 | 2,511,863 | 2,511,863 |
| Children's Basic Health Plan Medical and Dental Costs | 133,119,234 | 118,283,242 | 197,353,282 | 227,274,951 | 269,980,786 * |
| General Fund | 11,045,841 | 381,798 | 27,338,400 | 40,374,162 | 43,580,261 |
| General Fund Exempt | 0 | 0 | 305,324 | 305,324 | 305,324 |
| Cash Funds | 30,065,351 | 36,255,947 | 40,876,572 | 38,931,747 | 50,672,690 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 92,008,042 | 81,645,497 | 128,832,986 | 147,663,718 | 175,422,511 |
| Clinic Based Indigent Care | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| **TOTAL - (4) Indigent Care Program** | 452,974,698 | 437,737,460 | 498,015,969 | 514,649,958 | 556,241,987 |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| General Fund | 15,760,477 | 5,128,726 | 39,612,765 | 46,313,069 | 48,962,266 |
| General Fund Exempt | 0 | 0 | 305,324 | 305,324 | 305,324 |
| Cash Funds | 164,720,639 | 181,188,613 | 176,040,728 | 176,389,057 | 188,130,000 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 272,493,582 | 251,420,121 | 282,057,152 | 291,642,508 | 318,844,397 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| **(5) OTHER MEDICAL SERVICES** | | | | | | |
| Old Age Pension State Medical | 26,085 | 41,155 | 10,000,000 | 10,000,000 | 10,000,000 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 26,085 | 41,155 | 10,000,000 | 10,000,000 | 10,000,000 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| Senior Dental Program | 3,989,494 | 3,972,404 | 3,990,358 | 3,990,358 | 3,990,358 | |
| General Fund | 3,962,510 | 3,962,510 | 3,962,510 | 3,962,510 | 3,962,510 | |
| Cash Funds | 26,984 | 9,894 | 27,848 | 27,848 | 27,848 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| Commission on Family Medicine Residency Training Programs | 9,400,725 | 9,513,898 | 9,490,170 | 9,490,170 | 9,490,170 | |
| General Fund | 3,920,417 | 3,997,108 | 4,429,684 | 4,520,085 | 4,520,085 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 197,100 | 198,450 | 220,500 | 225,000 | 225,000 | |
| Federal Funds | 5,283,208 | 5,318,340 | 4,839,986 | 4,745,085 | 4,745,085 | |
| Medicare Modernization Act State Contribution Payment | 213,480,167 | 216,337,023 | 245,388,980 | 254,045,148 | 244,659,612 | * |
| General Fund | 213,480,167 | 216,337,023 | 245,388,980 | 254,045,148 | 244,659,612 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Public School Health Services Contract Administration | 845,196 | 915,650 | 2,000,000 | 2,000,000 | 2,000,000 | |
| General Fund | 422,598 | 457,825 | 1,000,000 | 1,000,000 | 1,000,000 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 422,598 | 457,825 | 1,000,000 | 1,000,000 | 1,000,000 | |
| Public School Health Services | 131,544,830 | 152,899,688 | 192,429,050 | 202,111,227 | 202,111,227 | * |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 58,592,464 | 68,247,434 | 91,181,029 | 100,427,269 | 100,427,269 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 72,952,366 | 84,652,254 | 101,248,021 | 101,683,958 | 101,683,958 | |
| Rural Provider Access and Affordability Fund, Created in Section 25.5-1-207 (6)(a), C.R.S. | 0 | 0 | 1,000,000 | 0 | 0 | |
| General Fund | 0 | 0 | 1,000,000 | 0 | 0 | |
| Screening, Brief Intervention, and Referral to Treatment Training Grant Program | 750,000 | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 750,000 | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation | |
|---|---|---|---|---|---|---|
| Reproductive Health Care for Individuals Not Eligible for Medicaid | 0 | 242,952 | 3,614,490 | 3,614,490 | 3,614,490 | |
| General Fund | 0 | 242,952 | 3,614,490 | 3,614,490 | 3,614,490 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| ARPA HCBS State-only Funds | 0 | 8,758,574 | 32,424,528 8.3 | 842,626 6.2 | 842,626 10.5 | * |
| General Fund | 0 | 0 | 0 | 0 | 0 | |
| Cash Funds | 0 | 8,758,574 | 32,424,528 | 842,626 | 842,626 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| Denver Health and Hospital Authority | 0 | 5,000,000 | 1,000,000 | 5,000,000 | 0 | * |
| General Fund | 0 | 5,000,000 | 1,000,000 | 5,000,000 | 0 | |
| Cash Funds | 0 | 0 | 0 | 0 | 0 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 | |
| Federal Funds | 0 | 0 | 0 | 0 | 0 | |
| Doula Scholarship Program | 0 | 0 | 100,000 | 0 | 0 | |
| General Fund | 0 | 0 | 100,000 | 0 | 0 | |
| Health Benefits for Colorado Children and Pregnant Persons | 0 | 0 | 0 | 2,102,665 | 2,102,665 | |
| General Fund | 0 | 0 | 0 | 2,102,665 | 2,102,665 | |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| Urban Indian Health Organizations State Only Payments | 70,825 | 48,025 | 0 | 0 | 0 |
| General Fund | 70,825 | 48,025 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| Primary Care and Behavioral Health Statewide Integration Grant Program | 0 | 127,944 | 0 0.0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 127,944 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| State University Teaching Hospitals Denver Health and Hospital Authority | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |
| State University Teaching Hospitals University of Colorado Hospital | 0 | 0 | 0 | 0 | 0 |
| General Fund | 0 | 0 | 0 | 0 | 0 |
| Cash Funds | 0 | 0 | 0 | 0 | 0 |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0 |
| Federal Funds | 0 | 0 | 0 | 0 | 0 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **TOTAL - (5) Other Medical Services** | 360,107,322 | 399,357,313 | 502,937,576 | 494,696,684 | 480,311,148 |
| *FTE* | 0.0 | 0.0 | 8.3 | 6.2 | 10.5 |
| General Fund | 221,856,517 | 230,045,443 | 260,495,664 | 274,244,898 | 259,859,362 |
| Cash Funds | 59,395,533 | 78,685,001 | 135,133,405 | 112,797,743 | 112,797,743 |
| Reappropriated Funds | 197,100 | 198,450 | 220,500 | 225,000 | 225,000 |
| Federal Funds | 78,658,172 | 90,428,419 | 107,088,007 | 107,429,043 | 107,429,043 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS** | | | | | |
| **(A) Executive Director's Office - Medicaid Funding** | | | | | |
| **TOTAL - (7) Department of Human Services Medicaid-Funded Programs** | 106,428,624 | 156,318,850 | 122,355,874 | 125,921,319 | 126,123,416 |
| *FTE* | 0.0 | 704.7 | 0.0 | 0.0 | 0.0 |
| General Fund | 44,517,842 | 63,303,334 | 58,156,610 | 60,791,119 | 60,892,167 |
| Cash Funds | 1,888,903 | 7,779,925 | 1,936,723 | 1,888,903 | 1,888,903 |
| Reappropriated Funds | 0 | 1,388,133 | 0 | 0 | 0 |
| Federal Funds | 60,021,879 | 83,847,458 | 62,262,541 | 63,241,297 | 63,342,346 |

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | FY 2024-25 Recommendation |
|---|---|---|---|---|---|
| **TOTAL - Department of Health Care Policy and Financing** | 12,653,933,920 | 14,269,559,447 | 14,921,116,092 | 16,460,377,917 | 15,863,700,866 |
| *FTE* | 629.6 | 1,443.1 | 805.5 | 832.2 | 834.7 |
| General Fund | 2,818,431,584 | 3,629,754,936 | 3,252,412,415 | 3,789,157,602 | 3,791,931,091 |
| General Fund Exempt | 0 | 0 | 1,181,498,489 | 1,181,498,489 | 1,181,498,489 |
| Cash Funds | 1,460,353,170 | 1,741,986,619 | 1,753,732,705 | 1,844,949,470 | 1,797,157,970 |
| Reappropriated Funds | 85,224,784 | 93,997,088 | 117,280,880 | 134,016,094 | 118,841,420 |
| Federal Funds | 8,289,924,382 | 8,803,820,804 | 8,616,191,603 | 9,510,756,262 | 8,974,271,896 |

# MEMORANDUM

JOINT BUDGET COMMITTEE

| | |
|---|---|
| TO | Members of the Joint Budget Committee |
| FROM | Eric Kurtz, JBC Staff (303-866-4952) |
| DATE | March 4, 2024 |
| SUBJECT | Health Care Policy and Financing Staff Comebacks |

1 **ELIGIBILITY APPEALS:** The Department requests an additional $119,995 total funds, including $37,199 General Fund, and 1.5 FTE to help process eligibility appeals related to the public health emergency unwind. After the Department submitted the January 2 supplementals and budget amendments, the Department realized that it had made a technical omission from the request for *BA6 Public health emergency unwind*. From previous budget actions by the General Assembly, the Department has approval for 2 positions to help process eligibility appeals related to the public health emergency unwind through September 2024. The funding for these two positions was built into the JBC staff recommendation for the Personal Services line item as part of the continuing budget. The Department had intended to request money to continue these positions through the end of FY 2024-25. The Office of State Planning and Budgeting supports extending the positions, but they were not built into the Governor's budget balancing.

Since June 2023, the Department has been receiving upwards of 200 appeals per month, compared to 50-100 per month prior to the public health emergency unwind. The Department adopted a federal waiver option that allows additional time to process appeals, but the Department must manually process continued benefits for a member until the appeal is resolved. During the unwind the federal government has increased its scrutiny of state appeal procedures and threatened to withhold federal funding for untimely appeals processing. The Department is now projecting an elevated volume of appeals work through the end of the fiscal year, rather than just through the first quarter.

**Staff recommends approval of the additional funding**. It is unknown when the appeals volume will return to a more normal trend. Based on the current rate of appeals and the existing backlog, the Department's assumption that there will be continued work for the extra appeals staff through the end of the fiscal year seems reasonable. The Department's failure to include additional funding for the two positions in the budget amendment request was a technical error.

Some of the counter arguments would be that this is a small dollar amount for a short duration of time that the Department could potentially absorb within existing appropriations; it was not included in the Governor's budget balancing; and it is uncertain what will happen with appeals as we get past the eligibility redeterminations for the unwind of the public health emergency.

2 **REORGANIZATION OF LONG BILL:** Staff recommends a reorganization of the Long Bill to consolidate transfers to other departments in one division. Federal law requires that all Medicaid

funding go through a single department, but there are several departments other than the Department of Health Care Policy and Financing that operate programs eligible for Medicaid funding. To satisfy the federal law, the state funds to match federal Medicaid dollars are appropriated in the Department of Health Care Policy and Financing and then the state funds plus the federal match are transferred to the departments that operate the programs. Currently, there is a subdivision in the Executive Director's Office that includes roughly $23.1 million total funds, including $8.9 million General Fund, for transfers to the departments of Education, Early Childhood, Local Affairs, Public Health and Environment, Regulatory Affairs, and Revenue. Then there is a separate division that includes roughly $126.1 million total funds, including $60.9 million General Fund, for transfers to the Department of Human Services.

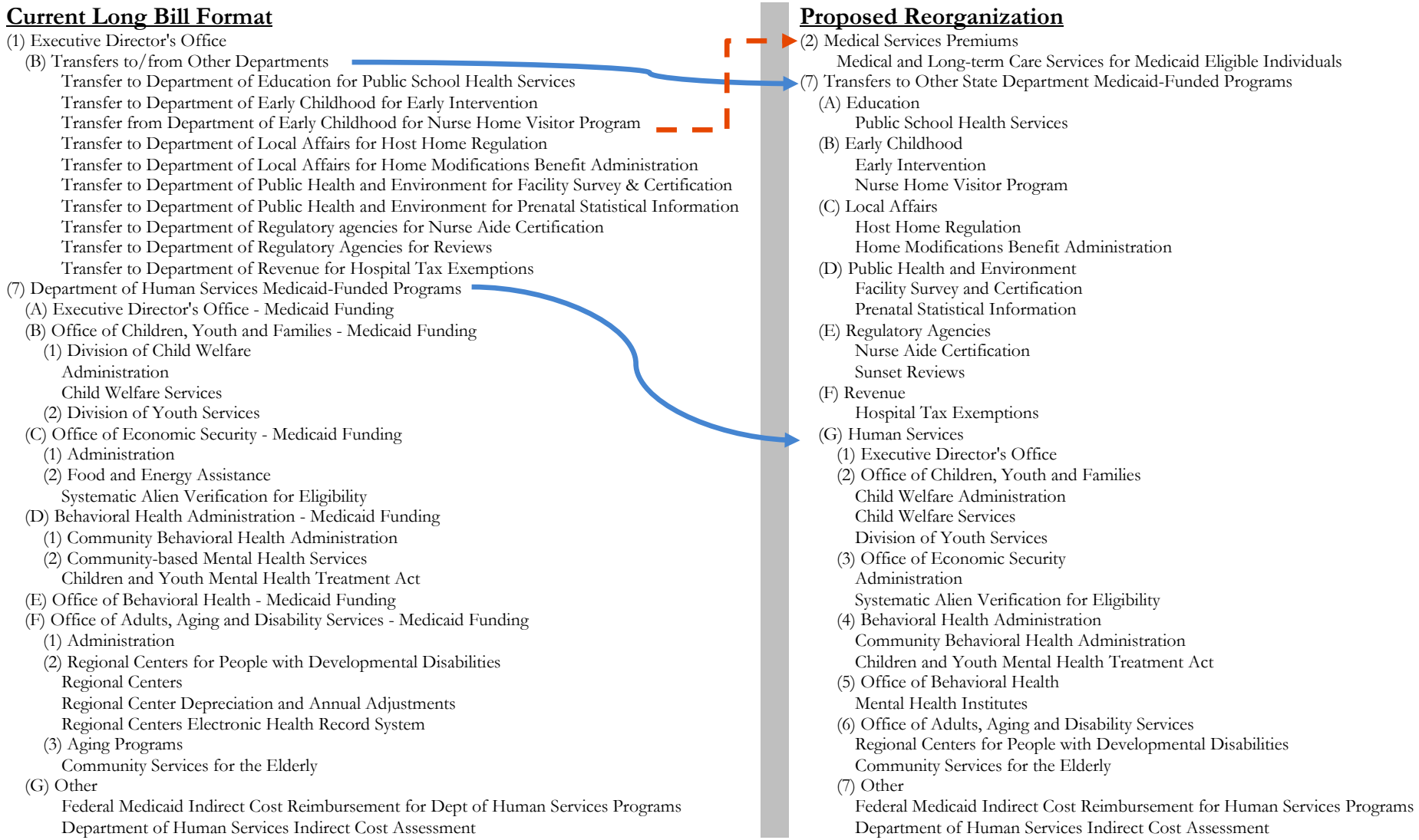
**Staff recommends consolidating the two divisions containing transfers to other departments into one division**. This is strictly a change in the way the appropriations are organized and presented in the Long Bill and has no bearing on the amount of funding, programmatic operations, or level of flexibility for the executive branch in how it uses the appropriations.

**In addition, staff recommends eliminating the Nurse Home Visitor line item and moving the funding to the Medical Services Premiums line item**. The Nurse Home Visitor line item is not really a transfer to another department, because the Department of Health Care Policy and Financing (HCPF) pays the providers directly. Funding for the program is appropriated to the Department of Early Childhood and then a portion is transferred to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. To make things even more convoluted, although the Department of Early Childhood is the lead agency for financing, the program is actually administered by the University of Colorado Health Sciences Center. Since HCPF is paying the providers directly, rather than through the Department of Early Childhood, the staff recommendation is to put the appropriation in Medical Services Premiums line item with other payments to providers. The reappropriated funds transferred from the Department of Early Childhood is just a unique source of funds for the state match, like transfers from the Department of Higher Education that are already included in the Medical Services Premiums line item.

The current appropriation for the Nurse Home Visitor program is way more than the Department typically needs. For example, in FY 2023-24 the Department was appropriated $3.0 million total funds, including $1.5 million reappropriated funds transferred from the Department of Early Childhood out of the Tobacco Master Settlement Agreement money, and only spent $268,101 total funds, including $111,259 reappropriated funds. The reason for the massive over appropriation is that we don't know how many claims for Medicaid clients will be submitted each year and the Department does not have overexpenditure authority for the Nurse Home Visitor

Program line item. Any unspent reappropriated funds are retained at the Department of Early Childhood and used to serve people who are not eligible for Medicaid. If the appropriation were in the Medical Services Premiums line item, then: (1) the Department would adjust the amount annually as part of the forecast of Medicaid expenditures, resulting in a more accurate appropriation; and (2) the Department would have overexpenditure authority if the projected amount ends up being slightly less than what the Department needs for this low volume population.

The table on the next page compares the current Long Bill format with the proposed reorganization.


Current Long Bill Format
(1) Executive Director's Office
(B) Transfers to/from Other Departments
Transfer to Department of Education for Public School Health Services
Transfer to Department of Early Childhood for Early Intervention
Transfer from Department of Early Childhood for Nurse Home Visitor Program
Transfer to Department of Local Affairs for Host Home Regulation
Transfer to Department of Local Affairs for Home Modifications Benefit Administration
Transfer to Department of Public Health and Environment for Facility Survey & Certification
Transfer to Department of Public Health and Environment for Prenatal Statistical Information
Transfer to Department of Regulatory agencies for Nurse Aide Certification
Transfer to Department of Regulatory Agencies for Reviews
Transfer to Department of Revenue for Hospital Tax Exemptions
(7) Department of Human Services Medicaid-Funded Programs
(A) Executive Director's Office - Medicaid Funding
(B) Office of Children, Youth and Families - Medicaid Funding
(1) Division of Child Welfare
Administration
Child Welfare Services
(2) Division of Youth Services
(C) Office of Economic Security - Medicaid Funding
(1) Administration
(2) Food and Energy Assistance
Systematic Alien Verification for Eligibility
(D) Behavioral Health Administration - Medicaid Funding
(1) Community Behavioral Health Administration
(2) Community-based Mental Health Services
Children and Youth Mental Health Treatment Act
(E) Office of Behavioral Health - Medicaid Funding
(F) Office of Adults, Aging and Disability Services - Medicaid Funding
(1) Administration
(2) Regional Centers for People with Developmental Disabilities
Regional Centers
Regional Center Depreciation and Annual Adjustments
Regional Centers Electronic Health Record System
(3) Aging Programs
Community Services for the Elderly
(G) Other
Federal Medicaid Indirect Cost Reimbursement for Dept of Human Services Programs
Department of Human Services Indirect Cost Assessment
Proposed Reorganization
(2) Medical Services Premiums
Medical and Long-term Care Services for Medicaid Eligible Individuals
(7) Transfers to Other State Department Medicaid-Funded Programs
(A) Education
Public School Health Services
(B) Early Childhood
Early Intervention
Nurse Home Visitor Program
(C) Local Affairs
Host Home Regulation
Home Modifications Benefit Administration
(D) Public Health and Environment
Facility Survey and Certification
Prenatal Statistical Information
(E) Regulatory Agencies
Nurse Aide Certification
Sunset Reviews
(F) Revenue
Hospital Tax Exemptions
(G) Human Services
(1) Executive Director's Office
(2) Office of Children, Youth and Families
Child Welfare Administration
Child Welfare Services
Division of Youth Services
(3) Office of Economic Security
Administration
Systematic Alien Verification for Eligibility
(4) Behavioral Health Administration
Community Behavioral Health Administration
Children and Youth Mental Health Treatment Act
(5) Office of Behavioral Health
Mental Health Institutes
(6) Office of Adults, Aging and Disability Services
Regional Centers for People with Developmental Disabilities
Community Services for the Elderly
(7) Other
Federal Medicaid Indirect Cost Reimbursement for Human Services Programs
Department of Human Services Indirect Cost Assessment