DEPARTMENT OF Public Health and Environment

FY 2023-24 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, December 20, 2023

1:30 pm – 3:30 pm

1:30-1:35 Introductions and Opening Comments

Presenter: Jill Hunsaker Ryan, Executive Director

1:35-1:45 Common Questions

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operating Officer

Supporting Presenters:

- Trisha Oeth, Director of Environmental Health and Protection
- Ned Calonge, Chief Medical Officer
- Karl Paulson, Budget Director

Topics:

- Question 1: Page 1, Question: One time State and Federal Stimulus Funds in the packet
- Question 2: Pages 1-2, Question: Fiscal Impacts of the Partnership Agreement in the packet
- Question 3: Page 2, Question: Ten percent General Fund Reduction in the packet

1:45-2:00 Administration and One-Time Funding

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer

Supporting Presenters:

- Trisha Oeth, Director of Environmental Health and Protection
- Ned Calonge, Chief Medical Officer
- Karl Paulson, Budget Director

Topics:

- Administration: Page 2-4, Questions 4-7 in the packet
- One-time Funding: Page 4-8, Questions 8-9 in the packet

2:00-2:30 Public Health Infrastructure

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer
- Scott Bookman, Division Director of Disease Control and Public Health Response Division

Supporting Presenters:

- Diana Herrero, Deputy Division Director of Disease Control and Public Health Response Division

Topics:

- Legislative Updates: Page 8-13, Questions 10-11 in the packet
- R1 Request: Page 13-16, Questions 12-13 in the packet
- Local Public Health Agencies: Page 16-21, Questions 14-17 in the packet

2:30-2:45 Environmental Division Funding

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer

Supporting Presenters:

- Trisha Oeth, Director of Environmental Health and Protection
- Jim Reasor, Deputy Director of the Air Pollution Control Division

Topics:

- Stationary Sources Control Fund: Page 21-33, Questions 18-26 in the packet
- Funding Sources and Uses: Page 33-36, Questions 27-30 in the packet

2:45-3:00 HEALTH FACILITY LICENSURE CASH FUND SOLVENCY

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer
- Elaine McManis, Health Facilities and Emergency Medical Services Division Director

Topics:

- R3 Cash Fund Proposal and Request: Page 36-39, Questions 31-33 in the packet
- Long-term Sustainability Plans for Cash Fund: Page 39-48, Questions 34-38 in the packet

3:00-3:15 ENVIRONMENTAL PROGRAMS

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer
- Trisha Oeth, Director of Environmental Health and Protection

Topics:

- Environmental Justice: Page 48-53, Questions 39-42 in the packet
- Lead Testing: Page 53-55, Questions 43-45 in the packet

3:15-3:30 OTHER PUBLIC HEALTH DECISION ITEMS

Main Presenters:

- Jill Hunsaker Ryan, Executive Director
- Erick Scheminske, Chief Operations Officer
- Scott Bookman, Division Director of Disease Control and Public Health Response Division

Supporting Presenters:

- Ned Calonge, Chief Medical Officer

Topics:

- R4 State Syphilis Response and R5 State Lab Operating: Page 55-56, Questions 46-48 in the packet
- R6 Tuberculosis Program Infrastructure: Page 56-58, Questions 49-53 in the packet

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FY 2024-25 JOINT BUDGET COMMITTEE HEARING

Wednesday, December 20, 2023
1:30 pm – 3:30 pm

COMMON QUESTIONS FOR DISCUSSION AT DEPARTMENT HEARINGS

1. *Please describe one-time state and federal stimulus funds that have been allocated to the Department but are not expended as of September, 30, 2023, by bill, budget action, executive action, or other source that allocated funds. The description should include but is not limited to funds that originate from one-time or term-limited General Fund or federal funds originating from the American Rescue Plan Act (ARPA)/State and Local Fiscal Recovery Funds/Revenue Loss Restoration Cash Fund. Please describe the Department's plan to obligate or expend all allocated funds that originate from ARPA by December 2024.*

   Please further describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information:

   a. Original fund source (General Fund, ARPA, other), amount, and FTE;
   b. Original program time frame;
   c. Original authorization (budget decision, legislation, other);
   d. Requested ongoing fund source, amount, and FTE; and
   e. Requested time frame (one-time extension or ongoing).

   Response:
   See Question 1 Table of CDPHE Stimulus Appropriations, Encumbrances, and Expenditures by Bill (millions) at the end of this response document.

2. *Please provide a description, calculation, and the assumptions for the fiscal impact of implementing compensation provisions of the Partnership Agreement, as well as a qualitative description of any changes to paid annual, medical, holiday or family leave as a result of the Agreement. Please describe any compensation and leave changes for employees exempt from the Agreement if applicable.*

   Response: The Colorado Partnership for Quality Jobs and Service Act recognized Colorado WINS (COWINS) as the certified employee organization for covered State employees. The initial Partnership Agreement as result of the COWINS bargaining went into effect July 1, 2022. The Department received salary survey allocations in FY 2022-23 and FY 2023-24 that were driven by Partnership Agreement clauses of across-the-board salary increases, salary range adjustments, and minimum wage increases. For the FY 2024-25 budget, the Department anticipates step pay will be the largest fiscal impact as a result of the renegotiated Partnership Agreement.

   Wage Components

Costs	FY 2022-23	FY 2023-24	FY 2024-25
Salary Survey(SS), Ranges, Min Wage	$6,603,978	$10,983,241	$8,460,594
Estimated Step Pay	N/A	N/A	$2,299,066 *part of SS total

Steward Time	$3,741	TBD	TBD
Paid Family Medical Leave*	$463,083	TBD	TBD

*This figure is for the portion of PFML over 80 hours.

Leave Components

The Partnership Agreement also adjusted accrual rates for time off and max accruals for employees depending on years of service. As a majority of employees at CDPHE have less than 36 months of service, it is unknown at this time how leave payouts and growing accrual balances will translate into realized costs for the Department.

Years of Service	Annual Leave Accrual Rate	# of Employees
1-36 Months	8	1,037
37-60 Months	9	202
61-120 Months	11	311
121-180 Months	13	174
181 Months or greater	16	331
	Grand Total	**2,055**

3. *Provide a prioritized list of budget reductions the Department would propose if 10.0 percent General Fund appropriation reductions were required of every Department.*

Response: We appreciate the question and the desire to partner with the Department on identifying reductions. On November 1st the Governor submitted a balanced budget that provided decision items for increases and reductions that we spent over a half a year to identify and prioritize across the entire Executive Branch. The proposed budget is balanced, maintains a reserve of 15%, and does not require a 10.0 percent reduction in the General Fund to balance. If the economic conditions change the Governor will take actions to propose reduced expenditures and submit a plan to address the shortfall to the General Assembly. If the Joint Budget Committee wants feedback on specific reduction proposals, we welcome the opportunity to work with JBC staff on estimating the impacts and tradeoffs of those proposals.

ADMINISTRATION AND ONE-TIME FUNDING

ADMINISTRATION

4. *[Sen. Kirkmeyer] Last year the Department had an issue with the federal government on their indirect cost plan. Please provide an update on the status of that situation.*

Response: The Department intends to submit a FY 2023-24 supplemental request to fund repayment of over collections of indirect cost recoveries from those collections with the Department's Indirect Excess Collections Fund. The U.S. Department of Health and Human Services made a determination on CDPHE's indirect cost rates for FY 2023-24 after review and provided an email on November 21, 2023 with the following directives: "As a result of the adjustments, the On-Site, Off-Site, and Sub-Award rates will be 4.2%, 1.7%, and 0.7% respectively, given that CDPHE refunds the Federal Government $5,584,476 for the FY 2021-22 Sub-Award rate over-recovery….Also, please provide an estimated date for the refund payment

or if CDPHE is able to make the Federal refund payment within 30 days so that I can proceed to issue the determination letter for the refund as well as the new rate agreement." Therefore, without payment to the federal government, FY 2023-24 indirect cost recovery rates will be incorrect and require readjustment, reassessment, and increase the operational uncertainty for the Department and the overall Administration Division's budget. The actual payment date, actual indirect cost recoveries and the outcomes of the CDPHE budget for FY 2024-25 will drive the overall indirect cost recovery status for FY 2025-26. It is uncertain whether or not additional over-recovery payments to the federal government will be necessary, and the overarching capacity of the Department's Indirect Excess Collections Fund to support all potential Administrative Division expenses remains uncertain. It is possible that CDPHE may require a future General Fund appropriation to maintain operations, but we are taking steps to minimize expenditures from indirect cost recovery appropriations during the current fiscal year in an effort to minimize that possibility.

5. *[Rep. Taggart] Please discuss why the DPA Central Services Omnibus never shows up as savings– including the increase of $2.2 million total funds in this Department.*

Response: The Department has worked with the Department of Personnel & Administration (DPA) to provide funding estimates by funding source for the DPA Central Services Omnibus request, which were included in the November 1, 2023 budget request submission. We expect that to have actual real costs every year for the central services provided in the request under the status quo and under the request. In general, when dollars are financed with anything other than General Fund there will be savings for the state. However, given the challenges with CDPHE's indirect cost recovery mechanism discussed in the question above, we do not believe it would be prudent to further rely on the Department's excess indirect cost recovery fund, and have therefore requested that a portion of the increase associated with DPA's omnibus request be funded with General Fund. We believe that any savings that may materialize from the omnibus request will be dependent on how the federal government responds to the proposed change, as DPA's proposal will cause a fundamental shift in how the federal government pays for DPA's central services, but will defer any further discussion of savings to DPA and the Office of State Planning and Budgeting.

6. *[Sen. Kirkmeyer] The auditor just published a report stating that CDPHE will have spending authority restricted on the Vital Records Fund and Medical Marijuana Cash Fund this year because the funds have been in excess of the maximum reserve requirements for three years. Please speak to the funds in question and the situation.*

Response: An excess fee waiver request was submitted for both of the funds at the time the auditor was developing the report. CDPHE requests the ability to retain funds and avoid a restriction for the following reasons:

Vital Records Fund (Cash Fund 1240) - The Department entered last fiscal year with a large receivable based on uncollected revenue from prior fiscal years. Over the past year, we initiated an effort to collect those receivables, which proved quite successful. Collection of revenue received from these previous fiscal years was significant, inflating the revenue in the cash fund. The unanticipated success of the program's collection efforts happened while other funding changes were realized, including: 1. Collection of billed revenue has increased due to new efficiencies in billing and collection efforts; 2. A significant federal grant was received to pay for urgent technology debt costs that had previously been included in program expense projections; 3. A Decision Item had been submitted and was successful, awarding funds in FY 2023-2024 to assist with program operating expenses.

An excess fund balance of approximately $1.1 million was identified in the Schedule 9 information for this fund. In order to reduce the fund balance, we are considering a future budget action to return the operating funding. In addition, the excess balance will be used to defray fee increases that were planned for July 1, 2024. Fees will not change for customers of the Vital Records Office, and fees charged to local offices will be reduced in January 2024. The balance is anticipated to be reduced steadily over the next two fiscal years to be compliant, and will prevent fee increases for services during that time.

Medical Marijuana Cash Fund (Cash Fund 14V0) - The program has seen an emerging and continuing trend of reduced medical marijuana license requests. As an explicitly fee-funded program, this slow reduction has raised concern in an environment of steadily increasing expense. In FY 2022-2023 the program received Board of Health approval to modestly increase fees to generate enough revenue to implement registry system upgrades identified in HB21-1317. However, revenue was inadequate to implement any system changes and those funds caused the fund to be identified on the excess uncommitted reserve list. The timing has proven to be fortuitous; the program is nearing the end of its contract with its current registry contractor and must raise funds to replace the existing system. Given the length of the process to raise fees (which has begun with stakeholder and Board of Health communication planned) the Medical Marijuana Cash Fund requests an ability to maintain its cash balance so they are available for the required system procurement.

7. *[Sen. Zenzinger] Please provide a very short summary of the results and recommendations coming out of the EMT Task Force.*

Response: The Emergency Medical Services System Sustainability Task Force released their report in September 2023. The following is a summary of some of their recommendations:

- Ensure adequate funding for a new work unit within the Emergency Medical and Trauma Services Branch. The task force recommends up to $1.3 million and 9.0 FTE.
- Identify gaps in data accessibility and enhance ability to make evidence-based decisions.
- Designate EMS as an Essential Service and assign a local or regional government entity the responsibility of ensuring EMS is provided.
- Establish equitable coverage of ambulance agency geographic service areas.
- Conduct a comprehensive statewide EMS systems analysis

Committee members and staff are welcome to read the task force's full report here.

ONE-TIME FUNDING

8. *[Sen. Kirkmeyer] Please provide the encumbered amounts for each appropriation in the tables on pages 16 and 17 of the public health December 11th briefing document.*

Response:

Department of Public Health & Environment - One-time General Fund					
Bill	Appropriation/	Expenditures	Encumbrances	End Date	Description/Antici

	Transfer				pated use of Funds
S.B. 20B-001 COVID-19 Relief	$6,780,000	$6,780,000	$0	Jun 2022	Appropriates GF for one-year hiatus on health inspection fees to retail food establishments and reimburses facilities for lost fee revenue.
S.B. 21-137 Behav Health Recovery Act	$750,000	$750,000	$0	Jun 2023	Appropriates GF for the STI, HIV and AIDS program as well as the Mental Health First Aid program.
S.B. 21-243 Public Health Infrastructure	$11,090,149	$11,090,149	$0	Jun 2023	Appropriates GF for DCPHR in FY 22-23.
	$10,000,000	$10,000,000	$0	Jun 2023	Appropriates GF for distribution to local public health agencies in FY 22-23.
H.B. 22-1358 Clean Water & Schools	$21,000,000	$1,580,040	$454,351	Jun 2026	Appropriates GF for CDPHE to distribute reimbursement to facilities for the costs of testing and remediation of lead in schools in the first year.
H.B. 22-1326 Fentanyl	$5,792,413	$429,521	$558,518	Dec 2024/Jun 2024/Jun 2025	Appropriates GF for opiate detection tests, education campaigns, regional trainings, website development, and independent studies.[1]
S.B. 22-193 Air Quality Improvement Investments	$7,000,000	$241,062	$2,234,269	Jun 2025	Appropriates $7.0 million GF to finance the aerial surveying of pollutants.

[1] Fentanyl test strip distribution was a new program for the department. The department spent time building the administrative infrastructure. To date, 51 agencies are directly enrolled in the program across the state. The department is on track for spending these dollars by June 30, 2024. The department has been steeped in the planning and coordination stages required for a public awareness campaign of this scope. CDPHE conducted an RFP over the summer and into the fall. Due to a procedural issue, the RFP was canceled. The department is evaluating the next steps and is still on track to implement the campaign in 2024. The website for the campaign was built and published in English and Spanish and held five regional trainings for community partners. The department contracted with an organization to build a study plan before releasing the RFP for the full project. The process is complete, and the study will be delivered on time.

	$65,000,000	$284,290	$1,080,377[2]	Jun 2028	Transfers $65.0 GF million for the electrifying school buses grant program.
H.B. 23-1194 Closed Landfill Remediation	$15,000,000	$0	$0	Aug 2033	Transfers $15.0 million for local landfill remediation grants.

9. *Please indicate which ARPA fund allocations the Department has received that are likely to not be fully expended, and the likely underspent amounts.*

Department of Public Health & Environment - One-time Federal ARPA Funds					
Bill	Appropriation/ Transfer	Expenditures	Encumbrances	End Date	Description/Anticipated use of Funds
S.B. 21-243 Public Health Infrastructure	$11,090,149	$10,958,360	$0	Jun 2022	Appropriates funding from ERRCF for DCPHR in FY 2021-22.
	$10,000,000	$9,235,322	$0	Jun 2022	Appropriates funding from ERRCF for local public health agencies in FY 2021-22.
S.B. 21-137 Behav Health Recovery Act	$5,900,000	$5,895,894	$0	Jun 2023	Appropriates $1.7 million from the Behavioral & Mental Health fund for loan repayments for participants in the Colorado Mental Health Services Corps and scholarships for addiction counselors; $1.0 million for the opiate antagonist bulk purchase fund; $2.0 million for the HIV and AIDS Prevention Grant Program; and $1.2 million for school-based health centers.
S.B. 22-182 Economic Mobility Program	$4,000,000	$1,815,878	$806,095	Jun 2024	Transfers $4.0 million from ERRCF to new Economic Mobility Program Fund in CDPHE, and appropriates annually to the Department for maternal and child health programs[3]
S.B. 23-214 Long Bill	$24,393,558	$10,434,667	$9,840,472	Jun 2024	Appropriates $21.1 million from RLRCF to refinance GF appropriated in SB 21-243 and

[2] Some of the grantees in the current award process are also in the queue for EPA grants; this number may increase by up to $26M in January 2024 from this award round alone. The Department is implementing a strategic process to braid the two funding sources to ensure as many school buses transition to electric as possible.

[3] Funds are spent seasonally to align with tax season work. The department anticipates spending to increase in calendar 2024.

					$1.2 million for the vital statistics fund fee subsidy
H.B. 22-1326 Fentanyl	$26,000,000	$8,071,620	$13,830,742	Jun 2024/Dec 2026	Appropriates funding from the Behavioral & Mental Health fund to the following cash funds administered by CDPHE: $19.7 million to the Opiate Antagonist Bulk Purchase Fund and $6.0 million to the Harm Reduction Grant Program Cash Fund. Also appropriates $300,000 to CDPHE for prevention services administration[4]
S.B. 22-147 Behav Hlth Srvcs Children	$1,500,000	$177,885	$1,001,763	Dec 2024	Appropriates $1.5 million from the Behavioral & Mental Health fund to CDPHE for school-based health centers
S.B. 22-181 Workforce Investments	$20,000,000	$6,520,579	$19,750	Dec 2024	Appropriates $20.0 million from the Behavioral & Mental Health fund to CDPHE for behavioral health care provider and candidate loan repayment and scholarships for addiction counselors.[5]
S.B. 22-226 Support Health-care Workforce	$35,000,000	$878,745	$16,159,483	Dec 2026	Appropriates $35.0 million from ERRCF to CDPHE for emergency preparedness, immunization operating, and prevention services primary care.[6]

Response: State agencies and the Governor's Office have undergone a collaborative and strategic process to identify potential reversions of ARPA allocations. The November 1, 2023 Budget Letter[7] from the Governor identifies these opportunities for reinvestment. The following allocations have been identified by CDPHE as likely to not be expended and have been included as part of the Governor's reinvestment plan:

[4] There are seven new Harm Reduction Grant Program grantees funded through these dollars. As is the case with many of our grant programs, some organizations in under-resourced areas may need more funds at the outset of their programs to cover start-up costs, while others may need less in the beginning planning stages but more funds as programming evolves.
The Opiate Antagonist Bulk Purchase Fund (Naloxone Bulk Fund) received some unexpected one-time federal funds that had to be spent first. Additionally, the cost of Narcan, the most requested naloxone product CDPHE offers, dropped significantly since these funds were appropriated. However, the Bulk Fund saw a 91% increase in the amount of entities enrolled last fiscal year, and demand is increasing every month. The department is on track to spend the funds within the timeline.

[5] Applications for this program are open twice annually. The department is negotiating contracts from the most recent application period and has two more rounds before the deadline. The department is on track to allocate all the funds.

[6] The majority of these funds were directed to two new programs. It took some time to build the administrative infrastructure. The RFAs were released and the department is in the process of finalizing contracts with the second cohort of grantees for the Practice Based Education Grant Program.

[7] See Budget Letter "Attachment 4: Stimulus Funds Overview"

SB 22-226 Healthcare Workforce Recruitment and Re-engagement Fund: The fund offered $20,000 to eligible facilities who hired a qualifying healthcare provider who would work for the facility for 20 hours or more per week. The Executive Branch has identified $3.88 million that is not obligated to facilities that can be used for reinvestments.

SB 23-214 Long Bill: The General Assembly appropriated $1.1 million ARPA Revenue Loss Cash Fund to the Vital Statistics Records Cash Fund as part of CDPHE FY2023-24 R-06. Through successful debt collection efforts, receipt of federal grant funding to address urgent technology debt issues, increased service volumes over the past year, the Vital Records program has received an unexpected increase in cash fund revenue and will be submitting a supplemental on January 2nd to return the appropriation.

PUBLIC HEALTH INFRASTRUCTURE

LEGISLATIVE UPDATES

10. *[Sen. Bridges] Based on S.B. 23-162 (Increase Access to Pharmacy Services), has the Department seen an increase in enrollment and if not, what are the barriers to enrollment? Was that bill a success?*

Response: Prior to beginning enrollment efforts, CDPHE performed several rounds of partner outreach and engagement throughout the summer months to gather feedback about the Vaccines for Children (VFC) Pharmacy Pilot Program, including how best to evaluate its success. CDPHE and HCPF worked together to identify 32 pharmacy locations across Colorado to target for VFC enrollment (20 are independently owned and 12 are retail locations). CDPHE and HCPF selected these target pharmacies based on one or more of the following criteria:

- they operate within a county with kindergarten measles-mumps-rubella (MMR) vaccination rates lower than 73%;
- they operate within a county with medium-high to high social vulnerability;
- they are widely accessible by residents in the county; and
- they are currently providing services to underserved populations.

In late September, CDPHE formally invited the 32 targeted pharmacy locations to enroll in the VFC program. In October, CDPHE held a webinar for the pilot invitees to discuss the details of the pilot program, requirements of the VFC program, and how CDPHE could support their efforts in becoming VFC providers. CDPHE is currently performing direct outreach to those pharmacies to provide technical assistance and guidance through the enrollment process. To date, CDPHE has received interest from only one independent pharmacy. CDPHE is currently performing direct outreach to invited pharmacies. While no pharmacies have completed the VFC enrollment process, it is still CDPHE's goal to enroll 5-10 pharmacies in the VFC program and evaluate how their participation impacts vaccination coverage, access to care and receipt of other essential health care services. Bringing VFC to pharmacies will address longstanding equity concerns, as privately insured children are already able to receive their vaccines at pharmacies while publicly insured children cannot. VFC-enrolled pharmacies have the potential to address socioeconomic and racial/ethnic disparities in vaccination coverage that stem from inequitable access.

11. *[Sen. Bridges] Please provide a detailed explanation and update on the status of programs under S.B. 21-243.*

Response: CDPHE has a mission to advance Colorado's health and protect the places where we live, learn, work, and play. A large part of this mission is establishing the foundational elements to prepare for and

respond to disease and disasters that impact the health of Coloradans. In the last two years since the formation of DCPHR, the division has utilized these elements to control and limit the spread of COVID-19, Mpox, influenza, and RSV and respond to disasters, such as the Marshall Fire, impacting Colorado communities. SB21-243 funding provided 121.3 FTE that were distributed between the state lab, immunization, epidemiology, policy and stakeholder engagement, health equity branch, administration and the office of emergency preparedness and response. The state unequivocally benefited from the work of these FTE. The following describe outreach and programs that are a direct result of the increased funding and the FTE funded by it.

- Development of the EpiTrax system which will replace nine siloed systems into one platform allowing data from these disparate systems to be accessible in a single location where it could be viewed and used to paint the full picture of disease transmission. This will allow the State to scale up its public health response when disease transmission is surging, and to scale down when transmission is low to contain costs. EpiTrax is a robust platform that allows for case management, contact tracing, and outbreak and facility management; ultimately allowing CDPHE to provide better disease control services to the public and ensure the State is prepared to respond in an emergency.
- Development of CDPHE's Data Lakehouse which will automate data analytics from systems including the Colorado Immunization Information System (CIIS), Epitrax, Vital Statistics, STI/HIV, and Newcomer Health. To provide a higher quality of data to LPHAs, epidemiologists and the CDC.
- Prior to the COVID 19 pandemic, the Electronic Lab Reporting (ELR) team had onboarded and maintained approximately 70 laboratory data feeds to receive reportable condition test data electronically. By late 2022, the number of laboratories onboarded and maintained had increased to 7,893.
- Electronic case reporting (eCR) has also dramatically improved with the help of 243 funds. eCR allows CDPHE to receive a wide range of information from a person's medical chart from an entire healthcare organization, as opposed to ELR which is only test data from a single laboratory. In 2020, CDPHE had one healthcare organization onboarded and was only receiving case information on COVID-19 status. Now, CDPHE has eight healthcare organizations onboarded and is receiving case information on 54 reportable conditions.
- Funds from SB21-243 allowed the disease reporting team to double which was necessary due to the changes that have taken place in reportable conditions in Colorado. Since 2019, 11 reportable conditions have been added, two reportable conditions have been removed and 18 reportable conditions have been modified in some way. With these changes there is generally an increased complexity within our systems and processing of data that needs to be modified, as well as, increased staff to manage the additional burden of these changes. From June 2022 to June 2023 when the team was fully staffed and trained, core data approval within 4 business days improved from 83.4% to 100%. This improvement is significant and allows epi investigation staff to more efficiently reach out to cases and conduct disease control and prevention. Core data includes patient demographic and test/result data completion.
- These funds enabled the hiring of a dedicated Product Manager for the Immunization Branch. This new position has effectively assumed responsibilities related to contract management, scope of work development, and project management for several major IT platforms maintained by the Immunization Branch, including CIIS and PrimaryHealth.

- SB21-243 allowed the division to hire Communication FTE to launch a vaccine campaign that resulted in Colorado: having the 14th-lowest rate of COVID-19 deaths in the nation, ranking 12th in the country in people ages 5 and older with an omicron booster and Colorado administering more than 12.7 million doses of the COVID-19 vaccines. Additionally, staff funded by SB21-243 lead Phase I of the COVID-19 Marketing Campaign which had 41.6 million TV impressions and 798,000 digital video completions. Phase II had more than 700 million impressions, 200 print inserts, and 900 out-of-home ad placements (billboards, bus shelters, etc.), as well as nearly 20,000 radio spots. Phase III garnered 83.5 million impressions using broadcast TV, digital placements, radio, out-of-home ad placements, print, and social media. The 2022 flu vaccine campaign, which ran Dec. 16, 2022 - Jan. 31, 2023 yielded more than 28 million impressions. The 2023 campaign to encourage parents and guardians to keep their children up to date on routine vaccinations is currently underway. As of July 20, 2023, it has garnered more than 7.6 million impressions. These same FTE are currently supporting CDPHE's respiratory season media campaign which includes TV, radio, print, and social media advertising and has garnered more than 12.8 million impressions. The focus of the media campaign on flu, RSV, and COVID-19 vaccines has resulted in 1,649,874 flu vaccines administered, 13.3% of Coloradans vaccinated against COVID-19, and 205,500 RSV vaccines administered.
- Perform 4,033,628 tests or 19.2% of all COVID-19 tests at the State Lab.
- Provide more than 1.25 million COVID-19 vaccinations.
- Provide direct outreach to parents and guardians of 457,000 children 5-11 years of age about COVID-19 vaccines.
- Healthcare Associated Infections (HAI) team, funded by SB21-2443, provides preventive technical Healthcare Associated Infections/ Microbial Resistance HAI assistance to 20% of healthcare facilities identified for outreach based on risk for HAI/AR by July 2023.
- The funding allowed CDPHE to hire a medical entomologist to track insect disease vectors across the state (including tracking the distribution of insect vectors in the setting of climate change), and monitor for the introduction of potential new vector-borne diseases in Colorado. The entomologist has conducted six formal training sessions and numerous one-on-one consultations to local partners on vector borne disease and how to collect and characterize mosquitoes to assess the risk of West Nile virus.
- The funding supports infection prevention activities, including those associated with the 2022 Mpox outbreak where staff assessed the risk of transmission to healthcare workers caring for cases and resulted in publication in a national journal.
- The funding supports an epidemiologist who led a recent Cyclospora (a parasite that causes gastrointestinal symptoms) outbreak that occurred in a restaurant in Ouray County, resulting in over 300 Colorado cases and contributing valuable epidemiological information to federal partners as part of a multistate investigation.
- The funding supports an epidemiologist who manages the viral respiratory disease program and led the fall 2022 response to the largest RSV epidemic reported in Colorado to date. This epidemiologist also responded to outbreaks of highly pathogenic avian influenza affecting poultry in commercial farms across the state, ensuring that people exposed to the virus did not become ill.
- The CA&E Unit Supervisors work in parallel with each other and are each responsible for leading the work for 4-5 of the 9 regional outreach coordinators, while ensuring cohesive

coordination across all 9 regions. This unit is focused around establishing a regional support network for local communities, primarily addressing the impacts of communicable disease on community health. The regional support network helps community-based groups access services, support and funding and other resources that aim to advance health equity and address social determinants of health as they relate to health disparities among populations at higher risk and that are underserved. Activities include, but are not limited to educational opportunities, cultural/community health navigation, wrap-around resource support, and community engagement and communications. The Community Engagement Team is responsible for being a resource to direct health equity programming within each region and across the state to assure community needs are met in populations experiencing a disproportionate burden of infection, severe illness, and death.

- The Health Educator has expanded the capacity of the Immunization Branch to deliver immunization-related training to healthcare providers and to develop communications for the general public that are culturally responsive.
- The Racial Equity Specialist increased the capacity of the Immunization Branch to perform authentic community engagement, especially with communities of color, through the expansion of its Champions for Vaccine Equity program.

All of this led to decreased rates of disease transmission and effective community support. The efficacious approach was a direct result of SB21-243 funding. DCPHR used the SB21-243 funding to implement public health best practice. While the majority of the service delivery and client outcomes focused on COVID-19, the last three years demonstrate the State's capacity to act quickly and prevent disruptive spread of disease. COVID-19's threat to the public is not as great as it was in 2020 but other diseases linger in its wake and DCPHR intends to utilize staff to implement effective methods of disease control to prevent further catastrophe caused by the spread of disease and disaster. These funds are critical for being prepared to ramp-up to effectively meet any future public health emergency and manage any outbreak.

LPHAs

With the funding allocated through SB21-243 agencies have begun to address long-standing challenges with staff recruitment and retention which began years before the COVID-19 pandemic thinned the workforce and record-high inflation made it increasingly difficult for agencies to offer competitive salaries. Every LPHA has similar needs as the entire system lacks funding that can be strategically used at the organizational level. The following agencies offer an insight into the current use of the funding. This information comes from OPHP's 2023 Annual Survey of all LPHAs as well as Colorado Association of Local Public Health Official interviews with selected LPHAs.

At the start of the pandemic, Elbert County Public Health was staffed by 3 people: a Director, Environmental Health Specialist, and Finance Specialist. They had not been in a position to provide clinical services to the community since 2016. Using the funds provided by SB21-243 the agency was able to hire a full-time Health Educator and two part-time Nurse Practitioners and is recruiting for a new Finance and Grant Specialist position. The agency also used the funds to improve its technological infrastructure by obtaining an Electronic Health Records (EHR) system. This new EHR system not only enables better tracking of patient care and outcomes but places the agency on the path to begin billing

public and private insurance for provided services, which in turn will help reduce their reliance on external grants.

Jefferson County Public Health, facing a budget shortfall and ongoing impacts from TABOR limitations, would have experienced a reduction of staff in critical areas during the pandemic including nurses if the funds provided through SB21-243 weren't available to those positions. The agency also built a five-person health equity and community engagement program. This work wasn't new within the agency but with the ability to use flexible funds, the work was able to be integrated and standardized across the agency. Importantly, since the creation of this program, the agency has experienced increased trust and understanding from the community on issues ranging from vaccinations to feedback on the agency's new community health assessment. The agency is looking forward to expanding the program to address community concerns with environmental justice issues in future years.

A strategic priority for the Broomfield Department of Public Health and Environment was to become a data-driven organization. The agency was able to begin localized data collection, analysis, and visualization during the pandemic through specific programmatic funding for a COVID-19 data analyst. Through this position, the agency produced hyperlocal data points that were not captured by the state and in turn was able to provide more accurate service delivery to targeted population groups within their community. This hyperlocal data also helped the agency provide justification for its actions with community stakeholders and local government partners. Using the SB21-243 funds the agency was able to expand the position and is now in the process of developing short and medium-term key performance indicators in areas like behavioral health which is leading to programmatic enhancements for community members needing these services. The agency also used the funding to develop a community care coordination platform, which is a closed-loop referral system connecting community members to other programs provided by the city & county or nonprofit entities of which the community member might not have awareness.

Dolores County Public Health is in a low-income rural area with many seniors and limited access to health care and behavioral health. With the SB21-243 funding, they started a program for Prescription Pickup that includes oxygen tanks refills. The need for this program became evident after an incident where a senior ran out of medication and was unable to drive, he took his wife's prescription because it was the same kind but ended up overdosing because they were different strengths. Other similar incidents involved difficult access to psychiatric prescriptions. This program not only can save people's lives but helps with the county's overall goals of chronic disease management, injury prevention, and behavioral & mental health. Since Dolores County is an area with lack of behavioral health access, even the little things like getting a prescription can make a world of difference. Dolores County Public Health would not be able to pay for the two employees that run the Prescription Pickup program.

Gilpin County Public Health hired their own Environmental Health Specialist and moved their On-site Wastewater Treatment System (OWTS) Program from their Community Development Department back to the Public Health Agency. Local public health agencies in Colorado play a crucial role in regulating and overseeing OWTS. Gilpin County is ensuring that these systems are installed, operated, and maintained in a manner that protects public health and the environment.

Silver Thread Public Health (Hinsdale and Mineral Counties) had zero staff turnover during this last fiscal year in part by raising the base salary of their employees to a more competitive level. Without the funding they would have to evaluate ways to keep the new baseline salaries in place –including patch working various funding streams to make up a fulltime positions. This would create siloed workloads that are difficult to maintain.

In the short amount of time that LPHAs have had access to flexible funds through SB21-243 the positive impact on the state's public health system has been notable, but to adequately address decades of chronic underfunding and limitations placed on agencies through inflexible funding sources it is critical that this funding be a consistent, ongoing funding source. The aforementioned success stories and growth agencies would not have been possible with any other existing funding source and as such if the allocation is not continued the negative impact on LPHAs and Coloradans would be equally notable. With the state operating in a post-pandemic environment now is the perfect opportunity to make sustainable investments in public health that will not only help mitigate the next public health emergency but will ensure that every Coloradan has access to core public health services within their local community.

R1 PUBLIC HEALTH INFRASTRUCTURE REQUEST

12. *[Rep. Bird] How much of the $7.5 million is allocated to each of the critical priorities outlined in the table on the bottom of page 25 in the public health briefing document?*

Response:

Staffing Changes Related to Public Health Infrastructure Requested in R1				
Program	**Total FTEs Currently Funded by SB21-243**	**FTEs Not Requested in R1**	**FTEs Requested in R1**	**Dollars Associated with Requested FTEs**
Administration & Fiscal Services	38.0	8.0	30.0	$2,605,415
Emergency Preparedness & Response	13.0	3.0	10.0	$776,227
Epidemiology & Reporting	16.5	6.0	10.5	$989,965
Laboratory Services	16.0	9.0	7.0	$746,902
Policy, Equity, and Immunization	24.0	9.0	15.0	$1,455,338
Strategy & Operations	13.5	3.0	10.5	$940,463
Total	**121.0**	**38.0**	**83.0**	**$7,514,300**

13. *[Rep. Taggart/Rep. Bird] Please provide the reasoning for the 50/50 breakdown between the State and the LPHAs requested in R1. Why should the State have 50.0 percent of that money when the locals are doing so much of this work? How*

would a 50/50 split meet the needs of the local partners? Is $7.5 million enough for the LPHAs? Would $12.0 million be more appropriate?

Response: Protecting Coloradans from public health threats is a coordinated and collaborative effort between state and local agencies that makes us work as a system.

CDPHE provides expertise at a level that would be unreasonable for LPHAs to maintain in-house. For instance, CDPHE has epidemiologists on staff who have the expertise to monitor and research respiratory illnesses such as RSV and tuberculosis, healthcare-associated infections, multidrug-resistant organisms, and zoonotic diseases such as West Nile and Highly Pathogenic Avian Influenza. Additionally, CDPHE employs five field epidemiologists who provide services for LPHAs during large outbreaks, (such as the Cyclospora food-borne illness outbreak that affected over 300 people in Ouray County this past summer) or outbreaks that span multiple counties. These epidemiologists serve LPHAs' mission and help increase the types of services that can be provided within their communities without having to hire more or specialized epidemiologists than they need on a regular basis. These field epidemiologists also frequently lead outbreak response or case investigations for small or rural LPHAs that do not have their own resources.
The success of the public health system depends on strong infrastructure at the local and state levels. CDPHE develops and maintains case and outbreak investigation protocols for over 100 reportable conditions in Colorado and trains LPHAs on those protocols. Due to the complexity or infrequency of certain reportable conditions, CDPHE takes either full responsibility or the lead role in investigating and implementing disease control strategies for approximately half of the reportable conditions.

Most LPHAs do not have labs, let alone high complexity laboratories capable of providing access to testing for novel infectious disease agents, newborn screening, outbreak detection, bioterrorism and chemical terrorism agents, next generation sequence analysis (a.k.a genetic fingerprinting); plus, wastewater food, milk environmental and drinking water testing not available elsewhere in the state. The CDPHE State Public Health Laboratory provides statewide lab support to LPHAs so they can access lab services without undue cost of supplies, maintaining highly specialized equipment or expertise and courier services. Additionally, specialized staff at the State Lab ensure LPHAs are provided appropriate sample collection and handling guidance, which is indispensable when dealing with highly contagious pathogens like Mpox, rabies, and tuberculosis. +

CDPHE operates the state's electronic disease surveillance system that is used by all LPHAs and serves as the data backbone for epidemiological work in Colorado. Currently, this is a system called the Colorado Electronic Disease Reporting System (CEDRS) and it is the repository for over 100 reportable diseases in the state. CEDRS is in the process of being replaced by a new, modernized and more robust system called EpiTrax in 2024. CDPHE staff will conduct extensive LPHA training in early 2024 to launch the system. CDPHE maintains the state's infrastructure to receive and input disease case reports from more than 320 health care providers, health systems, and laboratories including electronic reporting infrastructure and staff for manual data entry. The system maintains critical data for case investigation, outbreak response, other disease control strategies, and federal requirements for reporting to CDC. The integrity of the system is upheld by CDPHE staff who provide technical and onboarding support for LPHAs. CDPHE also operates the state's Health Alert Network (HAN) system, delivering urgent disease control information and guidance to Colorado's clinical community.

The number of communicable disease cases and outbreaks that CDPHE tracks and investigates has increased substantially in the last decade, even when accounting for the pandemic. In 2013, there were fewer than 10,000 cases compared to more than 20,000 non-COVID cases in 2022. Prior to the COVID-19 pandemic, an average of 348 outbreaks were reported per year. That number increased to more than 4,000 annually during the pandemic. Reported and investigated outbreaks have decreased since then but not returned to baseline with 1,822 outbreaks so far in 2023, more than five times the pre-pandemic average.

CDPHE has 10 field managers on staff that support activities such as shelter operations and health care access, especially for our smaller LPHAs, and work closely with their regions to maximize preparedness and response. CDPHE also has 10 regional equity coordinators on staff to help LPHAs connect with their BIPOC, homeless, LGBTQIA+, and differently abled populations. These staff are in place to give LPHAs a committed resource to address the varied public health concerns within a region and quickly implement interventions that meet their communities' needs.

A real world example of the division-wide support for LPHAs that the Disease Control and Public Health Response (DCPHR) division provides is occurring right now. Garfield county requested assistance with about 130 migrants that they are currently sheltering or are in their community. DCPHR's epidemiologists are providing surveillance and outbreak investigation support, CDPHE's State Public Health Laboratory is providing rapid COVID tests and DCPHR's office of emergency preparedness and response is delivering them, DCPHR's health equity team is providing cultural navigators and translation support, DCPHR's immunization branch is providing vaccine, and DCPHR's Mobile Public Health Clinic program is holding a weekend vaccine clinic.

It is the goal of the Department to equip LPHAs with the resources and information to handle a wide variety of public health concerns. When LPHAs are stretched beyond their capacity or request assistance, CDPHE provides support for epidemiological surveillance, provision of vaccines and testing services, communication and messaging, and coordination with other agencies and CDPHE divisions.

Public health is an integrated and coordinated system. However, the pool for highly skilled and experienced public health staff is finite. It is very difficult for the system to have this expertise in all of the (soon to be) 56 local health departments. The 2019 Public Health Needs Assessment calculated that it would require between $167 million to $188 million per year in additional funding to support full implementation of all of the Core Public Health Services in Colorado's local public health system. This gap necessitates having a strategic approach that creates efficiencies where there is flow of resources, support, and knowledge between all of the public health agencies, which includes CDPHE.

State Support for DCPHR Public Health Infrastructure and LPHAs

	FY22 Long Bill State Funding Levels	**FY24 State Funding Levels with SB 21-243 Dollars**	**FY25 State Funding Levels with approval of FY25 R-01**	**Percentage of State Funding with approval of FY25 R-01**
LPHAs*	$9,231,540	$19,698,658	$17,542,631	64%
DCPHR Administration**	$1,399,353	$12,652,286	$9,835,725	36%

and Support				

*LPHAs receive a combination of Marijuana Tax Cash Fund and General Fund. Both state fund sources are included in provider rate adjustments.
**DCPHR Administration and Support's state funding is the General Fund.

LOCAL PUBLIC HEALTH AGENCIES

14. *[Sen. Kirkmeyer] How much should the original distributions to LPHAs amount be increased each year without S.B. 21-243 and the pandemic, to keep up with inflation and per capita spending? Should this amount have been increasing regardless of the public health emergency? Were the increases previously keeping pace with inflation and local needs?*

Response:

CDPHE funding of LPHAs is multifaceted and includes both categorical and flexible funding streams. CDPHE receives categorical funding from the federal government that is passed through to LPHA's including for programs like WIC, HIV prevention, Family Planning, Emergency Preparedness and Response and many others. These dollars fluctuate and arguably do not keep pace with inflation. CDPHE also receives dollars from state sources like the taxes on tobacco products that it passes through to LPHAs for programs like tobacco use and HIV prevention. These dollars are declining as tobacco use declines.

Flexible funding from General Fund dollars provided to LPHAs arise from the 2008 Public Health Act and are intended to broadly support the core public health services and assessment planning functions to determine and respond to local needs. These are the only dollars subject to the community provider rate increase. SB 21-243 in effect doubled these dollars and are the only dollars provided to LPHAs (and CDPHE) that are flexible/non-categorical and are used for programs that prioritize their community's needs that might not be otherwise funded. The SB 21-243 dollars were not subject to the community provider rate increase.

Below are the historical "Local Planning and Support" distributions from CDPHE per CRS 25-1-512 and SB 21-243. Fiscal year 2022 through 2024 below includes the SB21-243 support.

Year	Actual Local Support Dollars	% Change	Population[1]	CPI (2008-2022)[2]
FY 09	$ 8,439,892		4,901,938	3.9
FY10	$ 8,540,933	1.20%	4,976,853	-0.6
FY11	$ 8,099,292	-5.17%	5,050,332	1.9
FY12	$ 7,981,128	-1.46%	5,123,550	3.7
FY13	$ 7,924,220	-0.71%	5,194,662	1.9
FY14	$ 8,513,222	7.43%	5,270,884	2.8
FY15	$ 8,552,223	0.46%	5,347,654	2.8
FY16	$ 8,591,224	0.46%	5,446,593	1.2
FY17	$ 8,794,812	2.37%	5,529,629	2.8
FY18	$ 8,918,099	1.40%	5,599,589	3.4
FY19	$ 9,007,281	1.00%	5,676,913	2.7
FY20	$ 9,097,353	1.00%	5,734,913	1.9
FY21	$ 9,006,380	-1.00%	5,784,156	2
FY22*	$ 19,231,540	113.53%	5,814,707	3.5
FY23*	$ 19,416,172	0.96%	5,924,628	8
FY24**	$ 19,698,657	1.45%	6,034,548	

*FY22 to FY24 are estimates for population

**FY24 is the forcasted population for 2025 in Colorado by the State Demographer. Forcast retrieved February 2023.

1 Population numbers retrieved from Colorado State Demographer's Office. February 2023

2 CPI numbers retrieved from the US Bureau of Labor Statistics. December 2023.

It is important to note that public health as a field serves the entire population. Therefore, while provider rate increases assist with the inflationary costs associated with providing a service, the increase does not account for the increased population, which strains the public health system. This is true for CDPHE and LPHAs.

15. *[Sen. Kirkmeyer] What is the local contribution to public health efforts and how much has the local contribution increased over the last five years? What would the State's increase be if it matched the local contribution?*

Response: Local Public health agencies must contribute $1.50 per capita (per CRS 25-1-512); however, many LPHAs contribute more. Information related to the revenue of LPHAs and revenue categories was asked in a 2023 CDPHE survey to LPHAs. Therefore, it is very important to note that the following are survey responses, not financial records.

During 2022, on average 17% or $60,379,650, of LPHA total annual revenue (~$354,859,509), is from local per capita contributions (excluding local fees, fines, and clinical service revenue). The state's population in 2023 is an estimated 5,924,628. Therefore, the local contribution averages to be $10.19 per person.

Calculating CDPHEs per capita contributions have usually only included the Local Planning and Support funding per CRS 25-1-512; however, there are many other sources of funding from CDPHE to LPHAs through other state funds and federal pass through dollars. In the same annual survey, LPHAs calculated all direct state funding to LPHAs to be approximately $53,110,958 and federal dollars that passed through CDPHE to LPHAs (including two years of SB 21-243 funding) was $78,847,839. For FY25, it is estimated that the state contribution for the Local Planning and Support funding only (per capita), excluding all other funding sources, would be approximately $2.82 per person.

16. *[Rep. Bird] Please discuss the various new issues that the LPHAs have had to respond to in addition to COVID. What are their cost drivers?*

Response: CDPHE works closely with all LPHAs, CDPHE thought that this answer would best come directly from LPHAs. Therefore, CALPHO provides this response:

Local public health agencies are currently facing a range of emerging issues, many of which are exacerbated by insufficient funding:

- **Influx of Migrants:** Agencies are increasingly required to develop longer-term strategies to integrate and provide services for migrants.
- **Local Environmental Contamination:** Addressing environmental health concerns like contamination from PFAS (per- and polyfluoroalkyl substances), meth production, or under-regulated CBD processors demands specialized equipment, technology, and expertise, often exceeding current budget allocations.
- **Behavioral Health & Substance Use:** Local public health agencies play a vital role in addressing behavioral health and substance use by assessing community needs and monitoring trends, implementing prevention and educational programs to reduce mental health issues and substance misuse, and leading initiatives to destigmatize mental illness and addiction, encouraging more individuals to seek help.These needs continue to grow as more individuals require services.
- **Childcare Inspections:** As the demand for childcare services grows, so does the need for food safety inspections in these settings. However, increased inspections have not always been matched with increased funding.
- **Climate and Emergency Management:** Addressing the health impacts of climate change, including emergency preparedness for events like heat waves or natural disasters, is a growing concern that is often underfunded.
- **Coordination Challenges:** There is increasing expectation for public health agencies to coordinate with other sectors (like health care providers, social services, education, and housing). This interdisciplinary approach is essential but often requires resources that aren't available, especially a stable, long-term workforce that is unsupported by short-term categorical funding.
- **Suicide Prevention:** Despite being a significant community concern, suicide prevention programs often lack dedicated state funding, hindering effective response and intervention efforts.
- **Social Disconnection:** The decline in community connectedness significantly impacts health, leading to costly societal issues like reduced civic engagement, domestic violence, misinformation proliferation, and limited access to healthful foods and physical activity. Public health agencies are tackling these challenges to enhance connectedness, often with limited or no funding.
- **Housing Insecurity:** The surge in housing instability and homelessness is straining public health agencies, tasked with providing more complex care coordination and health interventions for this growing population.

These issues highlight the complex challenges local public health agencies face, requiring not only more funding but also innovative approaches and collaborative efforts across various sectors to address these emerging public health needs effectively.

Cost drivers are similar across the public health system. Both CDPHE and LPHAs are faced with:

- **Personnel Costs:** Salaries and benefits for staff, including public health nurses, epidemiologists, health educators, and administrative personnel, are usually the largest expense. Associated staffing costs related to training and transportation for field staff are included in staff costs.
- **Medical Supplies and Equipment:** Costs for medical supplies, vaccines, testing kits, and medical equipment.
- **Information Technology:** Investments in IT infrastructure.
- **Administrative Costs:** General administrative expenses, including utilities, insurance, office supplies, and communication services. LPHA cost drivers also include expenses for maintaining and operating office spaces, clinics, and other facilities.

17. *[Sen. Kirkmeyer] Our Medicaid provider rate has not increased at a rate that is commensurate with inflationary requirements. Please discuss:*
    - *The role of LPHAs in safety net care;*
    - *The role of LPHAs in WIC programming; and*
    - *Efforts to cut local WIC program offices and create regional offices, and why adding/maintaining State FTE while cutting local FTE is appropriate?*

Response:

- The role of LPHAs in safety net care;

  While CDPHE works closely with all LPHAs, CDPHE thought that this answer would best come directly from LPHAs. Therefore, CALPHO provide this response:

  Local public health plays a pivotal role in the safety net healthcare system, which is designed to provide health services to populations who might otherwise lack access due to financial, geographic, or social barriers. The key roles of local public health in this system include:

- **Access to Care:** LPHAs ensure access to essential healthcare services for underserved and vulnerable populations. This includes providing or facilitating primary care, vaccinations, maternal and child health services, and mental health care.
- **Disease Prevention and Health Promotion:** They focus on disease prevention and health promotion, which includes running vaccination clinics, health education programs, and disease surveillance and prevention initiatives. These efforts help reduce the burden on the healthcare system by preventing illnesses.
- **Community Health Assessments:** LPHAs conduct community health assessments to identify health needs, especially among marginalized groups, and tailor services to meet these needs effectively.
- **Linkage to Services:** Local public health acts as a bridge, connecting individuals to various healthcare and social services. This includes referral to specialty care, social services, and support programs like food assistance and housing.

- **Health Education and Literacy:** They provide health education to the community, increasing health literacy and empowering individuals to make informed health decisions. This is especially important for populations that might have limited access to health information.

Directors specifically emphasized the following key areas as currently vital roles for LPHAs in the safety net healthcare system:

- **Family Planning:** Offering essential family planning services to the community, often at reduced costs or on a sliding scale. Funding sources like Title X don't fully cover the program's costs, including staffing. The actual cost of running these family planning programs is often significantly higher than the funding received.
- **Sexually Transmitted Infection (STI) Screening:** Specializing in STI screening and management, public health departments not only provide direct services but also impart training to other healthcare providers, showcasing their expertise in this area.
- **Home Visitation:** Conducting home visits for various health needs, which is a critical component of community health, especially for vulnerable populations.
- **Immunization:** Administering vaccines to protect against various infectious diseases is an essential public health service.

Despite the essential nature of these services, State funds and Medicaid billing often fall short in covering the full costs of these programs. The shortfall affects the ability to staff these programs adequately, with family planning services, for example, LPHAs are receiving less than half of their actual operational costs.

An estimated two thirds of LPHAs bill for medicaid services. Of those who bill, less than 5% of their total annual revenue comes from billing insurance.

- The role of LPHAs in WIC programming; and
- Efforts to cut local WIC program offices and create regional offices, and why adding/maintaining State FTE while cutting local FTE is appropriate?

WIC

The USDA-authorized state WIC agency is housed at CDPHE (COWIC) which provides the operational, regulatory, technology, compliance, policy and fiscal backbone for administering this highly-regulated federal program. COWIC currently works closely with 40 local agency partners who hold annual subcontracts (including local public health agencies, federally-qualified health centers, councils of government, and nonprofit health systems) to provide direct service to clients including program enrollment, nutrition consultations, and breastfeeding classes. Through the partnership between the state and the entities holding the subcontracts, clients have access to local agency staff with a local presence.

As a discretionary federal program, WIC funding is determined at a national level through the annual federal appropriations process. Funding is not necessarily increased or decreased year-to-year to match changes in participation or to other expenses involved in administering the Program. Each year the available administrative dollars are divided between state staff and local agencies with 80% - 84% going to local agency contracts. This provides the majority of administrative funds to local agencies, while sustaining a

core state staff to manage the critical systems and materials utilized by all local subgrantees to deliver Program services (texting services, Electronic Benefit Transfer (EBT) processing, benefit issuance, lab testing equipment and supplies, printing for nutrition education materials, WICShopper app, online nutrition education and training modules, technology infrastructure, breast pumps, contract management, etc.). A federal cut of 5% this year was absorbed by CDPHE completely by reducing, eliminating, or moving planned expenditures on state projects in order to buffer local agencies from any cuts. The proposed modifications to the funding and contracting models does not change this top line funding level for local contracts.

The proposed changes to the funding model allocates the available dollars differently to account for changes that have occurred over the last three years. During the COVID-19 public health emergency, contract amounts were not decreased for any local agency for three straight years (we are now in the fourth year of this practice). While this approach ensured no local agencies saw a decrease in funding during a public health emergency, it also drastically reduced the amount of funds that could be provided to agencies experiencing radical caseload growth. The proposed funding model returns to the pre-COVID practice of allocating funds in a manner responsive to changing WIC participant caseloads and other changing local factors.

Regional offices are not part of the current proposed contract model revisions. There are incentives that encourage the formation of voluntary partnerships between smaller local agencies as a way to maintain the existing network of local clinics while ensuring complete access to the full array of Program services for clients no matter where they live. Earlier versions of the proposed contract model required partnerships for agencies with caseloads below 2000. However, we've heard the concerns of our local partners, and these partnerships are voluntary under the current proposal. Additionally, in the current proposal, local agencies will continue to maintain their own contracts directly with CDPHE, regardless of whether they are in voluntary partnerships. The proposed revisions to the contract and funding models do not impact local agency control. Local agencies maintain control over hiring, supervision, payroll, benefits, dismissal, and all other staffing decisions.

CDPHE and our local partners are engaged in a series of meetings in the coming weeks and months to further discuss CDPHE's proposed changes to the funding and contract models. We look forward to these discussions as we work in pursuit of our shared goal of establishing sustainable WIC funding and contract models that will effectively serve Colorado's families and our local communities for years to come.

ENVIRONMENTAL DIVISION FUNDING

STATIONARY SOURCES CONTROL FUND

18. *[Rep. Bird] Please provide additional detail on how recent bills and decision items have impacted Department expenditures and any associated fee/General Fund impacts.*

Response: The revenue shortfall and fiscal sustainability challenges are driven by the approval of several major budget Decision Items and legislative bills over the past few years. The FY 2022-23 Air Quality Transformation Decision Item (CDPHE R-01) invested in programs/services, technology, programs, and staff capacity in several "pillars" of air quality transformation intended to rectify resource and capacity gaps (considered a long-standing issue within the Department). For example, oil and gas production has

increased by 500% since 2010, which requires additional permitting and inspection staff to manage effectively. CDPHE R-01 also provided resources for emerging and expanding programmatic, regulatory and oversight needs, such as federal mandates associated with the downgrade to Severe nonattainment for ozone within the Denver metropolitan and northern front range area which imposes additional and more stringent permitting requirements and and increases compliance and inspection standards

In addition to the FY23, R-01 Decision Item, recent legislative bills, notably HB 21-1266 (the Environmental Justice Act) and HB 22-1244 (Establishment of an Air Toxics Regulation Program) require implementation of major new programmatic and regulatory initiatives. For example, HB 22-1244 requires the Department to develop rules, regulate, monitor and report on air toxic contaminant emissions. This is an entirely new program for the Department..

All of these major budget and legislative items were originally funded with General Fund and proposed to be funded with fee increases - coalescing into a major fiscal cliff where additional General Fund support or significant fee increases are needed to sustain operations.

The General Fund support for these measures has either lapsed or will lapse over the next two fiscal years.

- The FY 2022-23 Decision Item (CDPHE R-01, Air Transformation) funds will be used by mid-year FY 2024-25 - $45.3M appropriated in FY 2022-23
- HB 21-1266 (EJ Act) funding ended in FY 2022-23 - $5,085,549
- HB 22-1244 (Establishment of an Air Toxics Regulation Program) funding ends in FY 2024-25 - $5,647,068

These three measures were all significant in scope, complexity, and overall associated costs. The measures were all identified as high-priority and time sensitive in order to implement critical new programs and services, meet EPA requirements, evaluate and implement new regulations, achieve existing and new air quality outcomes and goals, update outdated technology, and address other emerging needs. With this in mind, to expedite implementation, the legislature funded all three major initiatives with General Fund appropriations for their first two to three years. It was intended that ongoing funding sources would be revisited in the future and would be comprised of fees and, potentially, General Fund monies or other revenue sources. The R-02 Decision Item helps bridge the funding gap with a mix of fee increases, General Fund, and a transfer of funds from the Energy and Carbon Management Commission (ECMC) Cash Fund.

The Department will be proposing a funding plan to address long-term fiscal sustainability for the Stationary Sources Control Fund that uses a tiered and varied approach to address the revenue shortfall. The plfan will ideally be implemented over a multi-year period in order to phase-in fees for regulated entities. A total estimated shortfall of $28,000,000 to $29,000,000 will occur by FY 2025-26 when all General Fund appropriations have lapsed. The first fee proposal - a greenhouse gas fee authorized by 21-1266 - will generate approximately $7,000,000/year and is set for rulemaking by the AQCC at its February 2024. The remaining $21,000,000 to $22,000,000 funding gap will be addressed through a combination of new and existing fees, and allocation of potential General Fund monies or other funding sources.

19. *[Sen. Zenzinger] Are stationary sources fees assessed at business startup, or are these annual/recurring fees? Are these fees aligned with fines and penalties? Please provide additional detail on the fees, how many entities we are currently collecting fees from, the potential risks of increasing fees on a small number of businesses – or a lot of businesses. Give an overview of who is paying into this system and how much.*

Response: The Department's Annual Emission fees are assessed on all permitted entities that emit Criteria or Hazardous Air Pollutants. Currently 1,950 companies pay the annual fee, based on a per ton of emissions rate, with individual company fees ranging from a dollar up to $290K. The total revenue generated is $5.5M. The highest fees are paid by utility companies followed by oil and gas sector companies. Additional information on annual emission fees and other required fees associated with permitting matters are further outlined below.

The fees are completely separate and not associated with penalties and fines. Penalty and fine revenue is directed to the state's General Fund and the Community Impact Cash Fund based on the ratio authorized in H.B. 21-1266 (EJ Act). In FY22, the Community Impact Cash Fund received 20% of the penalty and fine revenue. The portion directed to the CICF increases by 20% each subsequent year until it reaches 100% in FY26. The Air Pollution Control Division does not receive any funding from penalties and fines enacted via its enforcement activities.

The air permitting and emission fees fall into 4 categories. Those categories are:

- APEN Filing Fees
- Hourly/General Permit Processing Fees
- Title V Permit Processing Fees
- Annual Emission Fees

The Department collects fees of this nature for approximately 1,900 companies, representing approximately 13,000 locations that are conducting operations in the state. Here is a breakdown of the different fees and some specific details regarding each category.

- APEN Filing Fees -

When sources submit an Air Pollutant Emission Notice (APEN) to the Division, they are required to pay an APEN filing fee. The current fee is $242.00 for each APEN submitted. The Division receives an average of 12,000 APENs each year, which calculates to approximately $2.9 million.

The largest industry sector submitting APENs to the Division is oil and gas. Oil and gas operators submit about 65% of the APENs received by the Division each year.

- Hourly/General Permit Processing Fees -

The Division processes approximately 2,000 construction permit and general permit applications each year.

Once the construction permits have been analyzed and written by the engineering staff, the Division issues the permit and generates an invoice for all of the time spent processing the permit. Alternatively, there are several general permit options available to permit requestors. When a general permit is requested, sources pay a general permit fee in lieu of the hourly fees associated with the construction permit route. The general permit fee is variable, depending on the source type covered under the specific general permit.

The purpose of the hourly and general permit fees are to pay for the engineering time spent to analyze the application and create the appropriate permit.

The Division issues fees for hourly/general permit work averaging $3.2 million per year. Much like the APEN filing fees, the largest fee payer of hourly/general permit processing fees is the oil and gas sector. Although the overall percentage can change from one year to the next, oil and gas companies pay approximately 60% of the hourly/general fees annually. The remaining 40% of the fee is paid primarily by manufacturing, utilities and fuel stations

- Title V Permit Processing Fees -

Title V permits represent the largest air pollution sources in the state. Because of the size and complexity of these facilities, it can take many years to issue a permit for these sources. Due to this, the Division generates invoices on a quarterly basis for all Title V permits. These invoices represent the amount of engineering time spent on each permit during the previous quarter.

The invoices issued for Title V permit processing fees has averaged $1-2 million per year. These fees, much like the hourly/general permit processing fees, are intended to pay for the permit engineer's time spent to analyze the application and create the appropriate permit. Although the amount of time billed to each company can vary each year, depending on permitting requests, the main industries paying these fees are public utilities, oil and gas, oil refineries and large scale manufacturing companies. These 3 industries represent almost all of the fees generated for Title V permit processing each year.

- Annual Emission Fees -

The Division also generates invoices for the ***actual*** emissions released by ***all*** emission points (after controls) contained within our database that are required to submit an APEN.

The Division issues approximately 1,950 annual fee invoices each year. The total dollar amount of these invoices are approximately $5.5 million. The overall average annual payment is $2,818 but varies significantly across regulated entities with the 25 highest emitters paying an average of $108,000/year. These fees represent the largest source of invoicing conducted by the Division. The largest annual fee payers are the public utility sector with oil and gas closely behind.

20. *[Rep. Bird/Sen. Kirkmeyer] What will the impact of the proposed transfer be on the ECMC and the fund's ability to continue to support services? What is the impact of the proposed transfer on both departments, as well as the stakeholders that actually pay the fees? What is the impact of transferring revenues collected in DNR for a totally different purpose to CDPHE? In addition, what fees does CDPHE charge these oil and gas entities, and where does that money go?*

Response: The Energy and Carbon Management Commission (ECMC) Cash Fund supports ECMC operations with revenue from a fee set as a levy rate that is paid by oil and gas operators on the market value of the oil and gas produced. The requested transfer from the ECMC Cash Fund to the Stationary Sources Control Fund will be contingent on ECMC being able to retain a reserve equal to 50 percent of appropriations for the upcoming fiscal year. This provision will be an important safeguard to help ECMC maintain fund balance. The request does not contemplate a change in the current levy rate to support the

transfers. The ECMC was chosen as a funding sources as the levy is on the same emitters that are regulated within the SSCF.

CDPHE assesses various fees on oil and gas regulated entities. An annual emission fee is based on reported emissions for criteria and hazardous air pollutants (HAPs). Permitting application and processing fees are assessed and vary based on complexity of permitting work and analysis. The fee structure is the same regardless of industry sector. The fee revenue is accounted for within the Stationary Sources Control Fund (SSCF) and is used to support permitting and regulatory oversight.

21. *Rep. Sirota/Sen. Zenzinger: Why did the Department not move forward with the fee increases that were discussed last year?*

Response: As a first step, the Department is moving forward to establish the greenhouse gas fee authorized by HB22-1266 (EJ Act). The fee will be assessed on businesses that emit in excess of 25,000 tons of greenhouse gases on an annual basis. The fee proposal is scheduled for rulemaking by the Air Quality Control Commission (AQCC) in February 2024. The greenhouse gas fee is estimated to generate $6.5M to $7.0M per year.

As a second step, it is anticipated that the longer-range revenue shortfall will be addressed through a combination of fee increases and other funding sources such as the General Fund or other sources. The specific timing will vary based on whether the ECMC transfer is approved. If the use of ECMC funds is approved, it is anticipated that additional fees and a potential decision point on allocating General Fund or other monies will be considered in FY 2025-26. The fee and/or funding is intended to cover the ongoing programmatic and implementation costs associated with FY23, R-01 Decision Item (Air Quality Transformation) and 22-1244 (Protecting the Public from Air Toxic Contaminants). These two initiatives were funded upfront with General Fund monies in order to expedite implementation. The General Fund dollars allocated to these initiatives will be depleted in early FY 2024-25 for the Decision Item and by the end of FY 2025-26 for the Air Toxics bill.

22. *[Rep. Taggart] Please outline a number of potential options and models that would lay out the different variables, permutations, and combinations to show how these fees would impact the various entities involved.*

Response:
The Department is proposing a long-term funding plan for the Stationary Sources Control Fund (SSCF) that incorporates a tiered and varied approach to address the revenue gap associated with the Air Quality Transformation Initiative along with recent legislation that impacts the SSCF. The revenue shortfall will be addressed through a combination of proposed revenue sources - an increase of current fees, implementation of new fee structures, General Fund support, and a transfer of funds from the Energy and Carbon Management Commission (ECMC) Cash Fund to ensure continued progress towards improving the state's air quality concerns and balance impact to industry. The estimated annual revenue shortfall is $27-29 million/year. If the pending greenhouse gas emission fee is approved by the AQCC in February 2024, the estimated shortfall decreases to $21-23 million/year.

Over the past few years, CDPHE identified that the Air Pollution Control Division (APCD) had significant funding deficiencies and insufficient staffing levels to meet high priority goals and initiatives. The capacity constraints were broadly identified throughout the APCD's existing programs and services, such as

implementation of climate and renewable energy initiatives, monitoring and regulating ozone pollution, and backlogs in permitting and inspections. In addition, new and evolving legislative and Administrative priority initiatives and goals (e.g., environmental justice, new regulatory initiatives) require additional resources from the fund. New and expanded Federal mandates and requirements to conduct more stringent permitting require additional resources as well. As an example, the recent EPA downgrade of the Denver Metro North Front Range ozone nonattainment region from Serious to Severe status will increase facilities subject to rigorous Title V permitting regulations.

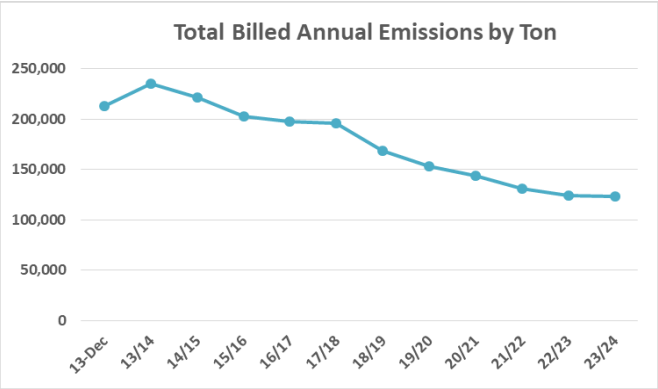
Long Term Funding

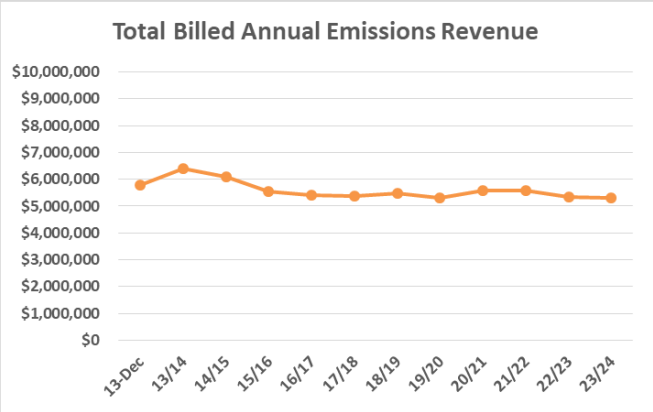
The Administration's FY 2024-25 Recommended budget includes a $15,000,000 dollar transfer of funds from the ECMC Cash Fund to the Stationary Source Control Fund. This infusion of funds will help sustain the SSCF through FY 2025-26. However, the long-term financial forecast indicates that the Stationary Sources Control Fund will face a significant revenue shortfall in FY 2026-27. To address the fiscal challenges, the Department recommends using a combination of existing and new revenue sources to address this revenue shortfall::

1. **Fee Increase** - The Annual Emissions Fee could be increased to provide additional funding to support the initiatives authorized by the Air Quality Transformation Decision Item and other funding gaps. This fee provides the greatest portion of funding within the Stationary Sources Control Fund. This funding stream generates less revenue as emissions decrease, which provides an incentive for companies to reduce their emission levels.

The Annual Emissions Fee has historically been the primary source and generated the greatest portion of revenue for the Stationary Sources Program. The emission fees are currently set at $36.00/ton for criteria pollutants and $239.00 per hazardous air pollutant with a weighted average of $42.00/ton. However, this revenue stream and other APCD fees have not kept pace with division costs for several reasons. First, the Department and Air Quality Control Commission's regulatory initiatives have successfully and consistently resulted in lower emissions released by stationary sources in the state. Second, an outcome of the economic uncertainty during the COVID pandemic is that many companies chose to reduce their permitted emission levels to more closely match actual emissions. In the past, it was common for companies to report emissions at their permitted levels and pay for additional emissions, rather than reporting their actual emissions. This 'belt-tightening' measure has also resulted in lower revenue.

The below charts illustrate total annual emission levels and total annual emissions fee revenue over the past 10 years. The pattern of decreasing emissions confirms that regulatory and compliance measures are working to decrease emitted pollutants. However, the associated revenue decrease creates significant fiscal sustainability challenges.





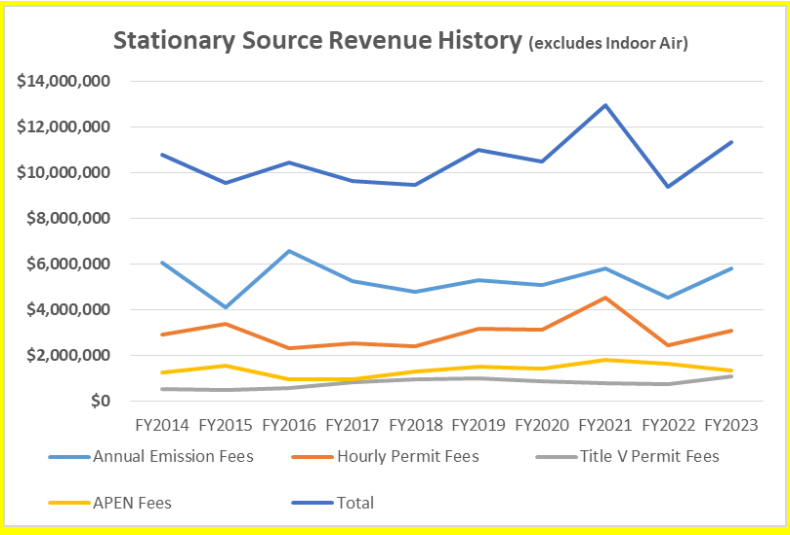
The below chart illustrates annual emission fees for a sampling of states and indicates that Colorado's fees are lower in comparison:

State	Fee
California	$213.25 per ton plus $202.42 per ton for point sources
Colorado	$36.00 per ton of criteria pollutants, $239.00 per ton of hazardous air pollutants, weighted emissions average of $42.00 per ton
Kansas	$53.00 per ton
Indiana	$63.00 per ton
Iowa	$70.00 per ton
Maryland	$50.00 per ton
Michigan	$66.10 per ton
Minnesota	$149.66 per ton
Missouri	$55.00 per ton
Montana	$44.35 per ton
New Hampshire	$286.84 per ton
New Mexico	$185.00 or $44.00 per ton, whichever is greater, hazardous fee pollutants $308/ton
New York	$60.00 to $90.00 per ton
North Carolina	$44.37 per ton
Oregon	$95.00 per ton
Pennsylvania	104.72 per ton
South Carolina	$58.85 per ton
Texas	$69.92 per ton
Utah	$101.75 per ton

Virginia	$98.62 per ton
Washington	$55.14 per ton
Wyoming	$34.50 per ton
Nevada	Flat rate based on quantity ranging from $500 to $10,000
Idaho	Flat rate based on quantity ranging from $1,000 to $10,000

The Annual Emissions fee revenue will remain a core component of the Department's revenue streams but it is timely to modernize the Air Pollution Control Division's financial structure to diversify revenue sources and improve fiscal sustainability.

Even with fee increases that were adopted for Colorado between FY 2018-19 and FY 2021-22, total SSCF revenue hasn't resulted in an increase in overall revenue due to both emission reductions and regulated entities reducing their permitted emission levels to reduce organizational expenses. If the prior fee increases had not been authorized, fee revenue would have decreased by a significant amount. The chart below illustrates that stationary source revenue has largely been flat over the past six years even with the fee increases that were implemented in FY 2021-22 and FY 2022-23.



2. **Stationary Source Maintenance Fee** - An annual maintenance fee could be established as a new funding source within the Stationary Sources Cash Fund. This proposed new fee would be set at a standard level and tiered based on total company or facility emissions. A facility or company with higher emissions would pay a higher maintenance fee than a company with lower emissions. An important consideration is that this fee would provide a consistent funding source for the Division's programs.

   The use of maintenance fees is a common funding source to support air quality and permitting programs within other states. The fees are applied in various manners by each state based on how they have structured their air permitting and oversight programs. Some states apply a flat fee to all permitted entities regardless of emission levels, others set fee tiers based on industry or overall emissions, and some apply the fee strictly to Title V Major Sources. In addition, these states also assess annual emission fees similar to Colorado's structure noted above. The below table illustrates maintenance fees for a sampling of states.

Annual Maintenance Fees		
State	Minimum	Maximum
Maryland	$ 5,000	$ 5,000
Michigan	$ 250	$ 45,000
Montana	$ 900	$ 900
North Carolina	$ 250	$ 9,733
Oregon		$ 12,504
Pennsylvania	$ 2,000	$ 8,000
Utah	$ 150	$ 1,500
Virginia	$ 646	$ 27,472
Washington		$ 30,006

3. **General Fund** - The Department could also receive an ongoing General Fund appropriation to support air quality initiatives and programs. This proposal both recognizes that air quality is a public good for the State of Colorado and recognizes that the economic burden on Colorado businesses of using fees to fund 100% of the revenue gap may be a significant issue. Additionally, as described above, as the Stationary Sources fees and regulations continue to encourage businesses to reduce their emissions, revenue to the fund will decrease over time. Therefore, some portion of General Fund may be appropriate to continue the air quality program at a baseline level.

4. **Additional Transfers of ECMC Cash Fund or Severance Tax** - The Administration recommends that additional transfers of the ECMC Cash Fund to the SSCF occur in FY 2024-25 and FY 2025-26. The amount will be determined based on available funding but is currently estimated at $7,500,000 for each of those two fiscal years. The ECMC Cash Fund and Severance Tax are appropriate fund sources because a large portion of the Stationary Sources program is focused on the oil and gas industry.

23. [Rep. Sirota] Does the Department assess fees based on modeled or actual emissions?

Response: The Department assesses fees based on actual emissions as reported by companies on their Annual Pollution Emission Notice form.

24. [Rep. Bird] What is the emissions fee increase necessary to make the SSCF solvent if no other actions are taken?

Response: The Stationary Sources Control Fund is facing a budgetary revenue shortfall based on the costs associated with new initiatives, regulatory and legislative action. General Fund appropriations were approved to pay for the initial implementation of the initiatives and bills shown below but the funding will lapse by the end of FY25.

- The FY 2022-23 Decision Item (CDPHE R-01, Air Transformation) funds will be used by mid-year FY 2024-25 - $45.3M appropriated in FY 2022-23
- 21-1266 (EJ Act) funding ended in FY 2022-23 - $5,085,549
- 22-1244 (Establishment of an Air Toxics Regulation Program) funding ends in FY 2024-25 - $5,647,068

A specific fee increase is challenging to describe precisely because the overall fee structure will likely change if the Department implements a new annual maintenance fee based on emission tiers and also because the pending greenhouse gas emissions fee will apply to a smaller group of regulated companies than those charged fees for criteria and hazardous air pollutants.

Current projections indicate a total funding gap of $28,000,000 to $29,000,000 will occur by FY 2025-26. This gap decreases to $21,500,000 to $22,500,000 if the 1266 greenhouse gas fee is implemented in February 2024. To ensure long-term sustainability, various strategies are being considered and evaluated but will likely

include an annual maintenance fee, increases to existing fees or other funding sources. A very rough preliminary estimate to provide a sense of the potential magnitude of the fee increase could be 200% to 250% if all fees are proportionately increased. However, please note that this is subject to change based on other potential funding scenarios.

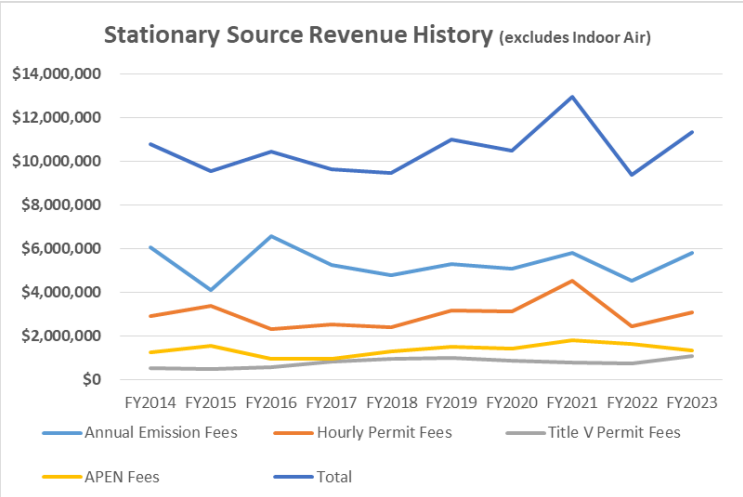
The total revenue shortfall for stationary sources is currently estimated at $28,000,000 to $29,000,000 by FY 2026-27. The first planned fee increase to establish a greenhouse gas emissions fee as authorized by HB21-1266 is scheduled for review and rulemaking by the AQCC in February 2024. The greenhouse gas fee is estimated to generate $6.5M to $7.0M per year. The remaining estimated revenue shortfall of $21,000,000 to $22,000,000/year will need to be addressed by FY 2025-26. The timing of any fee increases will vary based on whether the proposed ECMC transfers occur as proposed in the FY 2024-25 to FY27 timeframe.

25. *[Rep. Bird] Why might fee increases have a hugely detrimental impact on businesses, considering the comparatively low per ton fee rates Colorado has relative to other states?*

Response:

The planned fee increases have been noted by regulated industries as a potential issue that could drive some organizations to consider operational changes or transitioning some operational elements to neighboring states (e.g. oil and gas). The potential magnitude of the total fee increase associated with transitioning three significant recent decision items and bills is likely driving the concerns since utilizing fees alone to address the financial sustainability problem would result in quite significant fee increases and potentially the implementation of a new fee structure. In recognition of the potential magnitude of fee increases, the Department is considering fee structures that could be phased-in over a multi-year period.

The below chart illustrates that total stationary source revenue sources have been flat over the past 10 years, even with period fee increases during this period. This highlights that the Department's revenues have been struggling to keep pace with increased costs over this period. This financial strain will be further exacerbated by adding the FY23 Decision Item and other recent bill costs.



26. *[Rep. Bird] Why does the department argue that revenues to the SSCF need to continue increasing if emissions are falling? If emissions are falling, should the Department's costs decrease as well?*

Response: While emissions are declining over time and expected to continue doing so in the future, the regulatory requirements that the state must demonstrate for both Colorado law and federal statutes and regulations continue to increase. This is reflected in the increased frequency and duration of complex rulemakings, increased litigation against and by Colorado, and more complicated air permits.

Significant new initiatives and programmatic services have been added to the Department over the past two years, including an entirely new and broad area of regulatory oversight and emissions monitoring for air toxic contaminants. Addressing environmental justice concerns and conducting extensive community outreach is a high priority and resources provided in recent legislative sessions have facilitated progress in this area.

Additionally, the public continues to become more engaged and expects timely and transparent information to be provided. The division has grown in recent years to be responsive to all of these factors and these factors necessitate maintaining staffing levels across the Division for the foreseeable future.

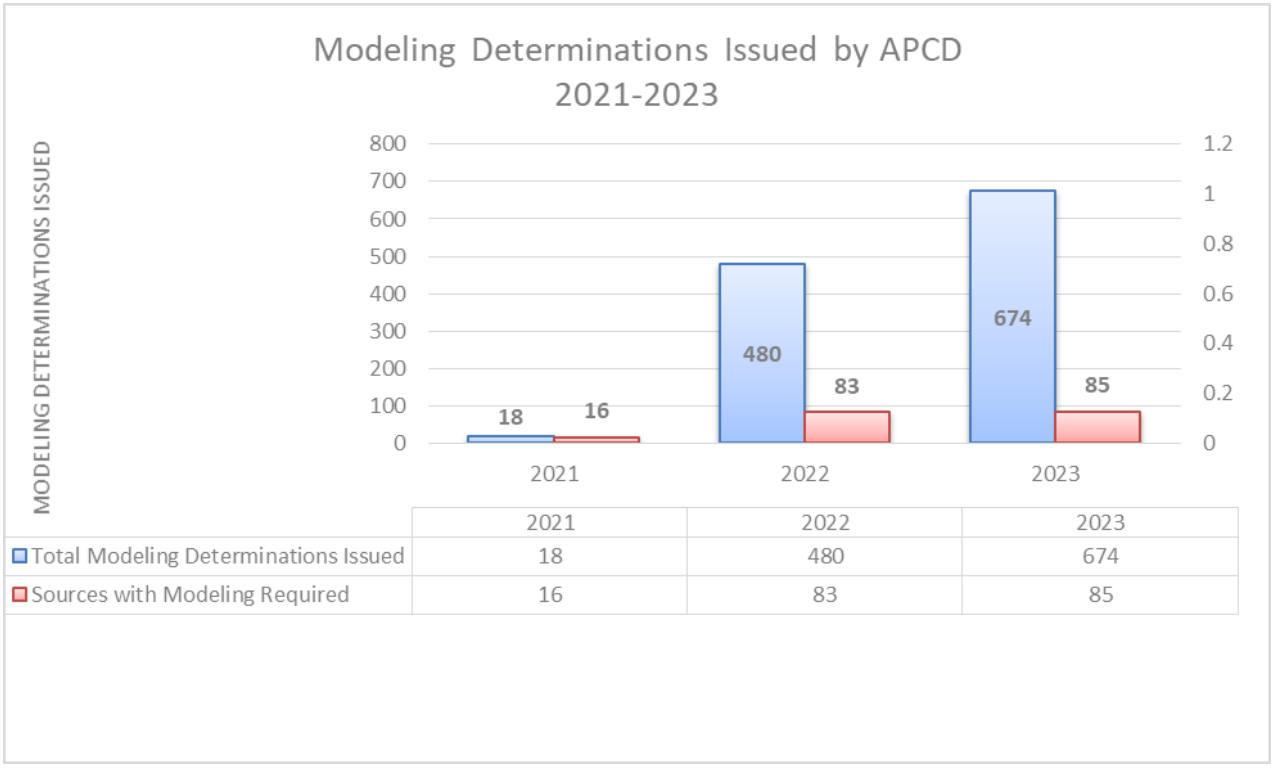
A few additional key examples are provided to illustrate that Department staffing and other resource needs are not decreasing at this time.

- While emissions in many sectors are reducing over time, so too are the major source thresholds in the non-attainment area. This increases the need for permitting actions, whether for sources to obtain limits below the major source threshold or to obtain a Title V operating permit.
- A regulated company may reduce its emission levels significantly but the state is still required to permit as a minor source
- In both permitting situations, those sources need effective compliance oversight by the division to: confirm appropriate permits are obtained timely; compliance with those permits; and compliance with all other state and federal regulations the source is subject to within the state.
- With the changes to the major source thresholds in the non-attainment area, the number of facilities subject to more frequent inspections per EPA's Compliance Monitoring Strategy increases. As a result, the division must complete a higher number of inspections on an annual basis. This also results in more non-compliance issues needing informal and formal enforcement to resolve. If the Department had fewer available resources, it would need to reduce source inspections and that would negatively impact our ability to identify potential issues in a timely manner.

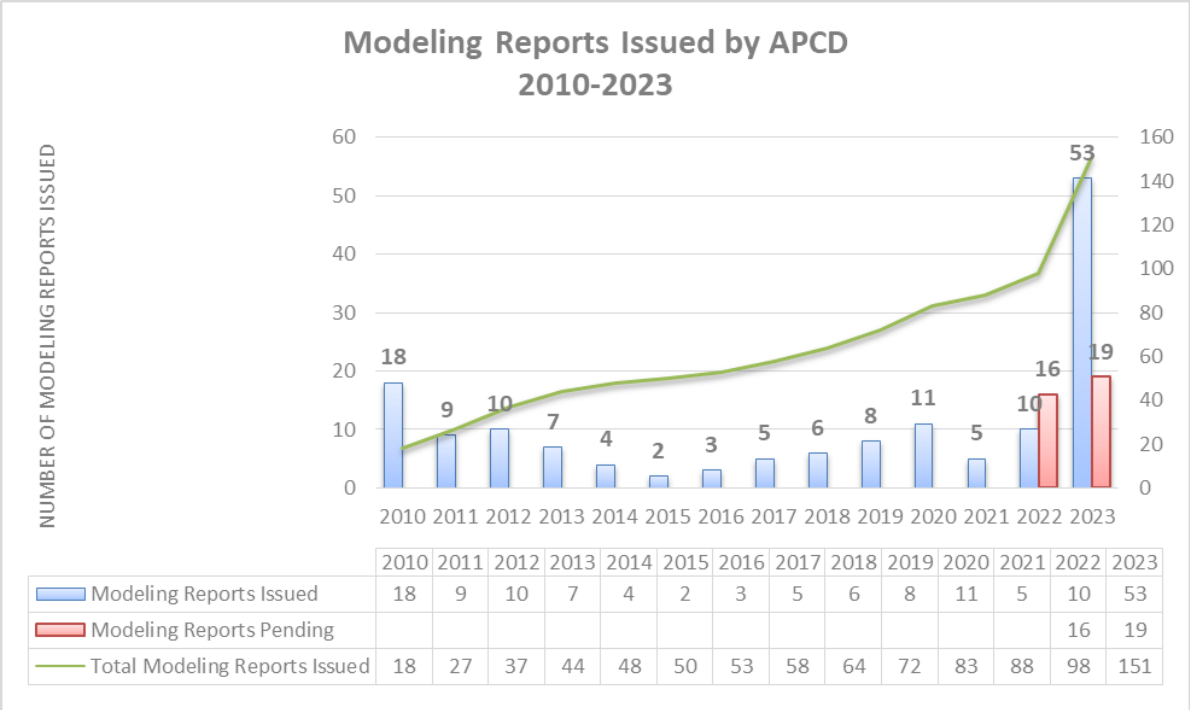
New regulations continue to be proposed and/or have been recently adopted. A sampling of new or pending regulations include:

- GEMM II (Industrial and Manufacturing)
- Advanced Clean Cars II
- Building Efficiency and Energy Standards
- Greenhouse Gas Intensity Verification
- Air Toxics
- Ozone State Implementation Plan (SIP) Updates

- Technology modernization updates are underway to replace outdated, paper-based permitting and compliance/enforcement, and data reporting systems. This effort will help in providing transparency to residents of the state so they have greater awareness of air quality information.
- Ambient monitoring. The Division is working on getting better coverage of monitoring networks by also prioritizing disproportionately impacted communities to better understand the impact faced by criteria pollutants and HAPs.
    - For example, per the Reg 3 updates to protect disproportionately impacted communities, new RACT requirements for CICs come into effect January 1, 2024. There will also be additional monitoring requirements for CICs that start mid 2024. We need the staff and resources to fully implement these new and important regulations.
- New enhanced and more extensive emissions modeling policies in place have significantly increased the workload for our permit modeling unit (PMU). See chart below:
    - Over 1200 modeling determinations have been completed since last year. This chart is as of last month.
    - Significant increase in dispersion modeling analyses. Again, this chart is from last month.



	2021	2022	2023
Total Modeling Determinations Issued	18	480	674
Sources with Modeling Required	16	83	85



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Modeling Reports Issued	18	9	10	7	4	2	3	5	6	8	11	5	10	53
Modeling Reports Pending													16	19
Total Modeling Reports Issued	18	27	37	44	48	50	53	58	64	72	83	88	98	151

FUNDING SOURCES AND USES

27. *[Sen. Gonzalez]: In the Cash Funds Detail table on page 5, the Water Quality Improvement, Water Quality Certification Sector, Drinking Water, etc., is the only place the table that reflects penalties. Where are other penalties deposited?*

Response: Penalty revenue is either deposited into cash funds (as allowed by statute) or by default penalty revenue is deposited to the General Fund.

HB21-1266 allocated increasing percentages of APCD penalty revenue to the Community Impact Cash Fund (CICF) each year. 20% of APCD penalty revenue was allocated to the CICF in FY 2021-22, 40% in FY 2022-23, 60% is being allocated to the CICF in FY 2023-24, 80% will be allocated to the CICF in FY 2024-25, and 100% will be allocated in FY 2025-26 and going forward. The Environmental Justice Advisory Board, with support from CDPHE's Environmental Justice Program, awards money in the CICF through Environmental Justice Grants to fund projects that avoid, minimize, mitigate, or measure adverse environmental impacts in disproportionately impacted communities. Department budget request R-09 proposes to create an Environmental Justice Grants subline within the Office of Health Equity and Environmental Justice line of the long bill where the community impact cash fund would be housed to improve transparency moving forward.

28. *[Sen. Zenzinger]: Are the fund sources within the Air Pollution Control Division available to provide modeling in addition to just monitoring? If not, what fund sources are available for modeling air quality?*

Response: The Air Pollution Control Division's Stationary Sources Control Fund is used to pay for emissions modeling work in addition to other core programs, such as permitting, inspections, enforcement, monitoring and data analysis. Over the past two years, the Emissions Modeling work team has grown from 3.0 FTE to 9.0 FTE based on a higher demand for modeling work to take place.

29. *[Rep. Bird/Sen. Zenzinger]: Please provide an update on the efforts to increase fees driven by last year's budget discussions. There are several related issues in this table on page 11. Where are those efforts for all of the areas that we discussed for fee increases? A specific note about the R4 Dairy Protection Fee Relief: Is the General Fund reduction related to the fee increase?*

Response: Yes, the General Fund reduction is related to the passage of SB 23-240, which increased the fees for the dairy protection cash fund. The General Fund in FY 2023-24 stabilizes the fund for this FY only while the increased cash fund revenue is received.

The Health Facilities and Emergency Medical Services Division has submitted R-03 Health Facilities sustainability which requests $2.1 million General Fund and $0.4 million cash fund spending authority (fee increases increased by CPI). Because two of the three cash funds are limited, by statute to CPI increases the funding for the program as a whole can not be generated by fees alone.

Since July 2023, in compliance with SB23-274, the Water Quality Control Division (WQCD) has engaged with stakeholders through numerous meetings, including large group discussions and subgroups focused on drinking water and clean water/commerce and industry sectors. Initially, the focus was on increasing fees for inflation adjustments for Drinking Water and Commerce and Industry Cash Funds to ensure financial stability and align revenue with spending authority. The WQCD plans to transfer the fees for these funds from statute to regulation during a May 2024 rulemaking with the Water Quality Control Commission. The next phase of the stakeholder engagement is to discuss the funding mix and additional funding needs for the clean water and drinking water programs, which the division started in mid-November, to inform a May 2025 rule-making.

The Center for Health and Environmental Data was directed to explore fee increases in concert with the approved R-06 decision item that would provide one-time cash fund fee relief in FY 2023-2024. Since then, unanticipated sources of revenue were received and resulted in significant excess uncommitted reserves in the Vital Records Fund. A supplemental decision item (FY 2024-2025 S-09) has been submitted to return the fee relief funds and this balance will be used to defray operational expenses of the program. No fee increases are needed in FY 2024-2025 as planned. The fund balance will be tapped until exhausted, meaning that it is likely that fee increases may be avoided for one additional year, i.e. through the end of FY 2025-2026. The Vital Records Unit will perform an annual analysis to determine the need for fee increases that will be implemented at the beginning of each fiscal year.

30. *[Sen. Kirkmeyer]: What is the status of the $65 million transferred to the Electrifying School Buses Program? What has been spent and what school districts have received the money? Please identify the school districts that have received the money, how much they have received, and explain any shortfall in expenditures.*

Response: As background, the legislature and the Administration authorized the Electric School Bus grant program in S.B. 22-193. The legislation allocated $65,000,000 to the Electric School Buses Grant cash fund

to support transition from traditional diesel-fueled to electric school buses. These funds will be continuously appropriated through fiscal year 2032-33.

The implementation of the grant program is underway. The department's Air Pollution Control Division selected awardees for the first two rounds of the Colorado Electric School Bus Grant Program (ESBG) in April and September 2023. State funding can be combined with federal funding for electric school buses, notably the electric school bus grant program authorized within the Inflation Reduction Act managed by the Environmental Protection Agency. The state's grant program is reimbursement-based, so specific funding amounts will depend on the vehicles and technologies that recipients procure, in addition to any federal funding received. The division is committed to supporting these school districts and has awarded up to approximately $26 million in combined state and federal funding to support electric school buses and related infrastructure. The ultimate amount contracted via awards will not be known, including the split of the ESBG to federal funds, until school districts receive confirmation of any pending federal funding awards for electric school buses. If federal funding is available, the state will award additional funds to cover any remaining funding gaps. While this funding structure makes it challenging to provide a specific number at this point, the federal grant program will significantly leverage state funding to permit the state to transition a higher number of buses from diesel fuel to electric than otherwise would have occurred if only state funds were available.

In total, 18 school districts have applied for the ESBG's funding with one entity being ineligible. The one applicant that was not selected was found to be ineligible for the Colorado Electric School Bus Grant Program, due to their status as a private school.

The 17 districts that will receive awards include:

- Big Sandy 100J School District.
- Boulder Preparatory Charter High School.
- Boulder Valley School District.
- Community Leadership Academy Inc.
- Denver Public Schools.
- East Grand School District #2.
- Fountain Fort Carson School District #8.
- Monte Vista School District.
- Primero Reorganized School District #2.
- Poudre School District.
- Sangre De Cristo RE-22J School District
- Sheridan School District #2.
- Steamboat Springs School District.
- Summit School District RE-1.
- Thompson School District 1-JT.
- Weld County School District #6.
- West Grand School District 1-JT.

At this time no school districts have received funding. While there are no expenditure shortfalls, the program is new to the department and the Fiscal and Mobile Sources Programs have been developing

contracts. Another award round will open in March, 2024. The department anticipates spending the entire $65 million by the program repeal date of September 1, 2034 and will be providing progress reports to the General Assembly on January 1 of each odd-numbered year beginning in 2025.

HEALTH FACILITY LICENSURE CASH FUND SOLVENCY
R3 CASH FUND PROPOSAL AND REQUEST

31. *[Rep. Bird] Do you know the scale of the fees that we are talking about here? What is the actual dollar impact of an increase of 8.01 percent in fees? How would that impact patients?*

Response: Below are examples of different facility types designed to illustrate the impact of the proposed fee increase on patients. The fees are variable based on facility type, size, etc. Please reference Appendix A at the end of this document for a detailed fee schedule of each cash fund showing current fees and fee projections with the 8 percent increase.

Assisted Living Residence Cash Fund (Last Fee Increase 2019)

Example 1 - Small Assisted Living, 8 beds. Annual License Renewal

Current Fee: $360 Base and $103 per bed fee ($824 total Bed fee) = $1,184
Proposed fee: $388.84 Base and $111.25 per bed fee ($890 total Bed fee) = $1,278.84

The table below shows the impact per patient, assuming 75% capacity for the year (i.e. 6 beds filled). The monthly impact is calculated by dividing the fee by the number of occupied beds, divided by 12.

8-Bed Assisted Living	Current	Proposed	Incremental
Total Fee	$1,184	$1,278.84	$94.84
Monthly Cost Per Patient	$16.44	$17.76	$1.32

Example 2 - Large Assisted Living, 100 beds. Annual License Renewal

Current Fee: $360 Base and $103 per bed fee ($10,300 total Bed fee) = $10,660
Proposed fee: $388.84 Base and $111.25 per bed fee ($11,125.03 total Bed fee) = $11,513.87

The table below shows the impact per patient, assuming 75% capacity for the year (i.e. 75 beds filled). The monthly impact is calculated by dividing the fee by the number of occupied beds, divided by 12.

100-Bed Assisted Living	Current	Proposed	Incremental
Total Fee	$10,660	$11,513.87	$853.87
Monthly Cost Per Patient	$11.84	$12.79	$0.95

General Licensure Cash Fund (Last Fee Increase 2019)

Example 1: Birth Center Annual License Renewal

Current Fee: $376.22
Proposed Fee: $406.36
Increase: $30.14

The table below shows the impact per patient. . The daily impact is calculated by dividing the total fee by 730, or 2 patients per day for 365 days per year.

Birth Center	**Current**	**Proposed**	**Incremental**
Total Fee	$376.22	$406.36	$30.14
Daily Cost Per Patient	$0.52	$0.56	$0.04

Example 2: General Hospital (100 bed). Annual License Renewal

Current Fee: $1463.07 Base Fee and $12.54 per bed fee ($1,254 Total Bed Fee) = $2,717.07
Proposed Fee: $1580.26 Base Fee and $13.54 per bed fee ($1,354.45 Total Bed Fee) = $2,934.70

The table below shows the impact per patient. The daily impact is calculated by dividing the total fee by the number of beds, then divided by 365 and assumes 75% capacity for the year (i.e. 75 beds filled each day). This would be $2.90 per bed, and $0.01 per patient per day. (217.63/75 = $2.90. $2.90/365 = $0.01)

100-Bed General Hospital	**Current**	**Proposed**	**Incremental**
Total Fee	$2,717.07	$2,934.70	$217.63
Daily Cost Per Patient	$0.10	$0.11	$0.01

Home Care Agency Cash Fund (Last Fee Increase 2012)

Example 1: Class A Home Care Over 100 patients Annual License Renewal

Current Fee: $1,550 base plus $200 (over 100 patients) = $1,750
Proposed Fee: $1,674.16 base plus $216.02 (Over 100 patients) = $1,890.18

The table below shows the impact per patient. The daily impact is calculated by dividing the total fee by the number of patients (100).

Home Care- >100 Patients	Current	Proposed	Incremental
Total Fee	$1,750	$1,890.18	$140.18
Daily Cost Per Patient	$17.50	$18.90	$1.40

Patient Impact of Fully Fee-Funded Model

The Department considered the full fee increase needed to fully fund the cash funds. The increase would need to be 85%. Given the current economic climate, including significant increases in staff personnel services costs, the stakeholders expressed significant trepidation about such a large increase. Concerns were raised about likely facility closures, which would lead to reduced access to care. Additionally, if the Department implemented a fully fee-funded model, it would have a significant impact on patients. Below is the same scenario from earlier involving a large Assisted Living facility, but with an 85% increase.

Current Fee: $360 Base and $103 per bed fee ($10,300 total Bed fee) = $10,660
85% increase: $666 Base and $190.55 per bed fee ($19,055 total Bed fee) = $19,721

Assuming 75% capacity for the year (i.e. 75 beds filled) the impact if passed along to each patient would be $10.07 per month, or a **960% increase over the proposed 8% fee increase above.**

100-Bed Assisted Living	Current	85% Fee Increase	Incremental
Total Fee	$10,660	$19,721	$853.87
Monthly Cost Per Patient	$11.84	$21.91	$10.07

32. *[Sen. Zenzinger] Thinking about the surveyor positions, "as of June 2022, 637 of the 2,373 state-licensed health facilities were overdue for re-licensure surveys." What is an updated figure for the number of facilities overdue for re-licensure and number of complaints overdue for investigation as of September 2023? What are the impacts on providers/facilities of being overdue? What is at risk in terms of payments and funding on the state and federal level? What are the risks to patients?*

Response: The number of State licensed facilities overdue for a survey has been reduced by approximately half, (approximately 300 overdue licensing surveys.) The reduction in backlog is, in part, due to the gradually reduced focus on infection prevention in relation to COVID-19 and resumed focus on licensure. As of November 2023, there are approximately 280 open complaint investigations associated with licensed facilities.

Impacts to providers/facilities for being overdue:

Facilities are required to renew their licenses on an annual basis. The division conducts relicensure surveys for the purpose of regulatory oversight on an average of every 3 years for most all providers. The facility remains actively licensed between surveys regardless of the frequency of surveys. State licenses are not

affected by survey frequencies. Licenses remain in good standing unless the division takes action against the license for cause, such as failure to renew or for enforcement actions. Thus, there are no impacts to funding for the providers in relation to the frequency of licensing surveys. Please note, this applies only to State licensed facilities. Facilities, such as nursing facilities, which must comply with federal requirements, must be surveyed at intervals established by Centers for Medicare and Medicaid Services (CMS). Failure to meet federal requirements can result in monetary penalties for the Division. As for facility payments, as long as the facility continues to be licensed and certified, the facilities will continue to receive federal payments for services they provide.

33. *[Sen. Zenzinger] How does combining the two line items for the different programs that are short on funding into a single line item actually make things better?*

Response: For the cash funds, combining the Long Bill lines does not provide significant benefits because each cash fund can only be used for work performed with the appropriate facility types. Combining the lines is beneficial because the General Fund could be used for the work that needs to be done, regardless of facility type. Under the current Long Bill structure, the $2.18 million requested General fund would have to be allocated to the Home and Community and Nursing and Acute Care lines in the Long Bill. Once the General Fund is allocated, the Division would be locked into that allocation. If workload in the Home and Community Programs increased, for example, the Nursing and Acute General Fund could not be shifted to respond to those changing program needs. Under the current structure, once General Fund is allocated to a Long Bill line, the Division does not have the flexibility to use the General Fund to respond to changing needs.

In the current Long Bill Structure, activities related to hospitals, Ambulatory Surgical Centers, Nursing Facilities, etc. are funded in the Nursing and Acute line item. The General Fund in that line can only be used for work associated with those specific facility types. The Home and Community line item contains funding for activities related to Home Care Agencies, Assisted Living Residences and Hospice. The General fund in this line can only be used for these facility types.

Under the Department's request, if a situation arises where resources need to be directed to a specific facility type, for example, hospitals, and the lines are combined, the division would have more flexibility to cover those costs with General Fund.

LONG-TERM SUSTAINABILITY PLANS FOR CASH FUND

34. *[Rep. Bird] Can the Department provide a solution to reach cash fund solvency utilizing a CPI-based increase, a tiered fee increase, and facility bed fees that would allow the cash funds to reach net positive annual cash flows by FY 2026-27?*

Response: For the General Licensure Cash Fund and the Assisted Living Residence Cash Fund, fee increases are limited to CPI each year and can not be accumulated. For example, the CPI for calendar year 2022 is 8.01%. This is the increase the Department is seeking for July 1, 2024. The 8.01% is an unusually high CPI increase. Based on historical data, the Division anticipates future CPI increases will return to the historical average of 1 to 3%. . Per statute, fees cannot be increased more than the CPI. This means that if CPI is 2%, fees cannot be increased by 5% under existing law.

If current law were to change, and the Department were not limited to CPI increases, the following scenarios could be considered. Each of the scenarios presented below include the $2.18 Million General Fund as requested in the Decision Item. Finally, it should be noted that with a positive cash flow each year, the Department will run the risk of exceeding the 16.5% uncommitted reserves limitation at some point in the future.

The Division proposes to base the CPI increase on the last fully completed calendar year. Because CPI is not finalized until February of the following year, basing the fee adjustments on prior year CPI will allow for more predictability. Using the prior year rate will mean that facilities will know, well in advance, what the adjustment will be. This will allow both the Division and facilities to plan for fee adjustments.

For the proposed fee increase, which would go into effect in July 2024, if approved by the Board of Health, the Division has utilized calendar year 2022 CPI data. 2022 is the last fully completed fiscal year before the stakeholder process. Because the Stakeholder process needs to start before the end of the calendar year immediately preceding the fee increase, the Department determined a one year delay was appropriate so that all parties can have advanced notice of the proposed increase.

The following tables show the current revenue, projected revenue with various fee increase options, estimated expenditures and the difference between estimated revenue and expenditures for the three cash funds: General Licensure, Assisted Living Residences and Home Care.

1). The current proposal R-03, $2.18 Million General Fund and 8.01% fee increases for FY 2024-25 and 2% in future years was presented in the Decision Item. This chart shows the 8.01% for FY 2024-25; estimated 5% for FY 2025-26; 3% for FY 2026-27; and 2% for future years (the updated assumptions reflect updated forecast information by the Office of State Planning and Budgeting as well as Legislative Council Staff). While the GF is not included on the table, anticipated cash expenditures are reduced because of the GF assumption.

Fund		FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
General Licensure	Estimated revenue (Base)	$2,276,005	$2,300,000	$2,507,308	$2,656,423
	Estimated Revenue from fee increases 2023-24 is ARPA Funds	$400,000	$182,308	$124,115	$78,943
	Estimated Cash Expenditures*	$3,312,179	$2,548,964	$2,693,462	$2,702,814
	Difference	($636,174)	($66,656)	($62,038)	$32,552
Assisted Living Residence Cash Fund	Estimated revenue (Base)	$3,185,200	$3,190,200	$3,455,335	$3,563,695
	Estimated	$600,000	$255,135	$103,360	$71,174

	Revenue from fee increases 2023-24 Is ARPA Funds				
	Estimated Cash Expenditures	$3,402,647	$3,488,590	3,558,224	$3,629,222
	Difference	$382,553	($43,255)	$471	$5,646
Home Care Agency Cash Fund	Estimated revenue (Base)	$1,357,000	$1,387,000	$1,525,696	$1,630,480
	Estimated Revenue from fee increases 2023-24 is ARPA Funds	$1,100,000	$108,696	$74,785	$48,014
	Estimated Cash Expenditures*	$2,086,232	$1,724,950	$1,759,919	$1,794,635
	Difference	$370,768	($229,254)	($159,439)	(116,140)

*Estimated cash expenditures for the General Licensure and Home Care Cash funds decrease in FY25 and future years as a result of moving expenditures to the General Fund, If the $2.18 Million General Fund in R-03 is approved.

Increasing fees by 8.01% for FY 2024-25; estimated 5% for FY 2025-26; 3% for FY 2026-27 and 2% for future years. Produces positive cash flow for General Licensure and Assisted Living, but not Home Care.

2). Tiered increase based on 5% each year (would require legislation to remove the CPI fee cap)

Fund		FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
General Licensure	Estimated revenue (Base) 2023-25 includes ARPA Funds	$2,276,005	$2,300,000	$2,438,800	$2,578,800
	Estimated Revenue from fee increases	$400,000	$113,800	$115,000	$121,940
	Estimated Cash Expenditures *	$3,312,179	$2,548,964	$2,693,462	$2,702,814
	Difference	($636174)	($135,163)	($139,662)	($2,074)
Assisted Living Residence Cash Fund	Estimated revenue (Base) 2023-24 includes ARPA Funds	$3,185,200	$3,190,200	$3,359,460	$3,523,970
	Estimated Revenue from fee increases	$600,000	$159,260	$159,510	$167,973
	Estimated Cash Expenditures	$3,402,647	$3,488,590	$3,558,224	$3,629,222
	Difference	$382,553	($139,130)	($39,254)	$62,721
Home Care Agency Cash Fund	Estimated revenue (Base) 2023-24 includes ARPA Funds	$1,357,000	$1,387,000	$1,484,850	$1,584,200
	Estimated Revenue from fee increases	$1,100,000	$67,850	$69,350	$74,243
	Estimated Cash Expenditures *	$2,086,232	$1,724,950	$1,759,919	$1,794,635
	Difference	$370,768	($270,100)	($205,719)	($136,192)

*Estimated expenditures for the General Licensure and Home Care Cash funds decrease in FY25 and future years as a result of moving expenditures to the General Fund, If the $2.18 Million General Fund in R-03 is approved.

Increasing fees by 5% beginning in FY 25 results in

- Close to a positive net cash flow for the General Licensure Cash Fund by FY27;
- A slight positive net cash flow for the Assisted Living Residence Cash Fund by FY27;

- A continued negative net cash flow for the Home Care Cash Fund by FY 27

3). Tiered increase based on 5.5% each year (would require legislation to remove the CPI fee cap)

Fund		FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
General Licensure	Estimated revenue (Base) 2023-24 includes ARPA Funds	$2,276,005	$2,300,000	$2,425,000	$2,601,680
	Estimated Revenue from fee increases	$400,000	$125,180	$126,500	$134,760
	Estimated Cash Expenditures *	$3,312,179	$2,548,964	$2,693,462	$2,702,814
	Difference	($636,174)	($123,783)	($116,782)	$33,626
Assisted Living Residence Cash Fund	Estimated revenue (Base) 2023-24 includes ARPA Funds	$3,185,200	$3,190,200	$3,375,386	$3,555,847
	Estimated Revenue from fee increases	$600,000	$175,186	$175,461	$185,646
	Estimated Cash Expenditures	$3,402,647	$3,488,590	$3,558,224	$3,629,222
	Difference	$382,553	($123,204)	($7,377)	$112,271
Home Care Agency Cash Fund	Estimated revenue (Base) 2023-24 includes ARPA Funds	$1,357,000	$1,387,000	$1,491,635	$1,597,920
	Estimated Revenue from fee increases	$1,100,000	$74,635	$76,285	$82,040
	Estimated Cash Expenditures *	$2,086,232	$1,724,950	$1,759,919	$1,794,635
	Difference	$370,768	($263,315)	($191,999)	($114,675)

*Estimated expenditures for the General Licensure and Home Care Cash funds decrease in FY 2024-25 and future years as a result of moving expenditures to the General Fund, If the $2.18 Million General Fund in R-03 is approved.

Increasing fees by 5.5% beginning in FY 2024-25 results in:

- A positive net cash flow for the General Licensure Cash Fund by FY27;
- A positive net cash flow for the Assisted Living Residence Cash Fund by FY27;
- A continued negative net cash flow for the Home Care Cash Fund by FY 27.

The Department has, over the years, discussed various funding scenarios with stakeholders. For example, ideas of low base fees and higher per bed fees (for appropriate facility types) have been considered along with higher base fees and lower per bed fees. The current fee structure of low base fees and higher per bed fees was endorsed by stakeholders as the final impact to each facility was based on their size (i.e. By number of beds, with larger facilities paying larger fees). It should be noted that not all licensed facilities offer nor provide residential care or overnight stays and thus bed fees would not apply. The Department has not considered overhauling the fee structure as part of the current sustainability process. Since the fees contained within the two cash funds can only be increased by CPI, there is little room for major restructuring. (For example, if the Department wanted to increase base fees and decrease the per bed fee, the per bed fee could be reduced, but the maximum amount of increase to the base fee would be CPI).

35. *[Rep. Bird] Can the Department provide a solution to reach cash fund solvency utilizing the alternative solutions previously considered that would allow the cash funds to reach net positive annual cash flows by FY 2026-27?*

Response: Legislation to establish fees would be required for each of the following scenarios. Legislation would need to authorize the imposition of such fees and determine the collection mechanism for the funds. A cash fund (or funds) would need to be identified for the revenue. Each would also have a TABOR Impact. Some of the below options would represent a broader distribution of the cost across a greater population of people, who may access services at a healthcare facility.

The Division considered alternative sources of funding for this request. These alternatives included:

Increasing licensing fees by 85% to fully cash fund the programs.

This would place all the cost burden of health facility oversight on the regulated facilities.

- This would fully fund division programs over the course of the next several years.
- An 85% fee increase would generate approximately $5.8 million based on FY 2023-24 anticipated revenues.

Medical glove fee - A surcharge placed on each box of Medical gloves purchased.

- Assume 5.8 million people used an average of 10 pairs of gloves over the course of the year this would equate to 58,000,000 pairs of gloves used each year. There are 50 pairs of gloves in a box. This results in approximately 1,160,000 boxes of gloves per year. To generate sufficient revenue to cover the funding need identified in R-03, approximately $2.6 million dollars would need to be collected. Assuming 1,160,000 boxes of gloves purchased annually This would be $2.24 per box.
- Alternatively, if people used an average of 50 pairs of gloves (i,e, one box) per person per year, there would be 5.8 million boxes of gloves used per year. This would result in a fee of $0.45 per box.
- Please note, the estimate of gloves per year is based on all uses of disposable gloves from doctors, dentist, veterinarians offices, personal use, etc.

- A surcharge on medical gloves would spread the cost across private consumers, health facilities, doctors offices, laboratories, veterinary clinics, and a multitude of other entities related to this uniform health service product.

Per capita basis fee- A charge placed on all facilities based on the number of occupied beds, active patients or clients, or other count that varies from day to day.

- This would place the burden on the facilities to calculate fees and remit it to the Department based on their daily census.
- Assume 62,721 beds across the state with a 75% capacity level. This would mean that 47,040 beds are filled on a daily basis. $2.6 million / 365 / 47,040 would be $0.151 per occupied bed per day.

Surcharge on prescription medications- this would spread the cost across a broad portion of the population.

- Assume 5.8 million residents in Colorado and that each person fills at least one prescription per year. $2.6 million / 5.8 million = $0.45 per prescription

Surcharge on non prescription medications -, this would spread the cost across a broad portion of the population.

- Assume 5.8 million residents and that each person purchases at least 4 over the counter medications in a year. This is 23,200,000 over the counter medications per year and $0.11 per medication

While complete analyses have not been conducted on each of these scenarios, each one could potentially generate sufficient revenue to support the funding needs identified in R-03. However, there are specific downsides to a fee-only approach. For instance, a difficulty with the scenarios would be assigning the proper proportion of the new fee to each of the separate cash funds as glove and medication fees are not directly tied to a specific facility license type. In the present situation, distribution of cash is based on the license fees being applied to the appropriate fund based on the facility type. For the above fees to be distributed across all license programs, the legislation would have to specify the allocation of revenue to a current cash fund or a new, general use, cash fund would have to be created. In addition, without GF support, the financial impact of an 85% fee increase, for example, would be particularly burdensome on providers still facing significant financial uncertainty.

36. *[Rep. Bird] What is the actual amount of General Fund needed for each of the cash funds to have net positive annual cash flows in FY 2024-25 and each fiscal year after, with an 8.01 percent fee increase in FY 2024-25 and CPI-based increases each year after, and the 36.0 currently vacant surveyor positions filled?*

Response: It is important to note that the Department is not requesting a transfer of General Fund to the cash funds. Instead, the Department is requesting General Fund appropriations to cover expenses that would have otherwise been borne by the cash funds. The General Fund requested in the Decision Item ($2.18 Million) would be applied to expenses attributable to each of the cash funds. The following table shows the projected expenditures from each of the cash funds for FY 2024-25, assuming the $2.18 million is approved. Based on this table, an additional $339,266 General Fund would provide each cash fund with a

net zero cash flow for FY 2024-25. Anything above that amount would generate a positive cash flow as expenses are transferred to the General Fund and off the cash fund.

Fund	FY 2024-25 total expenses	FY 2024-25 Estimated Fee Revenue (Base)	FY 2024-25 CPI (8.01%)	Shortfall
General Licensure Cash Fund	$2,548,964	$2,300,000	$182,308	($66,656)
Assisted Living Residence Cash Fund	$3,488,590	$3,190,200	$255,135	($43,356)
Home Care Agency Cash Fund	$1,724,950	$1,387,000	$108,696	($229,254)
Total	$7,7362,504	$6,877,200	$546,139	($339,266)

37. *[Rep. Bird] Can the Department provide a solution to reach cash fund solvency utilizing annual General Fund allocations that decrease over time until there is no General Fund necessary, and allows the cash funds to reach net positive annual cash flows by FY 2026-27?*

Response: This would require legislation as the cash fund fee increases would need to exceed CPI. Fee increases in the following amounts would be necessary for each of the cash funds to reach net positive cash flow, while decreasing the General Fund appropriation to be $0 for FY 2026 -27. Please note that each year's increases are compounded on the prior year. Therefore, for Home care, the fees would increase an additional 18% over the fees calculated for FY 2024-25 and be 65% higher overall by the end of FY 2026-27.

Fund	FY 2024-25	FY 2025-26	FY 2026-27
General Licensure Cash Fund	21.5%	18%	15%
Assisted Living Residence Cash Fund	8.01%	7%	5%
Home Care Agency Cash Fund	21.5%	18%	15%

38. *[Rep. Taggart] Please present a five-year plan showing a matrix for what needs to come from the General Fund each year to catch up these programs within five years. The proposal doesn't look like a solution for the 85.0 percent problem, and would put the cost on the back of the local providers that are strapped.*

Response: The Department is interpreting this question to mean that no cash fund fee increases are desired for the next five years. Presently the local providers collectively pay approximately $7 million in fees per year. For FY 2024-25, while the Division anticipates an increase in fee revenue of $546,138, the Division is requesting an increase in spending authority of $402,754. The difference ($143,384) is spending authority that the Division currently has, of which has been unused because of insufficient cash revenues. The table below includes General Fund for all cash fund revenues ($546,139).

For FY 2024-25, the Department would need an additional $885,405 General Fund to cover the costs of the program without any fee increases. The $885,405 General fund would offset the revenue from the $546,138, proposed CPI increase as well as the remaining, projected cash fund shortfall. Without any fee increases, the General fund would need to increase by approximately $300,000 in 2025-26 to offset the 5% estimated CPI fee increase and $200,000 in FY 2026-27 for the 3% fee increase. Please see the table below for a breakdown of the need by each cash fund.

Fund	FY 2024-25 Shortfall from Decision Item	FY 2024-25 CPI (8.01%)	General Fund Increase needed for FY 2024-25 (Over Decision Item)
General Licensure Cash Fund	$66,656	$182,308	$248,964
Assisted Living Residence Cash Fund	$43,356	$255,135	$298,491
Home Care Agency Cash Fund	$229,254	$108,696	$337,950
Total	$339,266	$546,139	$885,405

Fund	FY 2025-26 Shortfall from prior table	FY 2025-26 estimated CPI (5%)	General Fund Increase needed for FY 2025-26 (Over Decision Item)
General Licensure Cash Fund	$248,964	$124,115	$373,079

Assisted Living Residence Cash Fund	$298,491	$103,360	$401,851
Home Care Agency Cash Fund	$337,950	$74,785	$412,735
Total	$885,405	$302,260	$1,187,665

Fund	FY 2026-27 Shortfall from prior table	FY 2026-27 CPI (3%)	General Fund Increase needed for FY 2026-27 (Over Decision Item)
General Licensure Cash Fund	$373,079	$78,943	$452,022
Assisted Living Residence Cash Fund	$401,851	$71,174	$473,025
Home Care Agency Cash Fund	$412,735	$48,014	$460,749
Total	$1,187,665	$198,131	$1,385,796

ENVIRONMENTAL PROGRAMS

ENVIRONMENTAL JUSTICE

39. *[Rep. Taggart/Sen. Zenzinger]: If the Department believes that a new office is necessary, why is R7 prioritized over R9? Is there duplication in FTE request across R7 and R9? Adding up R7 and R9, they are asking to essentially double the staff. Please explain.*

Response: R-09 is not a request to create a new office. Instead, it is a request to reorganize where existing staff appear in the Long Bill by creating a combined Office of Health Equity and Environmental Justice structure in the Long Bill in order to be transparent with the legislature. R-09 also minimizes the inefficiencies that exist in the status quo with funding for the Department's Environmental Justice Program spread across multiple Divisions in the Long Bill. Right now, the Environmental Justice Program does not exist in the Long Bill. As a result, the existing 13.5 staff and operational funding for the Environmental Justice Program have been spread across the Administration Division, Air Pollution Control Division, Division of Environmental Health and Sustainability, and Water Quality Control Division lines in the long bill. But in practice, all of these individuals operate as part of a single team (the Environmental Justice

Program) that is housed within the Administration Division. This situation arose because these positions and funding were created through several recent pieces of legislation that each individually addressed environmental justice challenges. The goal of R-09 is to create better transparency by aligning the Long Bill with where these positions are functionally housed. The Department concluded that the best and most transparent place to allocate the positions in the Long Bill would be to a new combined Office of Health Equity and Environmental Justice structure. That is because the Office of Health Equity and the Environmental Justice Program have very similar roles and both are housed in the Administration Division. Both work in partnership with multiple CDPHE divisions to embed equity into their work, with the Office of Health Equity primarily focused on partnership with the public health divisions and the Environmental Justice Program primarily focused on the environmental divisions.

R-09 does request 5.5 new staff as well. This includes two staff (one in the Environmental Justice Program and one in the ASD fiscal program) to accommodate the expansion of the Environmental Justice Grant Program. In HB21-1266, the legislature allocated increasing percentages of air pollution penalty revenue to the Community Impact Cash Fund each year. In turn, the Environmental Justice Program works with the Environmental Justice Advisory Board to distribute the penalty revenue in the form of Environmental Justice Grants. As revenue in the Cash Fund has grown over time as intended, more staff are now needed to effectively administer the grant program. The other 3.5 FTE are also the long term result of the legislature's direction in HB21-1266. HB21-1266 created an Environmental Justice Action Task Force to recommend policy changes on a variety of environmental justice topics to the legislature, the Governor, and CDPHE. The Task Force submitted its final recommendations to the legislature, the Governor, and CDPHE on the statutory deadline of November 14, 2022. The Task Force recommended that the legislature fund new staff positions within CDPHE to conduct better interagency coordination on environmental justice, improve the use of data in CDPHE's environmental justice work, and implement best practices for engaging with disproportionately impacted communities. Since the recommendations from the Task Force were not known at the time the fiscal note was developed, the additional 3.5 FTE through R-09 is being requested to fulfill those recommendations.

By contrast, R-07 is the outgrowth of a very different piece of legislation. The purpose of R-07 is to expand capacity to enforce and help regulated entities come into compliance with environmental laws in disproportionately impacted communities. R-07 originates out of two initiatives. One is SB21-181, which directed the Office of Health Equity to develop a report on health disparities and recommend actions to address them. R-07 is one of the outcomes of one of those recommendations. By improving compliance with environmental laws in disproportionately impacted communities, we can reduce the pollution exposure of populations who are more vulnerable to poor health outcomes which addresses a key social determinant of health. R-07 also expands the Department's capacity to implement a voluntary agreement with EPA Region 8 on advancing environmental justice in enforcement and compliance. Colorado was only the second state in the nation to enter into this type of voluntary agreement to advance environmental justice with EPA, in March 2022.

There is no duplication in the FTE request between R7 and R9. R7 requests 8 new FTE to expand the Department's capacity for enforcement and compliance of environmental laws in disproportionately impacted communities. This includes 1 new inspector in each of the Air, Water, and Waste Divisions, 1 new compliance specialist in both the air and water divisions to work on complaint responses, 1 new community engagement specialist in both the water and air division to engage the public about

enforcement initiatives, and 1 Spanish translation specialist in the Environmental Justice Program. Only 1 of the 8 FTE requested in R7 will be housed in the Environmental Justice Program, and that FTE is not reflected in R9.

There are currently 13.5 staff in the Environmental Justice Program. R7 and R9 collectively add 5.5 new FTE to the Environmental Justice Program. Specifically, R7 adds 1 new FTE to the Environmental Justice Program (a Spanish translator). R9 adds 4.5 new FTE to the Environmental Justice Program: one new grants specialist to cover the increased revenue available to distribute as grants through the Community Impact Cash Fund, and 3.5 new FTE to implement recommendations of the Environmental Justice Action Task Force.

40. *[Sen. Kirkmeyer]: Is legislation required to authorize the Office of Health Equity and Environmental Justice? What offices does the Department intend to put under it? Furthermore, what is the funding source for the office? Are they planning to use gifts, grants, and donations? Please explain.*

Response: No, legislation is not required to authorize the Office of Health Equity and Environmental Justice. The JBC could determine that a bill similar to SB23-285 is needed to change all statutory references to the Office of Health Equity, however, the long bill structure transparency is most important to the department.

Both the Office of Health Equity and the Environmental Justice Program currently exist and were authorized by prior legislation. Both are part of the Administration Division. The Office of Health Equity already appears in the Long Bill in the Administration section. However, the 13.5 staff and operating costs for the Environmental Justice Program have appeared in four different sections of the Long Bill: the Administration Division, Air Pollution Control Division, Division of Environmental Health and Sustainability, and Water Quality Control Division. That is because there is currently no line in the Long Bill for the Environmental Justice Program. To improve transparency, this request would put all Environmental Justice Program staff and operating budget into one line of the Administration Division section of the long bill. Because the Office of Health Equity and Environmental Justice Program have parallel missions of embedding equity in the work of other CDPHE's divisions, R-09 also proposes putting both programs in the same section of the Long Bill. This improves transparency and makes it easier for legislators and the public to understand where equity work is housed within the department.

The Environmental Justice Program is currently funded by a mixture of APCD stationary source funds, reappropriated funds from the Water Quality Control Division, and federal funds (two separate federal grants). This proposal would change the funding balance so that positions would be funded primarily by indirect costs, with some limited general fund, cash fund, and federal funds. The cash funds, from the Community Impact Cash Fund (CICF), would be used only to fund the Environmental Justice Grant Program and staff to support it. General Fund would only be used to fund the work of the Environmental Justice Ombudsperson, in recognition of the independent role for that position spelled out in HB21-1266. The Ombudsperson was previously funded by General Fund in the FY 2022-23 Long Bill.

The Department does not intend to use gifts, grants, or donations to fund the Environmental Justice Program, with the exception of one position that is already funded by a federal grant that would continue to be funded by the same federal grant.

41. *Rep. Bird/Sen. Kirkmeyer: Is legislation required for this request? If not, provide the bill number authorizing this activity from the department, as well as an explanation of how the request R7 (Advancing Environmental Justice Enforcement and Compliance) aligns with the fiscal note for that legislation? Is this an expansion of the expected resources initially granted through legislation? How much of what is being investigated under this program is already being investigated by other entities?*

Response:

	APCD	HMWMD	WQCD
Current average number of annual inspections	Approximately 1,035	Approximately 250	Approximately 550
Expected number of inspections directly to DI Communities added by R-07	Approximately 50 additional inspections.	Approximately 35 additional inspections.	Approximately 30 additional inspections.
Percentage of current inspections conducted by local governments through contracts with CDPHE	For FY24, Local governments conduct 11.7% (187) of total planned inspections. CDPHE contracts with Boulder, Denver, Larimer, Jefferson, and Weld Counties for inspections.	No local government hazardous waste inspections. Some local governments do solid waste inspections, but this decision item does not cover solid waste inspections.	0 (local governments do not do inspections)

In the status quo, compliance specialists across the Department respond to complaints about a variety of topics. However, due to resource limitations it is not always possible to dedicate extensive time to complex matters that arise from disproportionately impacted community members, who may face barriers like language, working multiple jobs, and educational attainment levels to submit all necessary documents and information through a complaint process. It can take a great deal of staff time to work closely with community members who face these types of barriers, especially because they may require referrals to other state, local, and federal agencies who have jurisdiction to address certain aspects of their complaint that may exceed CDPHE's existing authority. Adding additional resources for complaint response will help increase the number of complaints resolved from multiple sources, including the EJ Ombudsperson complaint system. While the number of complaints and the complexity of the complaints varies widely within each division, it can be assumed that addressing a complaint can take anywhere from 2 hours to over 80 hours. In turn, it is estimated that two new compliance specialists can significantly assist with providing a timely response to DI Communities to help resolve the complaint. These complaints may lead to enforcement actions if violations are identified, which can in turn reduce exposure to harmful pollutants and benefit the health of DI Community members.

While only in recent years at CDPHE had the resources and statutory direction to pursue community engagement on a wide variety of issues, CDPHE has heard – and agrees – that there remain gaps in community understanding that this budget request intends to address. In particular, gaps in community understanding of how the Department is taking actions to hold entities that violate environmental laws accountable, and also missed opportunities to build community priorities into enforcement settlement agreements and/or pursue opportunities like supplemental environmental projects funded by enforcement penalty revenue to benefit communities that were harmed by the violation of an environmental law. To remedy that gap the Department has agreed with EPA to start conducting more outreach and engagement

about enforcement actions, but it is challenging to do so with existing engagement staff resources dedicated to other matters like rulemaking and permitting actions. We anticipate conducting six additional engagement events about significant enforcement actions per Division each year. It is anticipated that each event would require up to 120 hours in preparation and facilitation to support a successful event. It also includes significantly increasing communication through public announcements, web platforms, and other pathways about enforcement actions. Increasing transparency about enforcement actions can improve community trust in CDPHE's work and demonstrate to DI Communities that the Department is actively working to enforce environmental laws and protect their health every day.

Legislation is not required for R-07. The purpose of R-07 is to expand capacity to enforce and help regulated entities come into compliance with environmental laws in disproportionately impacted communities. R-07 originates out of two initiatives. One is SB21-181, which directed the Office of Health Equity to develop a report on health disparities and recommend actions to address them. R-07 is one of the outcome of one of those recommendations. By improving compliance with environmental laws in disproportionately impacted communities, we can reduce the pollution exposure of populations who are more vulnerable to poor health outcomes which addresses a key social determinant of health. R-07 also expands the Department's capacity to implement a voluntary agreement with EPA Region 8 on advancing environmental justice in enforcement and compliance. Colorado was only the second state in the nation to enter into this type of voluntary agreement to advance environmental justice with EPA, in March 2022.

The air, water, and waste divisions have received funding for staff to work on enforcement and compliance initiatives through dozens of different pieces of legislation and budget requests over the course of many decades. In the status quo, the Department does not have enough inspectors to inspect all sites each year, or to respond to all complaints in a timely manner. As a result, each division has to make hard choices each year about where to allocate its limited inspection resources and which complaints to respond to. Adding more staff capacity will allow the Department to inspect pollution sources in communities that are already overburdened by pollution more frequently and

R-07 does not change which facilities are subject to enforcement and compliance initiatives, including investigations. Instead it increases the frequency of inspections and the speed with which the Department can visit sites for inspections and how quickly the Department can respond to complaints. By conducting more frequent inspections and responding more rapidly to complaints, the Department will be better positioned to bring facilities back into compliance and reduce pollution above permitting health limits and in turn improve public health within disproportionately impacted communities.

42. *[Sen. Kirkmeyer]: Who are the disproportionately impacted communities that this is referring to, including which counties they are located in? Are these proposed FTE duplicating enforcement and compliance work already being done at the county level? What are the calculations used to determine these FTE?*

Response: Disproportionately impacted community is a term defined under Colorado law. The legislature updated the definition of disproportionately impacted community last legislative session in House Bill 23-1233. Under HB23-1233, the same definition now applies to all state agencies. A community must meet one of 8 factors to meet the definition of disproportionately impacted community: race, income, housing cost-burden, linguistic isolation, history of exclusionary policies, cumulative impacts, Tribal lands, or mobile

home parks. CDPHE maintains a publicly accessible map called Colorado EnviroScreen that shows a map of which places meet the definition of disproportionately impacted community.

Every Colorado county includes at least some areas that meet the definition of disproportionately impacted community, although in several counties this is just one or two mobile home parks. Areas that meet the statutory definition of disproportionately impacted community are found in both rural and urban areas across the state.

Some local governments, including but not limited to Boulder, Denver, Jefferson, Larimer, and Weld Counties, have contracts with CDPHE to lead enforcement and compliance initiatives under various environmental laws. R-07 does not duplicate the work done by these local government enforcement and compliance specialists. Rather, it expands the overall capacity available for enforcement and compliance work at both the state and federal level. CDPHE works with local government partners to identify whether the state or local government should inspect facilities to minimize duplication.

The calculations used to determine these FTE are found on pages 4, 5, and 6 of the Decision Item. These include:

- Table listing current total inspections per division and anticipated increase in number of inspections in DI Communities through new FTE requested (approximately 50 additional air inspections, approximately 35 additional hazardous waste inspections, and approximately 30 additional water quality inspections);
- Average hours (2 to 80) it takes to respond to complaints, which would be addressed by new compliance specialists ;
- Number of additional community engagement events about enforcement and compliance activities completed by new engagement specialists (approximately 18 additional engagement events per year in total across divisions)
- Number of words translated by a Spanish translator per year (approximately 276,000) and associated cost savings from conducting these translations in house rather than sending to a vendor (conservatively estimated at $5,832).

LEAD TESTING

43. *[Sen. Kirkmeyer]: She understands that the cost of the lead testing bill was reduced from $30.0 million. Please explain the reason for the reduction. How did that happen, and how does it interact with this request?*

Response: This question may be referring to the school lead testing bill (HB22-1358), and if so, the department is not aware of a reduction. The legislation allocated $21 million for the program, which has provided funding to test all Pre-K through 5th grade eligible schools, child care centers, and in-home daycares that opted into the program. That phase of the program has been completed, and the department is currently working on testing all middle schools per HB23-1298.

HB 22-1358, which is separate from this request, required schools and child care centers to test their drinking water for lead and if necessary remediate by fixing or replacing lead plumbing. Lead in drinking water is one potential source of elevated blood levels. HB 22-1358 is an intervention that can help reduce elevated blood level levels. The department's R-08 request is a separate strategy aimed at increasing blood lead testing and conducting outreach to providers and families.

44. *[Rep. Sirota]: It looks like some of the money is being used to purchase equipment. Is lack of equipment driving the small amount of testing that happens, or is it something else? What is the method for expanding the testing that is happening? Do we have certain environmental factors in Colorado that are driving lead poisoning for kids? Is there a broader plan once home investigations are expanded?*

Response: The lack of equipment contributes to Colorado's lower testing rates; however, it is not the only factor. The department has a three-part strategy. The first two strategies intend to increase blood lead testing:

1. Our first strategy is education and awareness for healthcare providers. More engagement is needed to communicate risk and the importance of testing to providers to increase testing rates. To achieve this, the department has requested resources to increase outreach and education to healthcare providers as providers are where the majority of blood lead level testing occurs.
2. The second strategy is testing. Healthcare providers, along with local public health agencies, conduct blood lead level testing; however, local public health agencies have indicated that the cost of testing equipment and material is a barrier. The testing machines and resources in the request are for local public health and clinics.
3. The third component of the request is funding for in-home investigations to act on testing results when they show an elevated blood lead level. The department has requested FTE and equipment to conduct these in-home investigations, which can help families identify the source and reduce exposure. In-home investigations largely would be conducted by the department as most local public health agencies do not have the personnel and expertise needed in-house. The department would coordinate with local public health before conducting an investigation in their community.

These three strategies work together to reduce lead poisoning. While all communities will benefit from increased testing rates, the department will prioritize communities that have low testing rates and higher risk. This will be done by looking at existing blood lead testing data in relation to tools that look at environmental conditions and the age of the community's housing.

There are a variety of sources of lead. Home based sources include lead-based paint, glazed pottery that may be used for cooking, imported spices and home remedies, products associated with hobbies such as bullets, fish sinkers, artist paints and furniture refinishing. Lead-contaminated soil or dust, exposure to certain industries such as construction, mining, welding and plumbing, and water from lead pipes are also sources of exposure. The department is currently studying the potential impacts and contributions of leaded aviation fuel on elevated blood lead levels in Colorado communities.

45. *[Rep. Bird/Sen. Zenzinger]: Please discuss whether the Department is planning to expand testing specifically for children living near airports. Please explain and please provide additional detail on the Department's efforts related to testing of children living near airports.*

Response: The department is currently studying the potential impacts and contributions of leaded aviation fuel on elevated blood lead levels in Colorado communities. We are working to have the study results in the coming weeks. Better understanding the source of an elevated blood lead level can help identify the

interventions needed to reduce exposure. We also want to better understand how the risk of living near an airport compares to the risk of lead-based paint in a home. What we know right now is that regardless of the source, blood lead level testing is important, particularly for high-risk children.

OTHER PUBLIC HEALTH DECISION ITEMS

R4 STATE SYPHILIS RESPONSE AND R5 STATE LAB OPERATING

46. *[Rep. Bird] R4 State Syphilis Response: Remembering that last year they had a request that focused on the jails in these counties. What does this proposed expansion look like? More focus outside of jails? Other areas? Please explain.*

Response: This request would provide resources for a statewide response to the increase in syphilis rates, particularly to prevent congenital syphilis, and will focus on the communities with the highest rates using evidence-informed interventions.

The jail request approved in the FY 2023-24 year's budget (R-07 Address Syphilis in Jails and Outreach Settings) exclusively addressed congenital syphilis prevention and treatment for women of reproductive age in the jails in Pueblo, El Paso, and Jefferson counties.

This State Syphilis Response is a separate request to address prevention and treatment across the state.

This broader request includes the following components:

- **Increased Access to Screening and Testing:** The Department proposes to increase screening for syphilis at emergency departments and community-based locations that serve priority populations.
- **Statewide Field-Delivered Therapy Program:** The Department proposes to develop a statewide field-delivered therapy (FDT) program in which a qualified medical provider would deliver treatment for syphilis at a person's home. FDT will strengthen the ability to locate clients, provide post-treatment, follow-up, and referrals, and increase the compliance and completion of treatment.
- **Medication Access Delivery Program:** The Department proposes to increase access to treatment and prevention medications throughout the state of Colorado, particularly in the areas most impacted by syphilis. This includes but is not limited to access to Bicillin and doxy-PEP. Through the implementation of a statewide medication access delivery program that would deliver low or no-cost treatment and prevention to individuals disproportionately impacted by syphilis, the Department would eliminate barriers to timely treatment and prevention.

47. *[Sen. Zenzinger] Last year's funding for the syphilis program was a pilot program. Please provide an update on the success/impact of the pilot program so far.*

Response: Here is our update for the congenital syphilis jail pilot that was funded as of July, 2023. Note: the State Syphilis Request (R4) is a separate request

- From July 1, 2023, 182 women of reproductive age (15-44) were screened for syphilis in Pueblo County. 10 were pregnant at the time of screening. Two of whom had a reactive syphilis test. There were 37 reactive results for a positivity rate of 20%. The treatment completion rate averages 70%, with several individuals still in the process of completing treatment. Both pregnant

persons were adequately treated, averting 2 cases of congenital syphilis. 108/182 were screened for substance use and mental health referrals.

- Since July, CDPHE finalized and executed contracts with El Paso and Jefferson County, both counties hired and trained their RNs and finalized standard operating procedures. Additionally, MOUs with the Health Departments, Detention Centers and Detention Center's contracted medical vendors were completed. Both counties have begun testing as of December, 2023.

State Lab

48. *[Rep. Bird] Presumably, this work has been happening already. How are they paying for it now? Why is the General Fund appropriation necessary for FY 2024-25?*

Response: The Courier Service has been in place since before 2013 has historically been supported by General and Cash Funds. The courier system transports a variety of samples to the State Lab including newborn screening, wastewater, tuberculosis, foodborne illness, rabies, and diagnostic samples to rule out bioterrorism agents. The pandemic created the demand for extra stops and extensive routes that ran every day all throughout the state. These additional COVID-19 related activities were paid for by federal funding.

The State Lab acts as a hub for all LPHAs and residents of Colorado testing needs. Circumstances beyond the pandemic have driven increased utilization of the State Lab services. Excluding COVID-19 samples, the State Lab received roughly 5,000 samples per month through Nov 2022 when, due to increasing infectious disease testing needs, samples started to rise and are now consistently above 10,000 per month. The State Lab is seeing a rise in testing demands for drinking water tests and infectious disease agents such as tuberculosis, foodborne illness and hospital acquired infections and the addition of wastewater surveillance. Increased costs for all types of testing supported by General Funds have increased, putting additional strain on this allocation. Escalating costs due to inflation coupled with increased sample volumes and increased expectations from LPHAs and other customers for courier service following the pandemic have led to the need for additional funds to support the courier service.

Without a courier network, the State Lab and its customers are vulnerable to hefty federal violations that would be incurred without the courier network's contracted responsibility to transport potentially infectious samples in accordance with federal regulations. Additionally, without an increase in funds, LPHAs outside the Denver metro area and Front Range would have to pay out of pocket to send samples to our State Lab to access the specialized testing not provided in other labs.

The Newborn Screening Cash Fund, with increased spending authority, can pay for the portion of the cost that is directly related to the Newborn Screening Program, however, in order to best serve our rural areas, the Department is seeking the difference from General Funds.

R6 TUBERCULOSIS PROGRAM INFRASTRUCTURE

49. *[Rep. Bird] There are a few discrete things included in this request (FTE, translation, etc.). Please break out the cost allocated for each part of the request.*

Response:

Amount	Purpose	Area impacted
$266,821	2.0 FTE TB subject matter experts (Nurse Consultant, other trained TB clinician, and/or Epidemiologist) to support LPHAs statewide, or a contract set up with TB-trained nurses/clinicians/epidemiologists	LPHAs needing consultation services, training, and clinical support that are managing confirmed TB patients, conducting TB contact investigations, or working-up presumptive TB patients
$1,470	Standard Operating	N/A
$3,000	Translate key TB forms/educational materials into Arabic, Spanish, Nepali, Somali, and Dari	Underserved populations who are at a greater risk of being diagnosed with TB
$35,881	TB treatment drug purchase, training of LPHA staff who investigate TB, contract with a TB SME to help our TB nurse and LPHAs manage cases	Increased capacity to respond to and effectively treatTB cases to prevent further spread
Total= $305,702		

50. [Rep. Bird] Did the local public health agencies ask for this help (nurse consultants)?

Response: 25-4-501 C.R.S. states that tuberculosis is a shared responsibility of state and local public health and a cooperative and collaborative effort between the two. Recent large tuberculosis contact investigations (where confirmed tuberculosis cases have potentially exposed large numbers of people in congregate settings like senior residential living/residential healthcare settings and schools) have highlighted the ever important need for resources at the state level that sufficiently meet the needs of all of Colorado LPHAs. As the state continues to receive migrants from areas of the world with higher rates of tuberculosis, the state's tuberculosis program needs the flexibility to pivot resources to jurisdictions who may experience an increase in tuberculosis cases. Two nurse consultants, epidemiologists, or trained tuberculosis clinicians at the state level will be able to manage the influx of LPHAs needing consultation services, provide clinical support managing confirmed tuberculosis patients, support large tuberculosis contact investigations, or working-up presumptive tuberculosis patients. This alleviates a burden for LPHAs to hire additional staff or expend resources not originally allocated for tuberculosis response. This support also provides an opportunity to train LPHA staff on tuberculosis response activities, as many LPHAs have had significant staff turnover since the pandemic. Training resources can be developed so that they can be used in the future, beyond the funding timeframe.

On Nov. 15, 2023, CDC released a report on the reported tuberculosis cases in the U.S. in 2022. In that report, CDC reports on the ongoing effects of the COVID-19 pandemic on tuberculosis disease, including increased rates of tuberculosis in 2022. Case rates in Colorado in 2023 are higher than in past years, with 84 cases reported to date in 2023, compared to 57 in 2022. Each reported case of tuberculosis disease requires 9-12 months of public health attention, as public health ensures that cases take daily medication to eliminate the infection. Tuberculosis can spread among people residing in congregate settings such as shelters,

correctional settings, residential healthcare settings, and schools, and requires a coordinated response from both local and state governments to effectively control.

51. *[Sen. Kirkmeyer] Are these permanent FTE with one-time funding? What is the plan here? Wouldn't it make more sense to just give the money to the LPHAs and then require them to work together to solve the problem?*

    Response: The Department requests one-time funding for 2.0 term-limited FTE nurse consultants, epidemiologists, or trained tuberculosis clinicians to provide flexible support to LPHAs who are investigating tuberculosis cases and potential outbreaks. Tuberculosis prevention and control is a shared responsibility between the state and local public health agencies, as directed by 25-4-501 C.R.S. Having these 2.0 FTE at the state level allows for more efficient and effective use of these funds as these staff can support a greater number of LPHAs that have tuberculosis cases within their jurisdiction, instead of spreading small amounts of money across 57 LPHAs that would not be enough to hire new staff. These 2.0 FTE can also focus on training staff at LPHAs, many of which had staff turnover during the pandemic. Tuberculosis response can be complex and nuanced, so having additional resources to help train local public health partners can help increase their capacity to respond now and into the future.

52. *[Rep. Taggart] Why would someone even accept a one-year temporary position for a program of this nature?*

    Response: CDPHE will use existing networks of public health professionals and clinicians to identify candidates (such as recently retired public health nurses, public health trainees who recently finished fellowships/training programs, COVID term-limited staff who have tuberculosis experience, etc.,). This type of position is ideal for a health care provider looking to transition from clinical care into public health practice. It is not uncommon for the State to offer term limited positions in light of changing circumstances like the one the state is seeing with increased tuberculosis case rates.

53. *[Sen. Bridges] Please give more detail on the overall plan for this request. How is it actually going to work? How will they adjust for inevitable turnover among the locals? Please explain the request.*

    Response: While turnover among local public health agencies (LPHA) is possible, the purpose of this request is to focus on the immediate need of LPHAs, and provide training and resources that LPHAs can use in the future. This request will fund two full time staff who will assist LPHAs in addressing their communities' increasing tuberculosis cases and orient/train LPHA staff on tuberculosis response activities. As tuberculosis disproportionately impacts BIPOC communities, the Department is requesting funding to provide forms and educational materials that are translated into Arabic, Spanish, Nepali, Somali, and Dari in lieu of LPHAs incurring this expense and to expand access to care for underserved populations. Finally, the Department is requesting additional funding to purchase necessary and costly tuberculosis medication that can be distributed to LPHAs, as needed.

Question 1. Table of CDPHE Stimulus Appropriations, Encumbrances, and Expenditures by Bill (millions)

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
General Fund / State Stimulus	SB21-137	HIV and AIDS Prevention Grant Program - CO Recovery	$0.500	$0.000	$0.500	$0.000	0%
	SB21-137	HIV and AIDS Prevention Grant Program - ARPA	$2.000	$0.000	$2.000	$0.000	0%
	SB21-137	Mental Health First Aid-Colorado Behavioral Health Council	$0.250	$0.000	$0.250	$0.000	0%
	SB21-137	Round 1: Mental Health Services Corps and Scholarships for Addiction Counselors	$1.700	$0.000	$1.700	$0.000	0%
	SB21-137	Round 1: Naloxone Bulk Purchase Fund	$1.000	$0.000	$1.000	$0.000	0%
	SB21-137	School-based Health Centers: Mental Health Services	$0.232	$0.000	$0.232	$0.000	0%
	SB21-137	School-based Health Centers: Other	$0.809	$0.000	$0.809	$0.000	0%
	SB21-137	School-based Health Centers: Testing	$0.096	$0.000	$0.092	$0.004	4%
	SB21-137	School-based Health Centers: Vaccination	$0.063	$0.000	$0.063	$0.000	0%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	SB21-260	Clean Fleet Enterprise	$1.700	$0.000	$0.000	$1.700	100%
	SB22-183	Crime Victims Services: Community Crime Victims Grant Program	$1.000	$0.520	$0.480	$0.000	0%
	SB20B-001	Funding to Locals to Offset Retail Food Establishment License Fees Losses	$6.800	$0.000	$6.800	$0.00	0%
		Subtotal	***$16.150***	***$0.520***	***$13.926***	***$1.704***	***11%***
American Recovery Plan Act	SB21-243	Disease Control and Public Health Response Administration and Staffing	$9.235	$0.000	$9.235	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Child Care	$0.004	$0.000	$0.004	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Community Health	$0.013	$0.000	$0.013	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Food Program	$0.016	$0.000	$0.016	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Healthy Child Home Visit	$0.025	$0.000	$0.025	$0.000	0%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	SB21-243	Distributions to Local Public Health Agencies: Housing Support	$0.023	$0.000	$0.023	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Medical Expenses	$0.017	$0.000	$0.017	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Mental Health Services	$0.170	$0.000	$0.170	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Other COVID-19 PH Expenses	$1.521	$0.000	$1.521	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Other Services	$2.170	$0.000	$2.170	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Payroll	$6.327	$0.012	$5.431	$0.884	14%
	SB21-243	Distributions to Local Public Health Agencies: PPE	$0.058	$0.000	$0.058	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Premium Pay	$0.375	$0.000	$0.375	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Social Determinants of Health	$0.044	$0.000	$0.044	$0.000	0%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	SB21-243	Distributions to Local Public Health Agencies: Substance Use	$0.020	$0.000	$0.020	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Testing	$0.171	$0.000	$0.171	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Tracing	$0.161	$0.000	$0.161	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Vaccination	$0.730	$0.000	$0.730	$0.000	0%
	SB21-243	Distributions to Local Public Health Agencies: Water Filtration	$0.009	$0.000	$0.009	$0.000	0%
	SB21-288	Alternative Care Staffing Surge	$6.835	$0.000	$0.000	$6.835	100%
	SB21-288	COVID-19 Testing Lab Certification - Health Facilities and Emergency Medical	$0.144	$0.000	$0.031	$0.113	78%
	SB21-288	Denver Health Services	$4.000	$0.000	$4.000	$0.000	0%
	SB21-288	Flu Vaccines for Low-Income Coloradans	$0.582	$0.348	$0.234	$0.000	0%
	SB21-288	Mpox Public Health Response	$2.899	$0.000	$2.893	$0.006	0%
	SB21-288	Payroll and Benefits for Public Health Response to COVID	$1.000	$0.000	$0.827	$0.173	17%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	SB21-288	Round 1: COVID-19 Public Health Response Initiatives: COVID-19 Testing	$63.901	$0.000	$0.263	$63.638	100%
	SB21-288	Round 1: COVID-19 Public Health Response Initiatives: COVID-19 Vaccination	$20.616	$0.000	$13.900	$6.716	33%
	SB21-288	Round 1: COVID-19 Public Health Response Initiatives: Other PH Expenses	$18.886	$0.000	$2.506	$16.380	87%
	SB21-288	Round 1: CTC/EITC Outreach - Prevention Services Division	$1.163	$0.002	$0.916	$0.245	21%
	SB21-288	Round 2: COVID-19 Public Health Response Initiatives: COVID-19 Vaccination	$14.975	$0.000	$12.578	$2.397	16%
	SB21-288	Round 2: COVID-19 Public Health Response Initiatives: Other COVID-19 PH Expenses	$13.823	$0.000	$13.515	$0.308	2%
	SB21-288	Round 2: COVID-19 Public Health Response Initiatives: Testing - BinaxNOW	$4.000	$0.000	$0.000	$4.000	100%
	SB21-288	Round 2: Naloxone Bulk Purchase Fund	$1.813	$0.000	$1.813	$0.000	0%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	SB21-288	Round 3: COVID-19 Public Health Response Initiatives: COVID-19 Testing	$41.202	$0.505	$34.825	$5.872	14%
	SB21-288	SERVE Colorado/AmeriCorps Healthcare Staffing Surge	$6.000	$4.565	$0.678	$0.757	13%
	SB22-147	Behav Hlth Srvcs Children	$1.500	$1.147	$0.057	$0.296	20%
	SB22-181	Round 2: Mental Health Service Corps and Scholarships for Addiction Counselors	$20.000	$0.020	$6.521	$13.459	67%
	SB22-182	Round 2: CTC/EITC Outreach - Prevention Services Division	$1.945	$0.202	$1.743	$0.000	0%
	SB22-182	Round 3: CTC/EITC Outreach - Prevention Services Division	$2.055	$0.600	$0.080	$1.375	67%
	SB22-226	Programs to Support Healthcare Workforce	$35.000	$16.159	$0.879	$17.962	51%
	HB22-1326	Round 3: Naloxone Bulk Purchase Fund	$19.700	$13.881	$5.656	$0.163	1%
	HB22-1326	Fentanyl Test Strips for Rural and Marginalized Communities	$0.300	$0.263	$0.034	$0.003	1%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	HB22-1326	Harm Reduction Grant Program	$6.000	$1.875	$0.129	$3.996	67%
	SB23-214	Department of Public Health and Environment Revenue Replacement for FY 2023-24	$24.394	$9.840	$10.435	$4.119	17%
	Direct Allocation to Agency	Emerging Infections Programs	$2.600	$0.331	$1.569	$0.700	27%
	Direct Allocation to Agency	Emerging Infections Programs: Surveillance and Reporting - CRRSA	$0.700	$0.001	$0.571	$0.128	18%
	Direct Allocation to Agency	Emerging Infections Programs: Surveillance and Reporting - Sequencing	$1.900	$0.133	$0.300	$1.467	77%
	Direct Allocation to Agency	Epidemiology and Lab Capacity (ELC) Advanced Molecular Detection/AMD Tech	$4.100	$0.014	$0.514	$3.572	87%
	Direct Allocation to Agency	Epidemiology and Lab Capacity (ELC) Healthcare Assoc Infection Prevention(SHARP)	$6.000	$0.306	$0.874	$4.820	80%
	Direct Allocation to Agency	Epidemiology and Lab Capacity (ELC) Mitigating COVID in Homeless Service Sites	$1.400	$1.075	$0.150	$0.175	12%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	Direct Allocation to Agency	Epidemiology and Lab Capacity (ELC) Strengthening Public Health Lab Prep	$0.285	$0.000	$0.042	$0.243	85%
	Direct Allocation to Agency	Epidemiology and Lab Capacity (ELC) Support for Screening Testing	$173.500	$61.330	$69.650	$42.520	25%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) AMD Tech 1	$0.245	$0.000	$0.008	$0.237	97%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) CARES Funding	$10.400	$0.000	$6.292	$4.108	39%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Community Surveillance	$0.500	$0.000	$0.454	$0.046	9%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Confinement Facilities	$11.760	$3.199	$2.507	$6.054	51%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Data Modernization	$2.796	$0.491	$0.585	$1.720	62%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Enhancing Detection	$159.500	$8.776	$145.258	$5.466	3%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Enhancing Detection Expansion	$331.745	$63.271	$146.495	$121.979	37%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Long Term Care (STRIKE)	$3.700	$0.475	$2.229	$0.996	27%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Project Firstline	$1.400	$0.174	$0.731	$0.495	35%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Public Health Lab Prep 1	$1.030	$0.000	$0.747	$0.283	28%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Skilled Nursing Facilities (STRIKE)	$3.760	$0.475	$2.217	$1.068	28%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Travelers Health 1	$0.937	$0.261	$0.225	$0.451	48%
	Direct Allocation to Agency	Epidemiology and Laboratory Capacity (ELC) Travelers Health 2	$0.937	$0.085	$0.085	$0.767	82%
	Direct Allocation to Agency	Funding for COVID-19 Public Health Crisis	$12.920	$0.300	$12.430	$0.190	1%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	Direct Allocation to Agency	Funding the Public Health Workforce	$34.700	$8.450	$13.340	$12.910	37%
	Direct Allocation to Agency	Funding to Address COVID-19 Health Disparities	$22.580	$1.579	$4.164	$16.837	75%
	Direct Allocation to Agency	Hospital Preparedness Program 1	$0.859	$0.000	$0.758	$0.101	12%
	Direct Allocation to Agency	Hospital Preparedness Program 2	$2.014	$0.00	$1.712	$.302	15%
	Direct Allocation to Agency	Hospital Preparedness Program-Ebola 1	$0.300	$0.000	$0.300	$0.00	0%
	Direct Allocation to Agency	Hospital Preparedness Program-Ebola 2	$0.350	$0.00	$0.338	$0.012	3%
	Direct Allocation to Agency	Immunization Cooperative Agreements- COVID Vaccine 1	$5.380	$0.082	$4.447	$0.851	16%
	Direct Allocation to Agency	Immunization Cooperative Agreements- COVID Vaccine 2	$43.830	$4.148	$35.779	$3.903	9%

Funding Type	Bill Number	Program Name	Appropriation	Encumbered	Expended	Unencumbered ($)	Unencumbered (%)
	Direct Allocation to Agency	Immunization Cooperative Agreements- Flu	$2.215	$0.000	$2.074	$0.141	6%
	Direct Allocation to Agency	Immunization Cooperative Agreements- Health Equity 1	$29.660	$9.131	$11.321	$9.208	31%
	Direct Allocation to Agency	Immunization Cooperative Agreements- Health Equity 2	$30.580	$2.780	$0.593	$27.207	89%
	Direct Allocation to Agency	Immunization Cooperative Agreements- Vaccine Confidence	$4.227	$0.000	$3.038	$1.189	28%
	Direct Allocation to Agency	Mental Health Disaster Assistance and Emergency Mental Health	$12.500	$0.000	$10.188	$2.312	18%
	Direct Allocation to Agency	Title X National Family Planning Services Telehealth Grant	$0.700	$0.330	$0.340	$0.030	4%
	Direct Allocation to Agency	WIC Fruit and Vegetable Benefit / Program Modernization	$3.834	$0.000	$3.834	$0.000	0%
		Subtotal	***$1,259.666***	***$216.616***	***$620.865***	***$422.185***	***34%***
		TOTAL	**$1,275.816**	**$217.136**	**$634.791**	**$423.889**	***33%****

*Unencumbered percentages are inflated due to the FEMA reimbursement process. Some ARPA has not been reallocated with the risk of certain expenses not being FEMA eligible due to the timing of match changes and the public health emergency ending.

Appendix A
Health Facilities Cash Funds

General Licensure Cash Fund

Entity Type	Current Fee			Increase 8.01% For FY 2024-25			New Fee as of 7/1/24		
Type of fee	Base	Bed	Cap	Base	Bed	Cap	Base	Bed	Cap
Chapter 2 - General Licensure Standards (29 Facilities)									
Initial License	$376.22			$30.14			$406.36		
Renewal License	$376.22			$30.14			$406.36		
Conditional License	$1,567.57			$125.56			$1,693.13		
Provisional License	$1,045.05			$83.71			$1,128.76		
Change of Ownership	$376.22			$30.14			$406.36		
Change in Licensed Capacity	$376.22			$30.14			$406.36		
Change of Name	$78.38			$6.28			$84.66		
Chapter 4 - General Hospitals (92 Facilities)									
Initial License									
1-25 beds	$8,360.40			$669.67			$9,030.07	$0.00	$0.00
25-50 beds	$10,450.50			$837.09			$11,287.59	$0.00	$0.00
51-100 beds	$13,063.14			$1,046.36			$14,109.50	$0.00	$0.00
101 and above				$0.00			$0.00	$0.00	$0.00
(Base / Per bed/ Cap)	$10,241.50	$52.25	$20,901.02	$820.34	$4.19	$1,674.17	$11,061.84	$56.44	$22,575.19
Certified Long Term Hospital							$0.00	$0.00	$0.00
(Base / Per bed/ Cap)	$5,956.78	$52.25	$10,973.03	$477.14	$4.19	$878.94	$6,433.92	$56.44	$11,851.97
Renewal License							$0.00	$0.00	$0.00
Deemed 1-50 beds (Base/per bed)	$846.49	$12.54		$67.80	$1.00		$914.29	$13.54	$0.00
Non -Deemed 1-50 beds (Base/per bed)	$940.54	$12.54		$75.34	$1.00		$1,015.88	$13.54	$0.00
Deemed 51-150 beds (Base/per bed)	$1,316.76	$12.54		$105.47	$1.00		$1,422.23	$13.54	$0.00
Non -Deemed 51-150 beds (Base/per bed)	$1,463.07	$12.54		$117.19	$1.00		$1,580.26	$13.54	$0.00
Deemed 151 + beds (Base/per bed/Cap)	$1,881.09	$12.54	$8,360.40	$150.68	$1.00	$669.67	$2,031.77	$13.54	$9,030.07
Non -Deemed 151 + beds (Base/per bed/Cap)	$2,090.10	$12.54	$8,360.40	$167.42	$1.00	$669.67	$2,257.52	$13.54	$9,030.07
Change of Ownership	$2,612.62			$209.27			$2,821.89	$0.00	$0.00
Provisional License	$2,612.62			$209.27			$2,821.89	$0.00	$0.00
Off campus Location - CAH	$522.52			$41.85			$564.37	$0.00	$0.00
Off campus Location	$1,045.05			$83.71			$1,128.76	$0.00	$0.00
Off Campus Location - Deemed	$470.25			$37.67			$507.92	$0.00	$0.00
Off Campus Renewal	$522.52			$41.85			$564.37	$0.00	$0.00
Off Campus removal	$376.22			$30.14			$406.36	$0.00	$0.00
Chapter 5 - Nursing Care Facilities (231 Facilities)									
Initial License	$6,270.31			$502.25			$6,772.56		
Renewal License							$0.00		
Certified (Base/Per bed)	$1,672.08	$8.36		$133.93	$0.67		$1,806.01	$9.03	
Non Certified (base/Per bed)	$3,636.78	$8.36		$291.31	$0.67		$3,928.09	$9.03	
Change of ownership	$6,270.31			$502.25			$6,772.56		
Opening a Secure Unit	$1,672.08			$133.93			$1,806.01		
Chapter 8 - Facilities for Persons with Intellectual or Developmental Disabilities (151 Facilities)									
Initial License									
Community Residential Home	$2,612.62			$209.27			$2,821.89		
Intermediate Care Facility	$6,270.31			$502.25			$6,772.56		
Renewal License				$0.00			$0.00		
Community Residential Home	$391.90			$31.39			$423.29		
Intermediate Care Facility	$1,672.08			$133.93			$1,806.01		
Change of ownership				$0.00			$0.00		
Community Residential Home	$2,612.62			$209.27			$2,821.89		
Intermediate Care Facility	$6,270.31			$502.25			$6,772.56		
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers (84 Facilities)									
Initial License									
Community Emergency Center	$2,873.89			$230.20			$3,104.09		
Clinic Operating Inpatient Beds	$2,873.89			$230.20			$3,104.09		
Clinic Operated under auspices of DOC	$2,612.62			$209.27			$2,821.89		
Clinic serving Un/Under Insured	$1,254.06			$100.45			$1,354.51		
Other Clinic	$2,508.13			$200.90			$2,709.03		
Renewal License				$0.00			$0.00		
Community Emergency Center	$1,410.82			$113.01			$1,523.83		
Clinic Operating Inpatient Beds	$1,410.82			$113.01			$1,523.83		
Clinic Operated under auspices of DOC	$1,358.57			$108.82			$1,467.39		
Clinic serving Un/Under Insured	$627.03			$50.23			$677.26		
Other Clinic	$1,254.06			$100.45			$1,354.51		
Change of Ownership				$0.00			$0.00		
Community Emergency Center	$3,239.65			$259.50			$3,499.15		
Clinic Operating Inpatient Beds	$3,239.65			$259.50			$3,499.15		
Clinic Operated under auspices of DOC	$2,612.62			$209.27			$2,821.89		
Clinic serving Un/Under Insured	$1,306.31			$104.64			$1,410.95		
Other Clinic	$2,612.62			$209.27			$2,821.89		

Chapter 10 - Rehabilitation Hospitals (5 Facilities"]									
Initial License	$5,956.78	$52.25	$10,973.03	$477.14	$4.19	$878.94	$6,433.92	$56.44	$11,851.97
Renewal License	$1,672.08	$12.54	$8,360.40	$133.93	$1.00	$669.67	$1,806.01	$13.54	$9,030.07
Change of Ownership	$2,612.62			$209.27			$2,821.89		
Provisional License	$2,612.62			$209.27			$2,821.89		
Chapter 13 - Freestanding Emergency Departments									
Initial License	$6,150.00			$492.62			$6,642.62		
Renewal License	$3,400.00			$272.34			$3,672.34		
Change of Ownership	$3,300.00			$264.33			$3,564.33		
Chapter 15 - Dialysis Treatment Clinics (81 Facilities)									
Initial License	$5,371.56			$430.26			$5,801.82		
Renewal License							$0.00		
1-12 stations	$1,672.08			$133.93			$1,806.01		
13-23 stations	$2,633.53			$210.95			$2,844.48		
24 = Stations	$3,589.75			$287.54			$3,877.29		
Change of Ownership	$5,371.56			$430.26			$5,801.82		
Chapter 18 - Psychiatric Hospitals (12 Facilities]									
Initial License	$5,956.78	$52.25	$10,973.03	$477.14	$4.19	$878.94	$6,433.92	$56.44	$11,851.97
Renewal License	$1,672.08	$12.54	$8,360.40	$133.93	$1.00	$669.67	$1,806.01	$13.54	$9,030.07
Change of Ownership	$2,612.62			$209.27			$2,821.89		
Provisional License	$2,612.62			$209.27			$2,821.89		
Chapter 19 - Hospital Units									
Initial License (Base/Per procedure room/Cap)	$5,538.77	$52.25	$10,973.03	$443.66	$4.19	$878.94	$5,982.43	$56.44	$11,851.97
Renewal License	$1,672.08	$12.54	$3,135.15	$133.93	$1.00	$251.13	$1,806.01	$13.54	$3,386.28
Change of Ownership	$2,612.62			$209.27			$2,821.89		
Provisional License	$2,612.62			$209.27			$2,821.89		
Chapter 20 - Ambulatory Surgical Center and ASC with a Convalescent Center (142 Facilities)									
Initial License									
ASC	$6,897.34			$552.48			$7,449.82		
ASC with Convalescent	$7,273.55			$582.61			$7,856.16		
Add Convalescent to existing	$376.22			$30.14			$406.36		
Renewal License				$0.00					
Non Deemed ASC	$1,504.88	$209.01	$3,135.15	$120.54	$16.74	$251.13	$1,625.42	$225.75	$3,386.28
Deemed ASC	$1,354.39	$209.01	$3,135.15	$108.49	$16.74	$251.13	$1,462.88	$225.75	$3,386.28
Additional fee for a convalescent center	$376.22			$30.14			$406.36		
Renewal Fee cap for a ASC with Convalescent	$3,511.37			$281.26			$3,792.63		
Change of Ownership				$0.00					
ASC	$4,284.70			$343.20			$4,627.90		
ASC with Convalescent	$4,660.92			$373.34			$5,034.26		
Provisional License									
ASC	$2,612.62			$209.27			$2,821.89		
ASC with Convalescent	$2,988.84			$239.41			$3,228.25		
Chapter 21 - Hospices (96 Facilities)									
Initial License	$6,656.97			$533.22			$7,190.19		
Initial License if no other licensed hospice within 60 miles	$4,336.96			$347.39			$4,684.35		
Renewal									
Base Fee	$4,075.70			$326.46			$4,402.16		
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld and providing 75 percent of services outside those counties	$2,508.13			$200.90			$2,709.03		
Fewer than 2,000 annual patients per most recent Medicare cost report	$1,567.57			$125.56			$1,693.13		
Fewer than 1,000 annual patients per most recent Medicare cost report	$783.79			$62.78			$846.57		
Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area and licensed as one entity.	$6,688.32			$535.73			$7,224.05		

Assisted Living Cash Fund

Entity Type	Current Fee			Increase percentages For FY 2024-25			New Fee as of 7/1/24		
					0.0801				
Type of fee	Base	Bed	Cap	Base	Bed	Cap	Base	Bed	Cap
Chapter 7 - Assisted Living Residences									
Initial License - 3-8 Beds	$6,300.00			$504.63	$0.00	$0.00	$6,804.63	$0.00	$0.00
Initial License - 9-19 Beds	$7,300.00			$584.73	$0.00	$0.00	$7,884.73	$0.00	$0.00
Initial License - 20-49 Beds	$8,750.00			$700.88	$0.00	$0.00	$9,450.88	$0.00	$0.00
Initial License - 50-99 Beds	$11,550.00			$925.16	$0.00	$0.00	$12,475.16	$0.00	$0.00
Initial License - 100 + Beds	$14,750.00			$1,181.48	$0.00	$0.00	$15,931.48	$0.00	$0.00
Qualifying Disproportaionate share	$3,000.00			$240.30	$0.00	$0.00	$3,240.30	$0.00	$0.00
				$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Renewal License	$360.00	$103.00		$28.84	$8.25	$0.00	$388.84	$111.25	$0.00
Renewal for High Medicaid Utilization	$360.00	$38.00		$28.84	$3.04	$0.00	$388.84	$41.04	$0.00
Secure Unit	$350.00			$28.04	$0.00	$0.00	$378.04	$0.00	$0.00
Change of Ownership				$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3-19 Beds	$6,250.00			$500.63	$0.00	$0.00	$6,750.63	$0.00	$0.00
20-49 Beds	$7,800.00			$624.78	$0.00	$0.00	$8,424.78	$0.00	$0.00
50-99 beds	$10,600.00			$849.06	$0.00	$0.00	$11,449.06	$0.00	$0.00
100 + Beds	$13,700.00			$1,097.37	$0.00	$0.00	$14,797.37	$0.00	$0.00
Additional facilities in one transaction	$4,500.00			$360.45	$0.00	$0.00	$4,860.45	$0.00	$0.00
New Secure Unit	$1,600.00			$128.16	$0.00	$0.00	$1,728.16	$0.00	$0.00
Change of administrator	$500.00			$40.05	$0.00	$0.00	$540.05	$0.00	$0.00
Change in Address	$75.00			$6.01	$0.00	$0.00	$81.01	$0.00	$0.00
Change in Licensed Capacity	$500.00			$40.05	$0.00	$0.00	$540.05	$0.00	$0.00
Change of Name	$75.00			$6.01	$0.00	$0.00	$81.01	$0.00	$0.00

Home Care Agency Cash Fund

Entity Type	Current Fee	Increase 8.01% For FY 2024-25	New Fee as of 7/1/24
Type of fee	Base	Base	Base
		0.0801	
Chapter 26 - Home care agencies			
Initial License Class A	$3,000.00	$240.30	$3,240.30
Initial License Class B	$2,200.00	$176.22	$2,376.22
Renewal License - Class A	$1,550.00	$124.16	$1,674.16
Renewal License - Class B	$1,325.00	$106.13	$1,431.13
Additional Volume Fee 50-99	$100.00	$8.01	$108.01
Additional Volume Fee Over 100	$200.00	$16.02	$216.02
Medicare discount	-$100.00	-$8.01	-$108.01
Deeming discount	-10.00%	-0.80%	-10.80%
Branch Fee	$200.00	$16.02	$216.02
Workstation Fee	$50.00	$4.01	$54.01
Change of Ownership Class A	$3,000.00	$240.30	$3,240.30
Change of Ownership Class B	$2,200.00	$176.22	$2,376.22
Change of address	$75.00	$6.01	$81.01
Change of Name	$75.00	$6.01	$81.01

COLORADO
Department of Public Health & Environment

Joint Budget Committee Hearing

Jill Hunsaker Ryan, MPH
Executive Director

December 20, 2023

CDPHE BUDGET THEMES FY 24-25

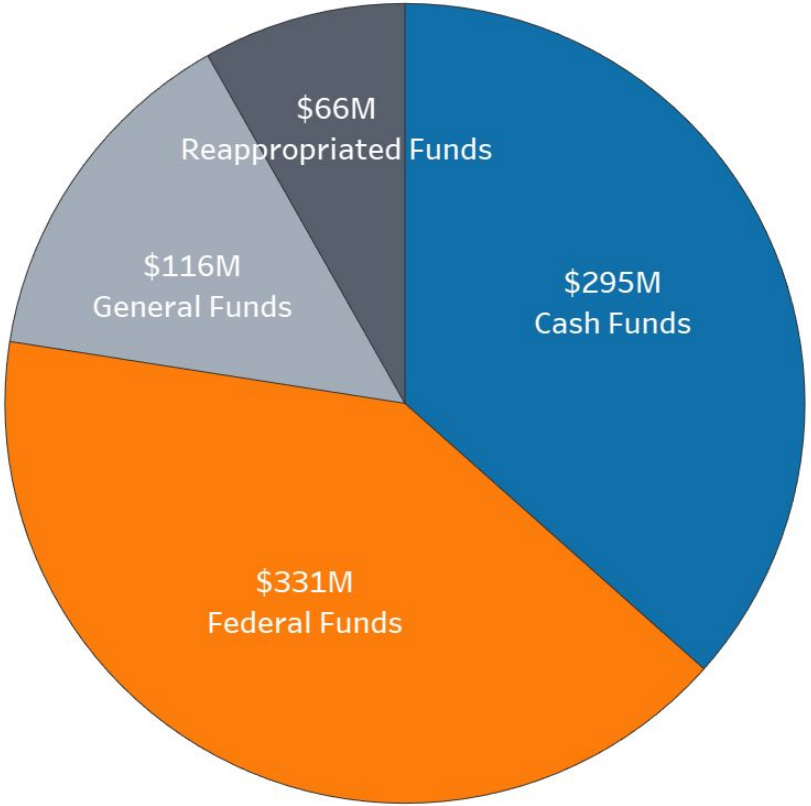
A continuation of our journey to **modernize, right size,** and **financially sustain** the Agency.

-Technology upgrades
-Maintaining minimum staffing levels with right expertise
-Using process improvement too to assure efficiency
-Adapting to our changing environment

What's Changed over 10-20 Years

- The department is much more complex with new programs and 1700 staff
- Colorado's population has grown by nearly 23 percent or 1.3 million people.
- Our risks are different today:
  - A doubling of the non-COVID reportable diseases cases over 10 years (from 9,362 to 18,694) and a drastic increase in diseases like syphilis
  - COVID-19 and other emerging diseases like Mpox
  - Pandemic precursors like the worldwide prevalence of Highly Pathogenic Avian Influenza
  - Climate change
  - PFAS water contamination
  - Gun violence and mass shootings
  - Two new ozone standards and federal downgrades of air quality
  - Wildland fires/Marshall fire
  - Environmental justice
  - Health care system challenges post COVID
  - Migrants
  - Homeless

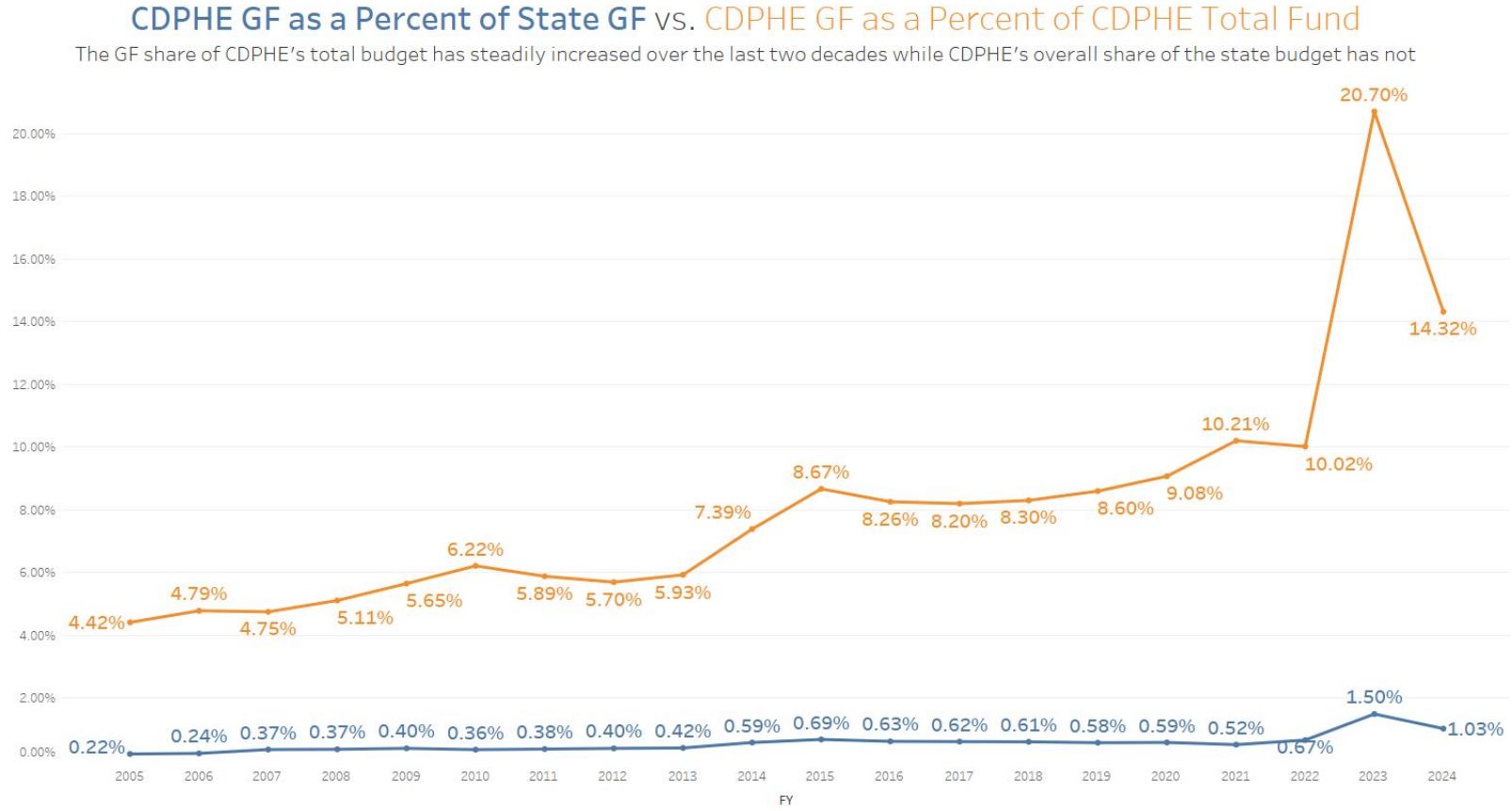
FY24 Budget (Current Long Bill)



*GF Exempt is immaterial

$808 million total funds

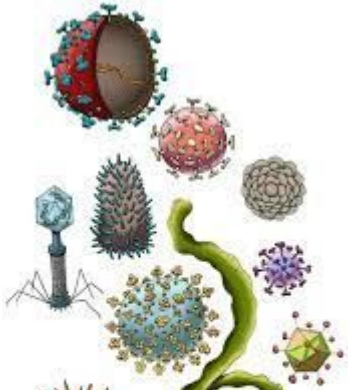
Historical Appropriation



CDPHE Budget Highlights

R-01: Public Health Infrastructure

Public Health Infrastructure:
Fills gaps, responds to needs



R-01:A Continuation of SB 21-243 "Appropriation Public Health Infrastructure"

- $15.0 million General Fund: $7.5M for distributions to local public health agencies and $7.5M to CDPHE for disease control, laboratory, communications, public health response, and administrative functions, safety net services for LPHAs.

R-12 Provider Rate Increase ($300,000 GF and $30k CF)

- Add these Local Public Health Agencies Infrastructure Dollars to the annual provider rate adjustment to keep up with inflation (assuming a $7.5M continuation from SB21-243).

R-02 Stationary Sources

Air Quality

R-02 Stationary Sources Control Fund Stabilization

- $6.5M in fee increases; $15M transfer of Energy and Carbon Management Commission (ECMC) funds (Additional transfers of $7.5M ECMC proposed in FY25 and FY26 if ECMC reserve targets are met).
- Will allow the state to continue making progress towards federal and state requirements and goals associated with ozone pollution, monitoring efforts with air toxics and ozone precursors, climate change, and modernize outdated technologies.

R-03 Health Facility Licensure

Assuring Quality of Care:
Community Based and Residential Care Facilities

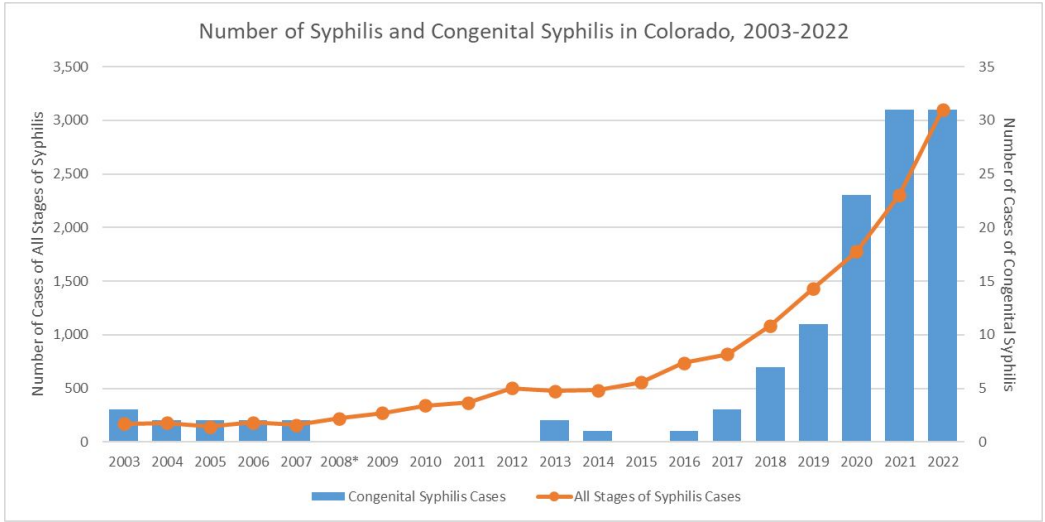
R-03 Sustainable Funding for Health Facility Licensure (Cash Fund Relief)

- $2.2M GF, $0.4M CF spending authority and 1.8 FTE to provide a long-term funding mechanism for health facilities programs that license most health facilities in the state (over 2,400)
- The Department seeks an annual CPI-based fee increase and ongoing General Fund to meet regular surveying and complaint inspection needs. The FTE are additional surveyors to support the programs.

R-04 State Syphilis Response

R-04 State Syphilis Response Investment

- $2.0M GF in FY25-FY28 to launch a state syphilis response program that increases access to testing and screening, develops a field-delivered therapy program, and increases access to treatment and prevention medications through an access delivery program.



R-05: Colorado's State Public Health Laboratory

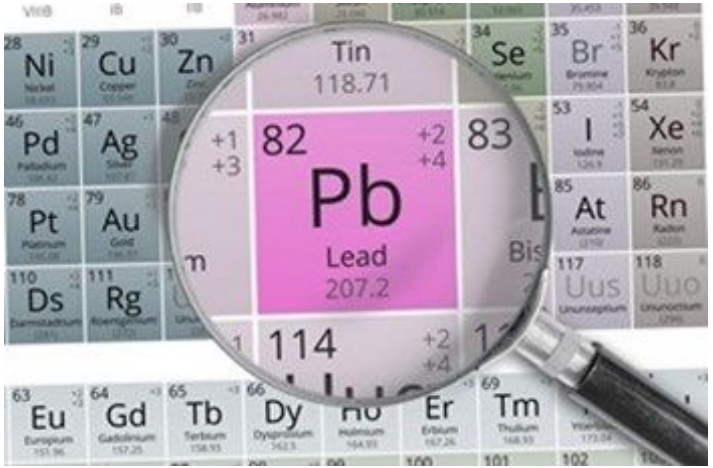
Operating: Courier, waste disposal, supply distribution compliance software

- **R-05:** Operating costs of Colorado's State Public Health Laboratory: $1.3M GF and $1.4M CF spending authority to cover State Lab operating expenses including courier services, biological and chemical waste disposal, distribution of supplies, and regulatory compliance software

R-08 Lead Testing Support

- $1.3M GF for outreach and education for healthcare providers and lead testing equipment and resources for LPHAs to improve lead testing rates in high-risk children

- Not related to legislation, expanding work currently funded by a small, restrictive CDC grant



R-07,09 Environmental Justice Requests

R-09 Office of Health Equity and Environmental Justice ($194k GF; $1.1M CICF; $2.0M RF)	R-07 Advancing EJ and Enforcement ($920k GF)
• Mainly technical DI to realign Environmental Justice Program staff with appropriate funding sources and provide transparency in the Long Bill • 5.5 new FTE to address grant requirements and Environmental Justice Action Task Force recommendations	• Addresses recommendations in SB21-181 report on health disparities and MOU with EPA Region 8 on advancing justice in enforcement and compliance • Includes additional resources for enforcement, compliance, and community engagement in the Air, Water, and Hazardous Waste Divisions

In Conclusion

Thank you!