Joint Budget Committee

Staff Budget Briefing
FY 2025-26

Department of Health Care Policy and Financing

(Excluding Behavioral Health and Office of Community Living)

JBC Working Document - Subject to Change

Staff Recommendation Does Not Represent Committee Decision

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December 11, 2024

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Contents

ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2024 legislative session that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy24-25apprept.pdf

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

Overview: Health Care Policy and Financing

The Department helps pay health and long-term care costs for low-income and vulnerable people. Federal matching funds assist with these costs. In return for the federal funds, the Department must follow federal rules for program eligibility, benefits, and other features. Major programs administered by the Department include:

- **Medicaid** -- serves people with low income and people needing long-term care
- **Children's Basic Health Plan** -- provides low-cost insurance for children and pregnant women with income slightly higher than Medicaid allows
- **Old Age Pension Health and Medical Program** that serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare

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

Recent Appropriations

Health Care Policy and Financing: Recent Appropriations

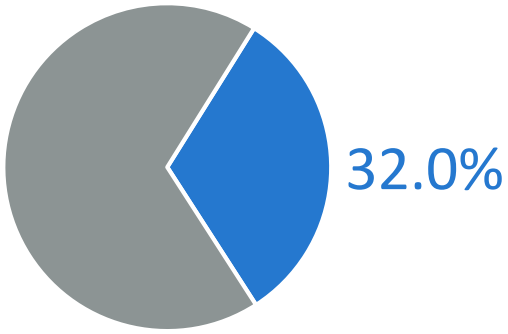
Funding Source	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26*
General Fund[1]	$3,675,376,287	$4,467,260,980	$4,988,234,973	$5,410,393,152
Cash Funds	1,858,468,793	1,750,664,426	1,790,865,897	1,956,787,771
Reappropriated Funds	95,031,721	117,280,880	137,606,638	118,914,926
Federal Funds	9,054,693,848	8,672,401,300	9,043,840,556	9,911,000,256
Total Funds	$14,683,570,649	$15,007,607,586	$15,960,548,064	$17,397,096,105
Full Time Equivalent Staff	745.0	805.5	844.5	844.8

* Requested appropriation

[1] Includes General Fund Exempt

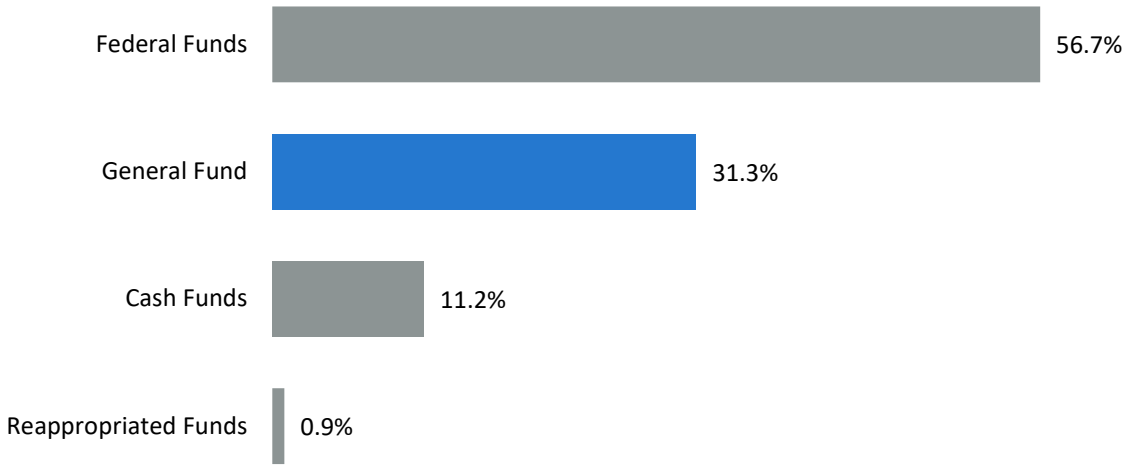
Graphic Overview

Department's Share of Statewide General Fund



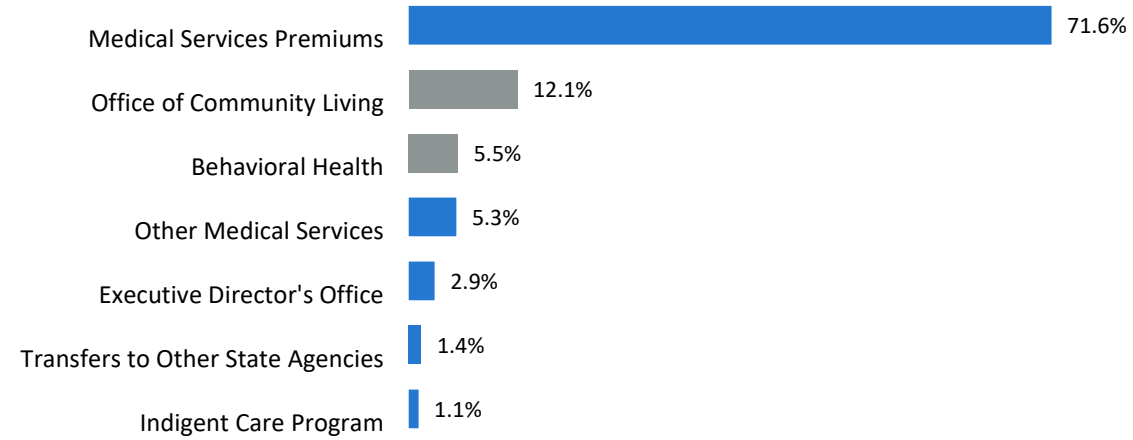
Based on the FY 2024-25 appropriation.

Department Funding Sources



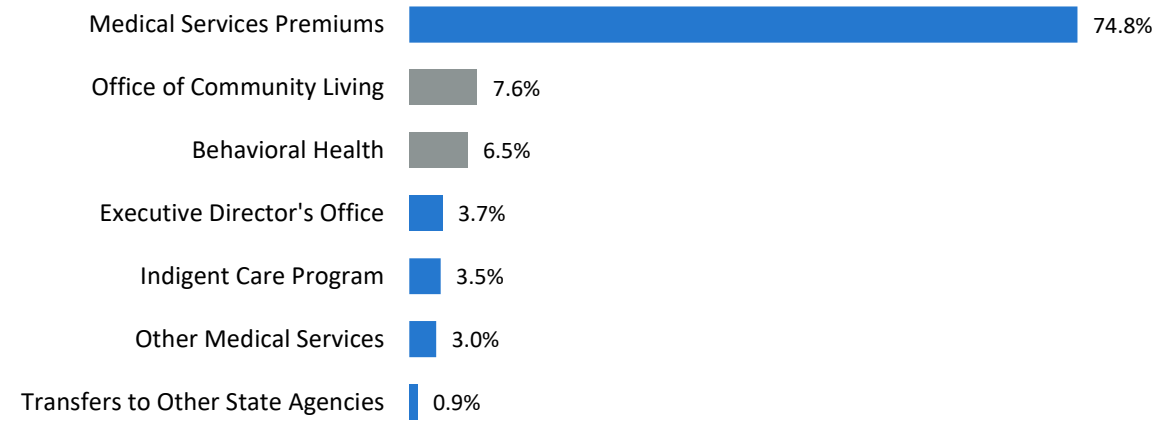
Based on the FY 2024-25 appropriation.

Distribution of General Fund by Division



Based on the FY 2024-25 appropriation.

Distribution of Total Funds by Division



Based on the FY 2024-25 Appropriation

Cash Funds Detail

Cash Funds Appropriation Detail				
Fund Name	FY 24-25 Approp.		Primary Sources	Primary Uses (in this Department)
Healthcare Affordability and Sustainability (HAS) Fee Cash Fund	1,298,262,989	[1]	Hospital fees	Increase hospital reimbursements ($619M); eligibility expansions ($504M); General Fund relief ($16M); and admin related to the above ($47M)
Certified public expenditures	180,033,206	[1]	Local government expenditures for Medicaid that are certified by the state as eligible for a federal match	Reimbursements to school districts ($100M), emergency medical transport providers ($50M), and hospitals, nursing homes, and Connect for Health ($30M)
Tobacco taxes	65,660,721	[1]	Tobacco taxes to: Health Care Expansion Fund ($45M); Primary Care Fund ($18M); Tobacco Tax Cash Fund ($2M); Tobacco Ed Programs ($1M)	Eligibility and benefit expansions and primary care grants
Recoveries and recoupments	76,933,040	[1]	Recoveries from overpayments, 3rd party insurance, and estates	Offset the cost of Medicaid services
Nursing Facility Fee; Service Fee Fund	58,596,824		Fees on nursing for the elderly and for people with intellectual and developmental disabilities	Increase nursing provider reimbursements
Adult Dental Fund	45,489,526		Unclaimed Property Trust Fund	Adult dental benefit
Local funds	19,254,185	[1]	County funds	County administration of eligibility determinations for health benefits
HCBS Improvement Fund	18,465,455	[1]	Time-limited federal stimulus funds	Improvements to Home- and Community-Based Services that support the elderly and people with disabilities living at home
Children's Basic Health Plan Trust	14,529,950	[1]	Tobacco settlement and annual premium fees	Children's Basic Health Plan (marketed as the Child Health Plan Plus or CHP+)
Old Age Pension Health and Medical	10,000,000	[1]	Constitutional allocation from General Fund	Offsets Medicaid costs for people who qualify for the state old age pension
Marijuana Tax Cash Fund	1,500,000	[1]	Marijuana taxes	Screening, Brief Intervention, and Referral to Treatment (SBIRT) training grant program
Intergovernmental transfer from Denver Health	700,000		Payment from Denver Health	Increase payments to private nursing facilities for admitting difficult to discharge patients from hospitals
Breast & Cervical Cancer Prev & Treatment Fund	682,637		Specialty license plate surcharge and interest on tobacco settlement	Breast and cervical cancer prevention and treatment
HCPF Fund	625,749		Federally required provider enrollment fees	Offset to administration
Nursing Home Penalty Cash Fund	131,615		Civil penalties for violating state and federal regulations	Administration and emergency closures
Medicaid Buy-in	0		Premiums from people with disabilities who "buy-in"	Offsets Medicaid services for people with disabilities
Total	$1,790,865,897			

[1] Exempt from TABOR.

Additional Detail for Select Funds

Exempt from TABOR: Much of the Department's cash funds are exempt from TABOR. The bullets below describe the reason for each exemption:

- HAS Fee is exempt as part of an enterprise
- Certified public expenditures are exempt from the state's TABOR limit because they are expenditures by local governments; they might be subject to local TABOR limits
- Tobacco taxes supporting HCPF are exempt by voter approval; not all tobacco taxes are exempt, but these are
- Recoveries and recoupments from overpayments were counted against the TABOR limit when the money was first collected but not again when it is returned; 3rd party insurance and estate recoveries are offsets to what the Department owes
- Local funds are exempt from the state's TABOR limit because they are expenditures by local governments; they might be subject to local TABOR limits
- HCBS Improvement Fund is exempt because it was originally federal funds
- Children's Basic Health Plan Trust receives mostly tobacco settlement revenue that is exempt as part of a court-ordered settlement; the much smaller premium revenue is subject to TABOR
- Old Age Pension Health and Medical revenues were counted against the TABOR limit when the General Fund was collected but not a second time when the constitution diverts the General Fund to this purpose
- Marijuana Tax Cash Fund is exempt by voter approval

Healthcare Affordability and Sustainability (HAS) Fee Cash Fund: The HAS Fee is the largest source of cash funds for the Department. Hospitals pay fees that are matched with federal funds and returned with the federal funds to the hospitals through supplemental payments. The Department makes supplemental payments in proportion to the indigent care provided. Fees paid might not match supplemental payments received. In addition, a portion of the HAS Fee pays for expansion populations (primarily for adults without children and higher income parents). To the extent hospitals serve the expansion populations, they receive Medicaid and CHP+ reimbursements. The General Assembly designated the HAS Fee a TABOR enterprise, exempting the revenue from TABOR. The enterprise's board sets the fees annually to maximize supplemental payments while not exceeding federal regulatory limits.

Nursing Facility Fee; Service Fee Fund: These two fees operate similar to the HAS Fee to increase federal funds for providers. The fees are not currently part of an enterprise. Making them an enterprise would use similar legal arguments to making the HAS Fee an enterprise. The General Assembly created the HAS Fee in a way that did not adjust the TABOR base.

Adult Dental Fund: The adult dental benefit is financed with transfers from the Uncalimed Property Trust Fund to the Adult Dental Fund. When a TABOR refund is due, funding the adult dental benefit with General Fund costs the same as transfers from the Unclaimed Property Trust Fund (UPTF). A transfer from the UPTF contributes to TABOR revenue and the General Fund obligation for a TABOR refund. The State Treasurer otherwise holds money in the UPTF for

claims. If the General Assembly expects consistent TABOR refunds, replacing the UPTF transfer with General Fund would simplify appropriations, improve budget transparency, and increase the UPTF available for claims.

Intergovernmental transfer from Denver Health: When a TABOR refund is due, this transfer from Denver Health costs the same as paying General Fund to nursing facilities for admitting difficult to discharge patients. The transfer from Denver Health contributes to TABOR revenue and the General Fund obligation for a TABOR refund. Denver Health would otherwise use the money for operations. If the General Assembly expects consistent TABOR refunds, replacing the UPTF transfer with General Fund would save money for Denver Health, simplify appropriations, and improve budget transparency.

Medicaid Buy-in: During the pandemic the Department suspended premiums for people with disabilities who want to buy-in to Medicaid. The premiums restart July 2025 and the Department projects annual revenues of $6.7 million. The premiums offset service costs that are otherwise paid from the HAS Fee and federal funds. The Governor proposes enterprising the buy-in to exempt the revenue from TABOR.

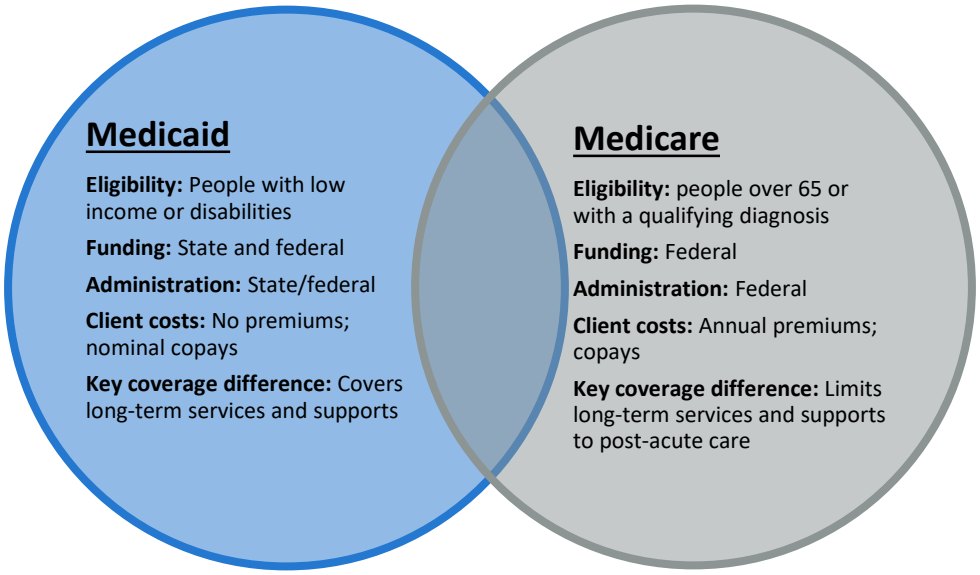
General Factors Driving the Budget

Medicaid

Medicaid provides health insurance to people with low income or disabilities. Participants do not pay annual premiums[1]. Copayments are either nominal or not required. The federal and state government share the cost and administration.

Medi**caid** differs from the similarly named Medi**care**. Medicare provides insurance for people who are elderly or with a specific eligible diagnosis regardless of income. The federal government administers Medicare and finances it with federal funds and annual premiums.

Some people qualify for both Medicaid, due to their income, and Medicare, due to their age. For people dually eligible, Medicaid pays the Medicare premiums and may help with copayments, depending on the person's income. Medicaid covers some services not covered by Medicare. Most notably, Medicaid covers long-term services and supports (LTSS) while Medicare limits coverage to post-acute care. Nearly all Medicaid clients over 65 and some younger Medicaid clients with disabilities qualify for Medicare.



The federal government matches state expenditures for Medicaid. The match rate varies based on economic conditions in the state, the type of service provided, the population served, and federal policies.

The federal match for state fiscal year 2024-25 for most Colorado Medicaid expenditures is 50.00 percent. Colorado received a higher federal match during the public health emergency

[1] A voluntary "buy-in" program for people with disabilities with income up to 400 percent of the federal poverty guidelines requires a premium.

for COVID-19. Small changes in the federal match rate drive large changes in state expenditures.

Standard Medicaid Federal Match					
State Fiscal Year	Ave. Match	Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	50.00	50.00	50.00	50.00	50.00
FY 19-20	53.10	50.00	50.00	56.20	56.20
FY 20-21	56.20	56.20	56.20	56.20	56.20
FY 21-22	56.20	56.20	56.20	56.20	56.20
FY 22-23	55.90	56.20	56.20	56.20	55.00
FY 23-24	51.00	52.50	51.50	50.00	50.00
FY 24-25	50.00	50.00	50.00	50.00	50.00
FY 25-26	50.00	50.00	*50.00*	*50.00*	*50.00*

Italicized figures are projections.

States receives a 90.0 percent federal match for adults newly eligible through the federal Affordable Care Act. For Colorado this includes adults without children with income to 138 percent of the federal poverty guidelines and parents with income from 69 percent to 138 percent of the federal poverty guidelines.[2]

Medicaid operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits[3]. If the eligible population and/or services utilized exceed the appropriation, then the state and federal government must pay the higher cost. The Department has statutory authority to overexpend the Medicaid appropriation for this purpose[4].

Medicaid effectively covers people to 138 percent of the federal poverty guidelines, after accounting for federally required income disregards, or an annual income of $20,783 for an individual and $35,632 for a family of three. The Medicaid eligibility limits are slightly higher for children and pregnant women and if these populations earn income above the Medicaid limits they can still qualify for the Children's Basic Health Plan up to effectively 265 percent of the federal poverty guidelines, or $68,423 annual income for a family of three.

Annual Income Limits for Medicaid/CHP+		
Population	Individual	Family of Three
Adults < 65	$20,783	$35,632
Children or Pregnant Women	$39,909	$68,423

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

Special Medicaid Eligibility Categories	
Category	Eligibility Standard
Adults 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit

[2] In statute the income limit is 133 percent of the federal poverty guidelines but the effective income limit is 138 percent after federally mandated standard income disregards.

[3] Except where federal waivers allow enrollment and/or expenditure caps for certain populations and services.

[4] See Section 24-75-109 (1)(a), C. R. S.

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

The table below summarizes a few key federal indexes used for determining Medicaid and CHP+ eligibility.

Key Federal Income Indexes for Eligibility		
Family Size	Federal Poverty Guideline – 2024	SSI Annual Income Limit
1	$15,060	$23,652
2	$20,440	$34,980
3	$25,820	
4	$31,200	
More	add $5,380 each	

The biggest driver of Medicaid expenditures is enrollment. Factors influencing enrollment include:

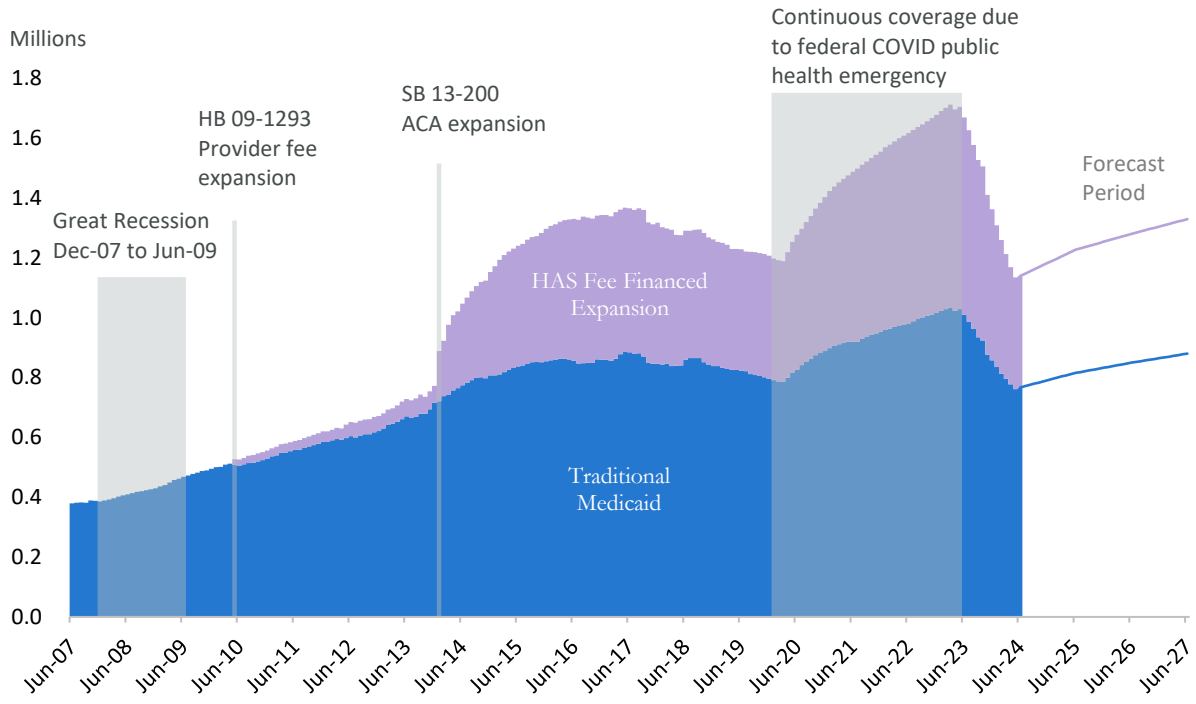
- the state population and demographics
- economic conditions that affect who meets the income eligibility criteria
- state and federal policy changes regarding eligibility

State expenditures can vary significantly based on where enrollment occurs. A provider fee on hospitals pays the state match for certain expansion populations, including adults without children and higher income parents. This provider fee, called the Healthcare Affordability and Sustainability (HAS) Fee, is exempt from TABOR as part of an enterprise. As a result, enrollment changes in the expansion populations do not impact General Fund expenditures.

General Fund expenditures are driven by the traditional Medicaid populations. These include people with disabilities, the elderly, children, and very low-income parents.

The table below shows enrollment over time separated into traditional populations and expansion populations. The chart includes labels for major events, such as eligibility expansions, recessions, and the COVID-19 public health emergency. Federal policy protected people from losing Medicaid coverage during the public health emergency for a change in income or family size.

Medicaid Enrollment of 1,139,901 as of June 2024
373,085 Healthcare Affordability and Sustainability (HAS) Fee Expansion
766,816 Traditional Medicaid (General Fund and non-HAS Fee sources)



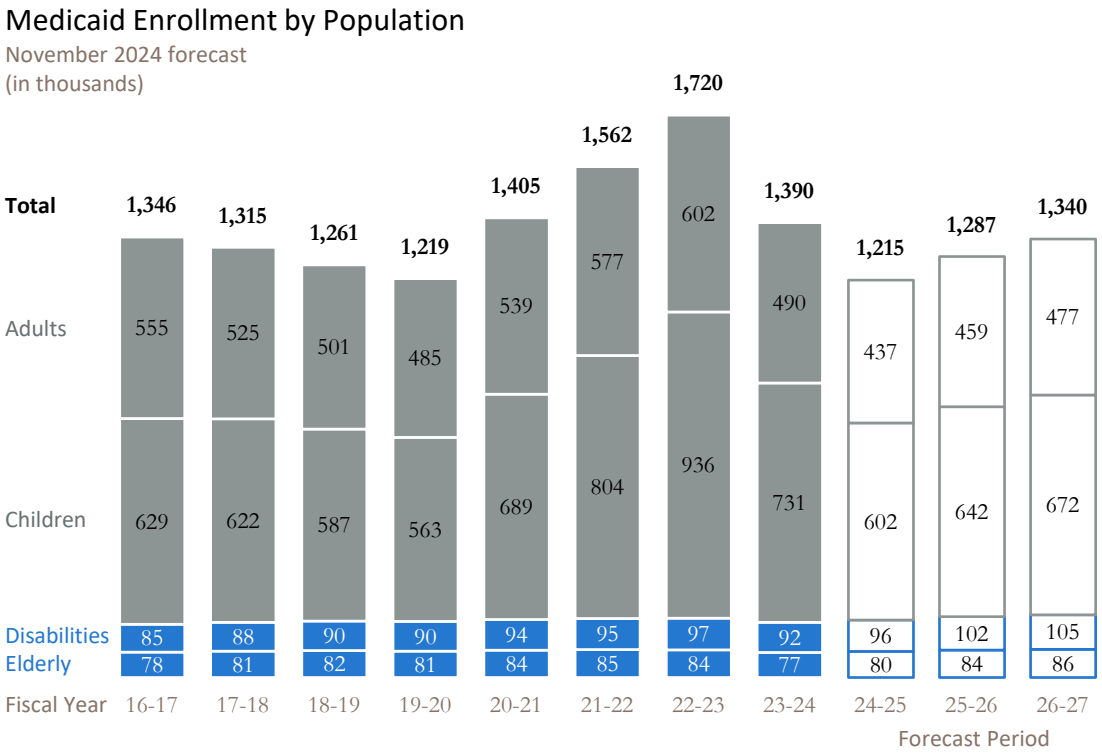
During the continuous coverage period Medicaid enrollment soared to cover nearly 30 percent of Colorado's population. The projected enrollment for FY 2024-25 is closer to 20 percent of Colorado's population. The percentage of the population enrolled in Medicaid varies significantly by county with the highest percentages in rural counties.

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

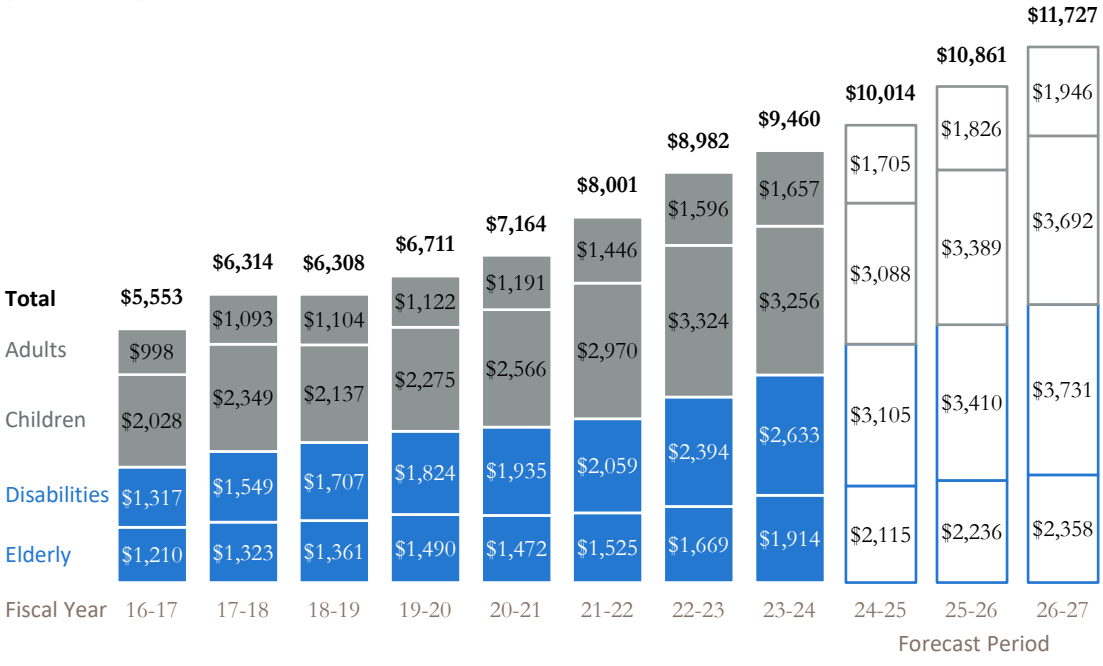
(1) Medical Services Premiums

Medical Services Premiums is a subset of Medicaid expenditures that pays for physical health care and most long-term services and supports. Medical Services Premiums can be further divided into services and special financing. Service expenditures are driven by the number of Medicaid clients, the costs of services, and the utilization of services. Special financing includes supplemental payments to providers that serve a large number of indigent patients. The category also includes miscellaneous small fund source adjustments that are not services. Special financing expenditures are more dependent on state and federal policies and limitations than on enrollment, costs, or utilization.

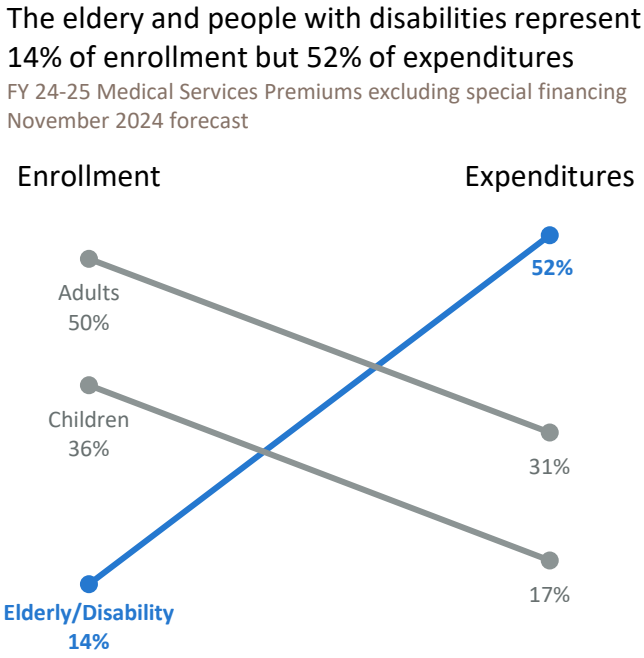
Medicaid serves a large number of low income adults and children.



However, people with disabilities and the elderly drive a disproportionate share of service expenditures.



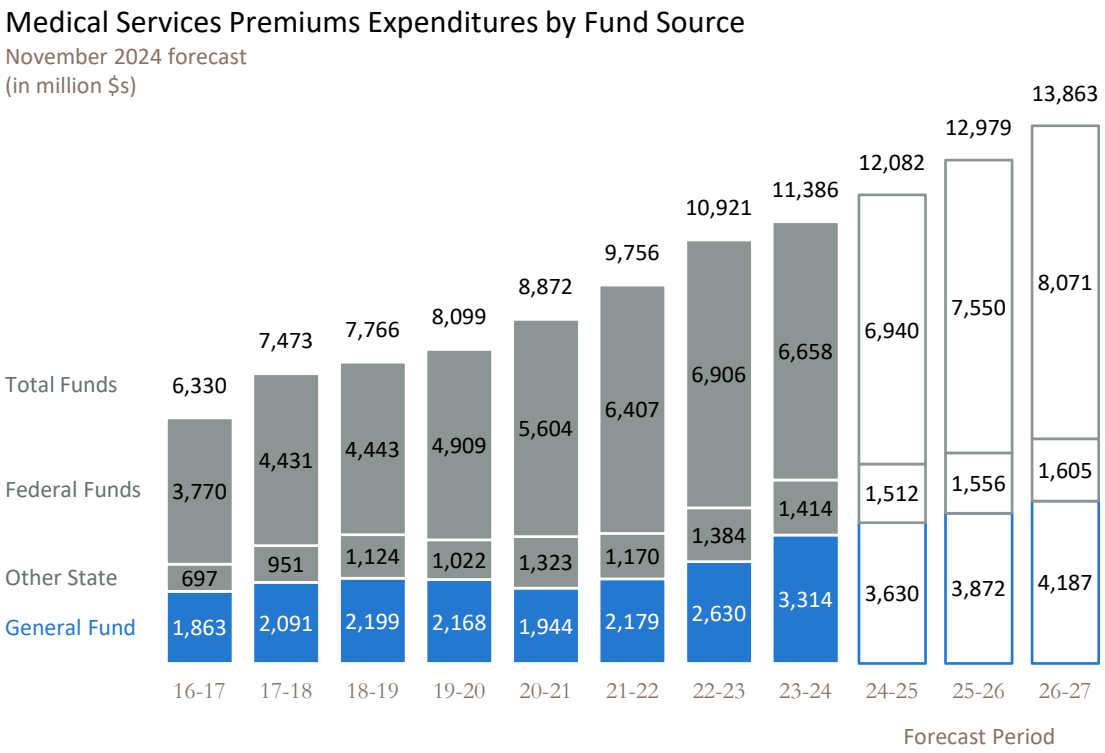
The elderly and people with disabilities represent only 14 percent of enrollment but 52 percent of service expenditures in Medical Services Premiums. This is partly due to higher acuity and medical costs but also to their utilization of long-term services and supports.



The elderly and people with disabilities represent an even larger share of General Fund expenditures. General Fund costs get reduced for some services to adults and children that receive higher federal match rates and/or cash funds. For example, there are no General Fund costs for expansion adults. In Medical Services Premiums the elderly and people with disabilities represent 14 percent of enrollment but nearly 70 percent of General Fund service costs.

In addition to acuity, long-term services and supports explain the higher costs for the elderly and people with disabilities. Long-term services and supports include nursing homes, in-home nursing assistance, in-home therapy services, and Home- and Community-Based Services (HCBS) that help people with medical needs stay at home rather than in an institution. The biggest components of HCBS are personal care and homemaker services that help with feeding, bathing, and clothing. Other parts of HCBS include transportation, adult day centers, respite care, and hospice. In Medical Services Premiums the long-term services and supports represent 35 percent of total funds and 46 percent of General Fund expenditures for services.

General Fund trends for Medical Services Premiums follow the enrollment trends for the elderly and people with disabilities more than overall enrollment. A higher federal match rate and temporary financing from the HAS Fee reduced General Fund during the public health emergency.



Special financing supports supplemental payments for providers who serve large numbers of indigent patients. The supplemental payments are in addition to what the providers normally earn from seeing Medicaid patients.

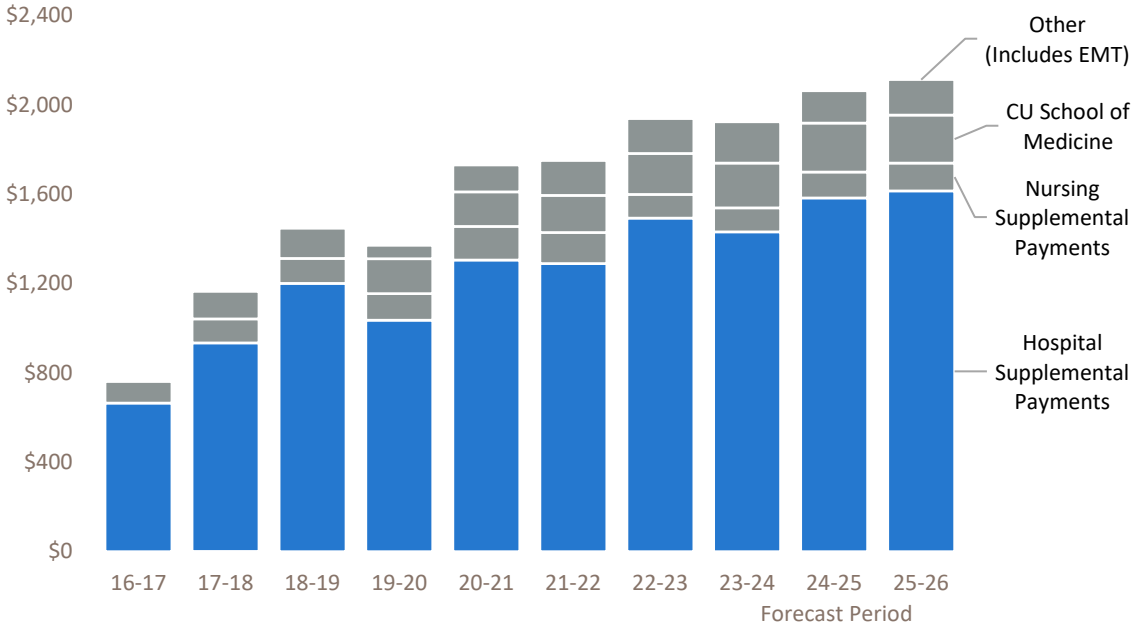
The largest supplemental payments go to hospitals. The State collects a provider fee from hospitals, called the Healthcare Affordability and Sustainability (HAS) Fee. The HAS Fee is exempt from TABOR as part of an enterprise. A portion of the HAS Fee pays for enrollment expansion. The majority of the fee matches federal funds for supplemental payments back to the hospitals based on the services they provided to indigent patients. In aggregate the hospitals earn significantly more from the supplemental payments and expansion populations than they pay through the HAS Fee. The HAS Fee collections and payments are limited by federal and state policy and often vary by state fiscal year based on the timing of federal approvals.

Other supplemental payments go to nursing homes, the University of Colorado's providers, and public emergency medical transportation providers. Nursing provider fees support supplemental payments to nursing facilities. The nursing provider fees operate similar to the HAS Fee but on a much smaller scale. Higher education funding matches federal funds for supplement payments to physicians of the University of Colorado's School of Medicine. Beginning in FY 2019-20, Colorado started certifying public expenditures by local public emergency transportation providers to draw additional federal matching funds for these providers. Federal and state policies setting parameters on these types of special financing influence expenditures more than enrollment, service utilization, or service costs.

Medical Services Premiums Special Financing Expenditures

November 2024 forecast

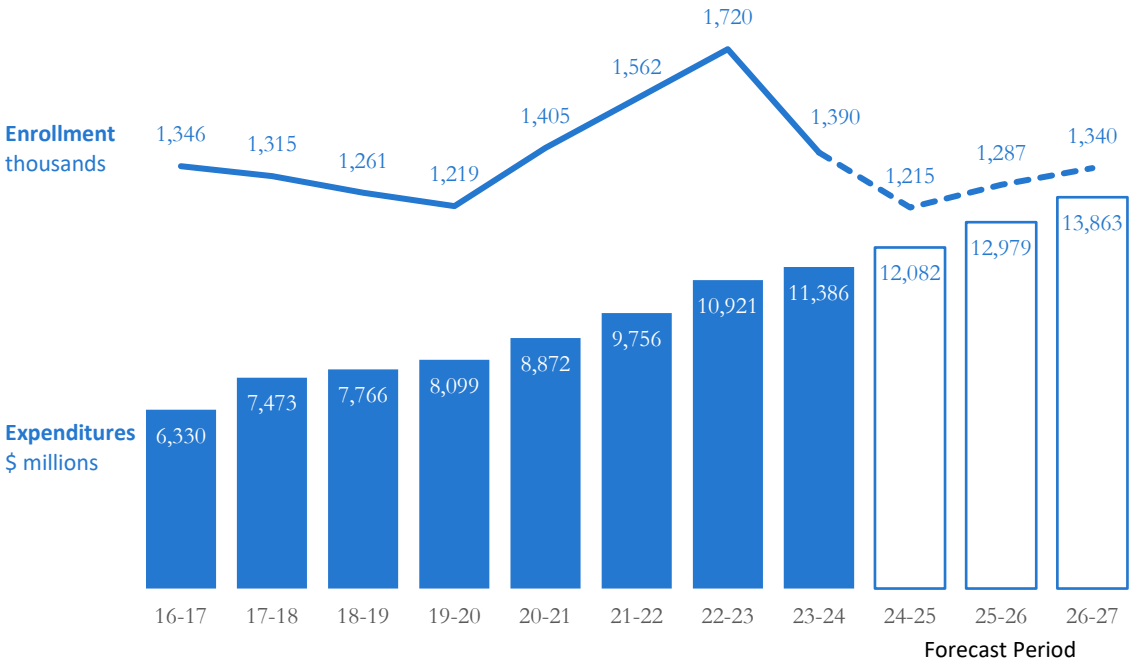
in millions



The chart below puts direct expenditures for services together with special financing and enrollment to show the full picture.

Medical Services Premiums Enrollment and Expenditures

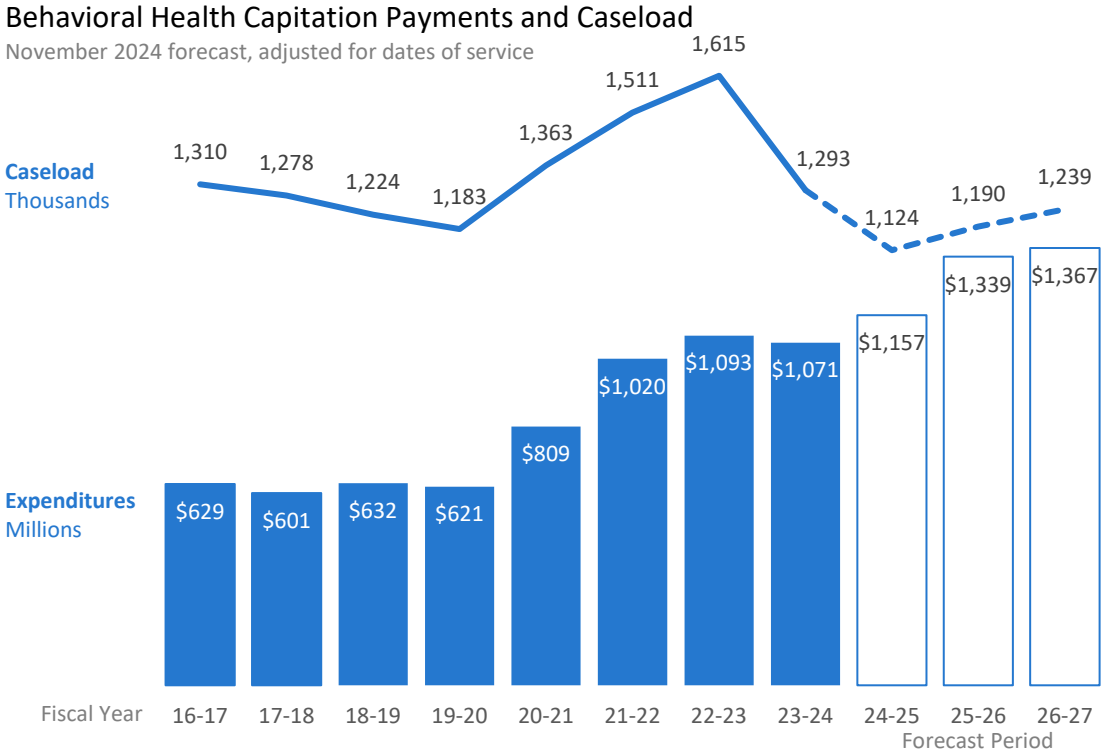
November 2024 forecast



(2) Behavioral Health Community Programs

Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Regional Accountable Entities (RAEs) to provide behavioral health services for clients enrolled with each RAE. Each RAE receives a pre-determined monthly amount for each behavioral health Medicaid client. Rates paid to each RAE are unique for each service and geographic region. These rates are periodically adjusted based on actual utilization and expenses.

Behavioral health services are primarily supported by the General Fund and federal funds. Capitated behavioral health program expenditures are driven by changes to caseload, rates, economic conditions, and services eligible for coverage. The state receives a 90 percent federal match for adults who are “newly eligible” pursuant to the federal Affordable Care Act. Services for these adults represents a significant portion of caseload, but expenditures tend to be driven by higher cost populations such as children and people with disabilities.



(3) Office of Community Living

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. As part of the waiver, Colorado is allowed to limit the number of waiver program participants resulting in a large number of individuals being unable to immediately

access the services they need. Colorado has four Medicaid waivers for individuals who qualify for intellectual and developmental disability services:

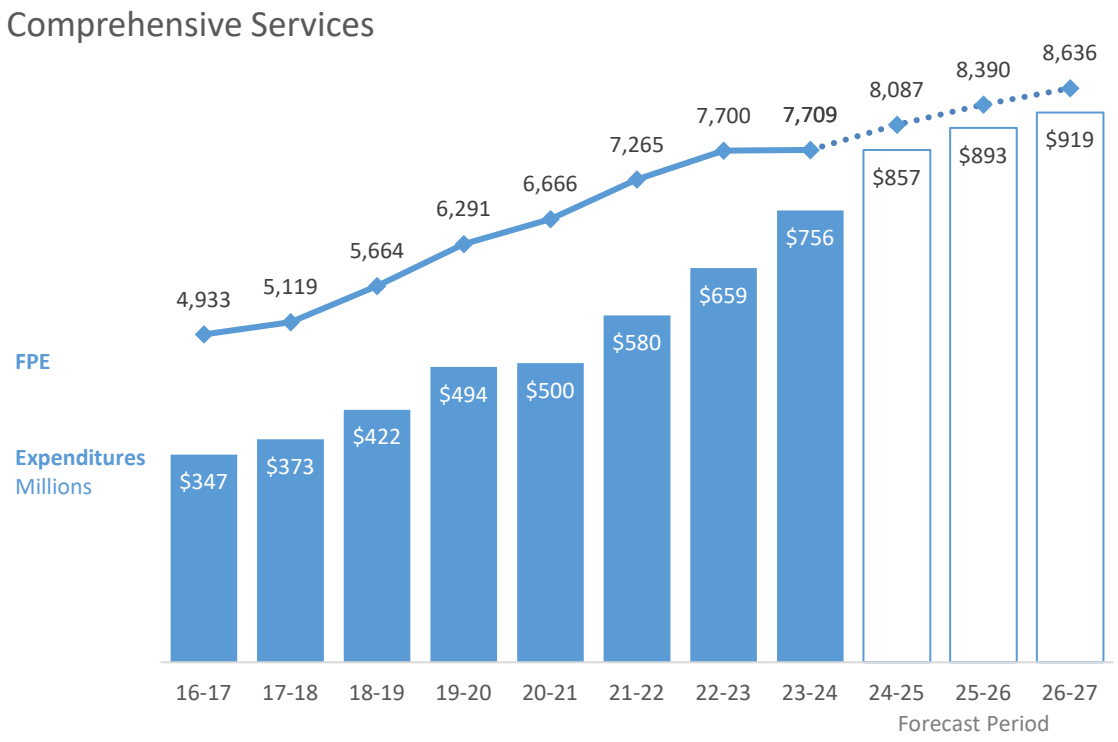
Adult Comprehensive waiver (also called the Comprehensive or Comp waiver) is for individuals over the age of 18 who require residential and daily support services to live in the community.

Supported Living Services waiver (SLS waiver) is for individuals over the age of 18 who do not require residential services but require daily support services to live in the community.

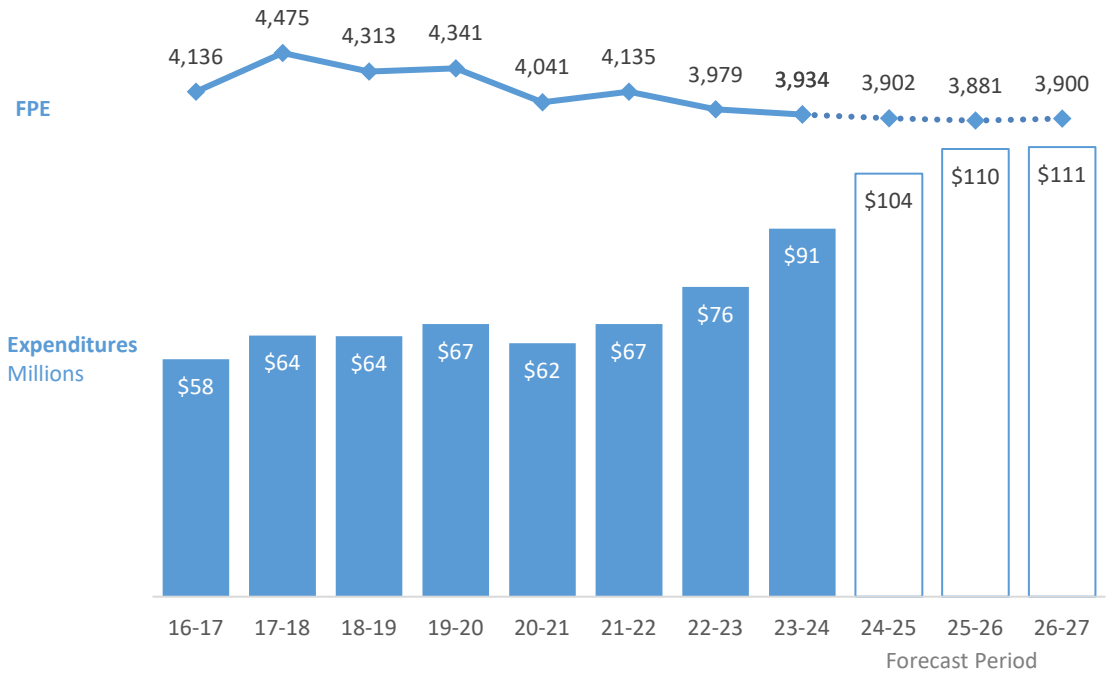
Children's Extensive Services waiver (also called the CES waiver or children's waiver) is for youth aged 5 to 18 who do not require residential services but do require daily support services to be able to live in their family home.

Children’s Habilitation Residential Services waiver (CHRP waiver) is for children with intellectual and developmental disabilities and complex behavioral support needs requiring home- and community-based services.

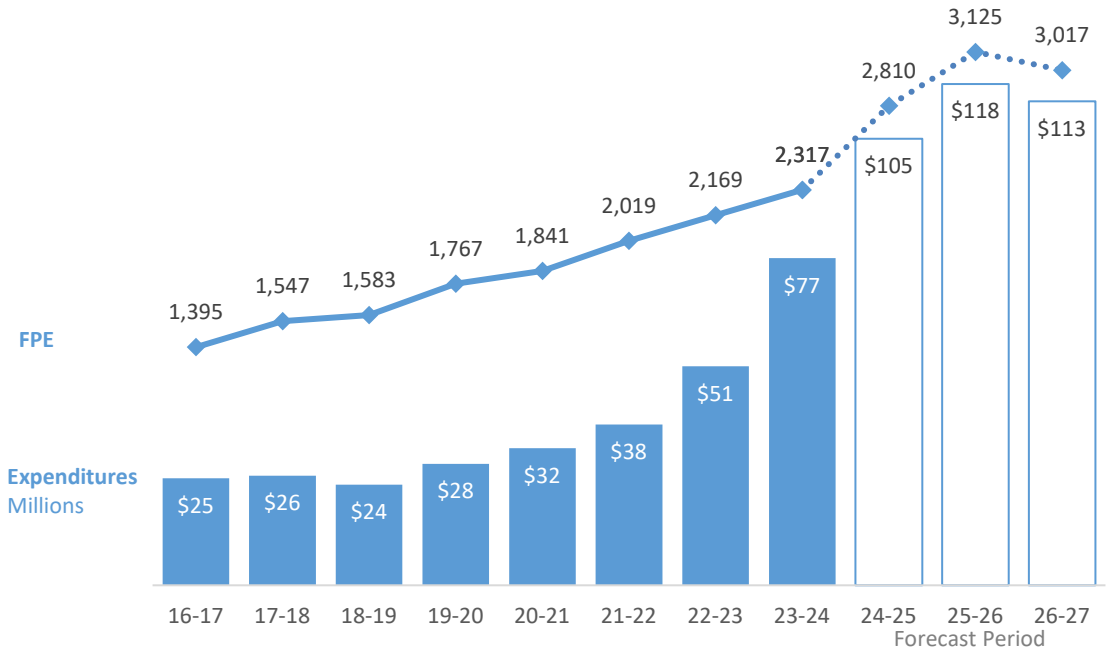
New enrollments are funded for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and to serve all individuals eligible for the Supported Living Services (SLS) and Children's Extensive Services (CES) waivers. The Adult Comprehensive wavier is the only wavier that currently has a waitlist, which stands at just above 3,000 individuals. The average number of individuals receiving services at a given time is referred to as Full Person Equivalent (FPE). The following graphs illustrate the growth in adult and children enrollments respectively.

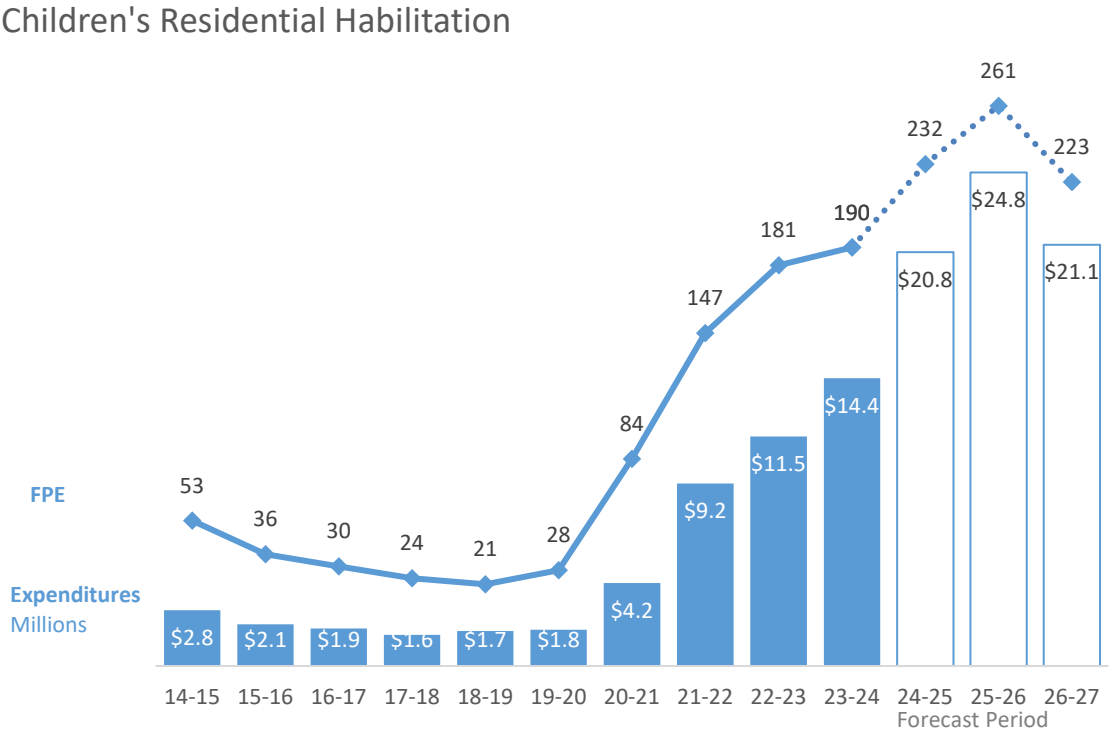


Supported Living Services



Children's Extensive Support





Please note that in the above chart, the FY 2018-19 reduction in the costs associated with CES waiver services is due to a portion of those services being moved to the Medicaid State Plan, including behavioral services, personal care, assistive technology, specialized medical equipment and supplies, and vision services.

(4) Indigent Care Program

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Participating providers agree to accept reduced payments, on a sliding scale based on income, from people enrolled in the program. In exchange, the providers receive supplemental Medicaid payments.

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

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

Related to the Indigent Care Program there is a primary care grant program financed primarily with tobacco taxes that serves a similar purpose of paying providers who treat patients

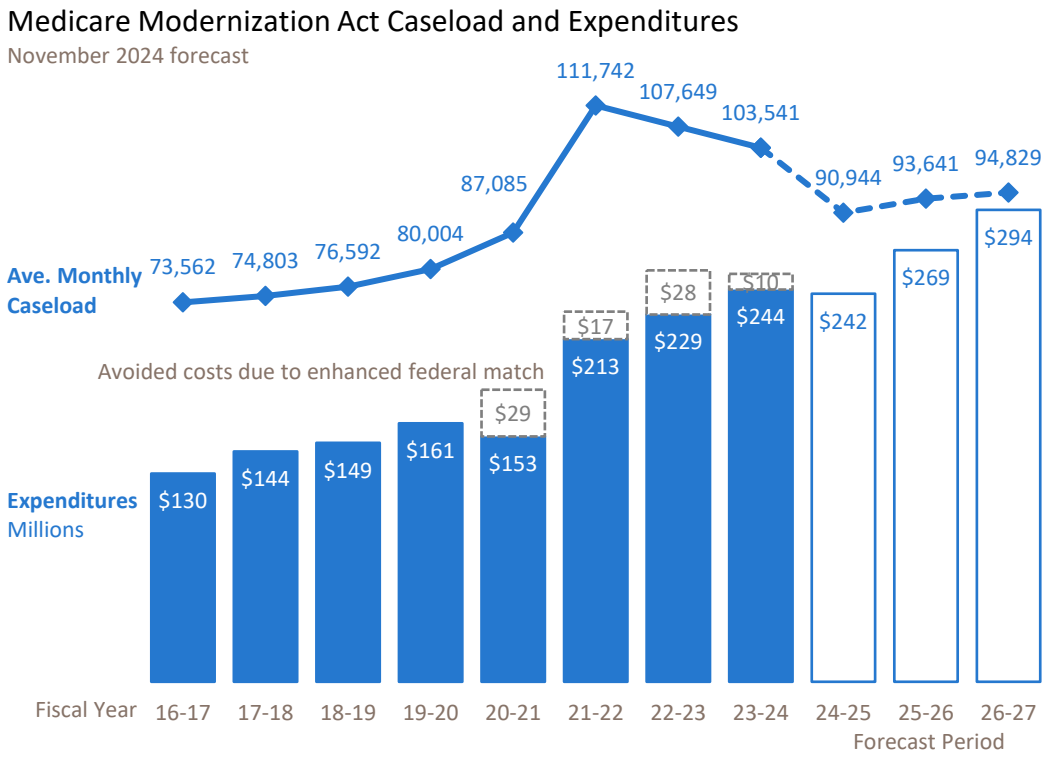
regardless of insurance using a sliding fee schedule based on income. The primary care grant program has distinct constitutional payment criteria and there are some eligible providers that do not participate in Medicaid. However, S.B. 21-212 instructed the Department to align the primary care grant program more closely with the Indigent Care Program such that almost all of the primary care payments qualified for a Medicaid match.

(5) Medicare Modernization Act

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

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

This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes.



Children's Basic Health Plan

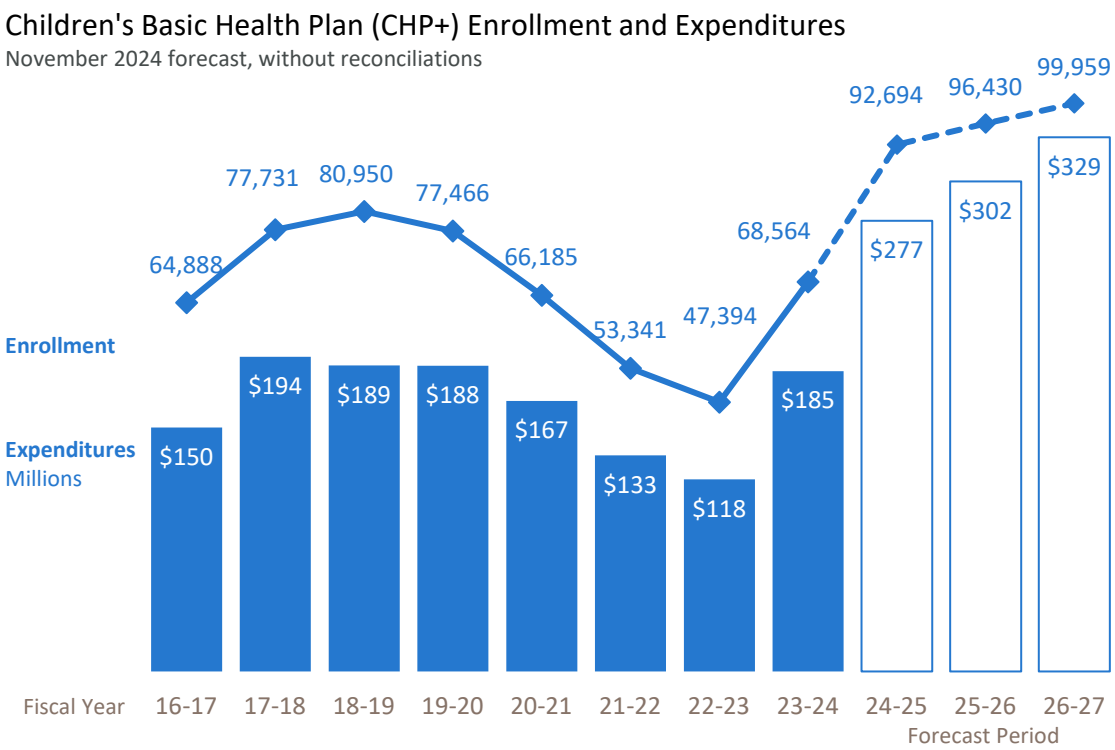
The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with more income than the Medicaid eligibility criteria allow, effectively to 265 percent[5] of the federal poverty guidelines or $68,423 annually for a family of three. Annual membership premiums are $25 for families with one child and $35 for families with two or more children. Coinsurance costs are nominal.

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

Federal funds match state funds for program costs not covered by member contributions. The federal match rate for CHP+ is derived from the standard match for Medicaid. Federal policies provided a temporary boost to the match rates for federal fiscal years 2015-16 through 2019-20. The federal match for FY 2025-26 is 65 percent

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

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


Children's Basic Health Plan (CHP+) Enrollment and Expenditures
November 2024 forecast, without reconciliations
Enrollment
Expenditures
Millions
64,888
77,731
80,950
77,466
66,185
53,341
47,394
68,564
92,694
96,430
99,959
$150
$194
$189
$188
$167
$133
$118
$185
$277
$302
$329
Fiscal Year
16-17
17-18
18-19
19-20
20-21
21-22
22-23
23-24
24-25
25-26
26-27
Forecast Period

Summary of Request

Department of Health Care Policy and Financing						
Item	Total Funds	General Fund[1]	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
H.B. 24-1430 (Long Bill)	$15,945,013,018	$4,979,207,987	$1,790,475,824	$137,606,638	$9,037,722,569	836.2
Other legislation	15,535,046	9,026,986	390,073	0	6,117,987	8.3
Total	$15,960,548,064	$4,988,234,973	$1,790,865,897	$137,606,638	$9,043,840,556	844.5
FY 2025-26 Requested Appropriation						
FY 2024-25 Appropriation	$15,960,548,064	$4,988,234,973	$1,790,865,897	$137,606,638	$9,043,840,556	844.5
R1 Medical Services Premiums	969,133,681	310,969,228	124,733,393	-716,036	534,147,096	0.0
R1b Health benefits for children lacking access due to immigration status	27,714,743	27,714,743	0	0	0	0.0
R2 Behavioral Health	255,996,379	51,266,218	19,371,605	0	185,358,556	0.0
R3 Child Health Plan Plus	29,171,107	6,130,200	4,079,687	0	18,961,220	0.0
R4 Medicare Modernization Act	24,231,765	24,231,765	0	0	0	0.0
R5 Office of Community Living	95,262,068	38,115,413	11,214,952	0	45,931,703	0.0
R6 Accountable Care Collaborative	-2,465,730	-1,254,288	275,580	0	-1,487,022	0.0
R7 Eligibility administration	38,246,175	4,137,117	5,199,974	2,155,070	26,754,014	15.7
R8 Claims systems reprocurement	1,900,121	343,562	0	0	1,556,559	16.6
R9 Provider rates	-74,557,080	-22,148,958	-6,183,380	0	-46,224,742	0.0
R10 HAS Fee admin & refinance	-4,261,930	-2,199,800	68,836	0	-2,130,966	6.4
R11 Long term care benefits	1,354,223	478,573	0	0	875,650	2.0
R12 BH and primary care integration	1,575,367	368,170	117,691	0	1,089,506	0.0
R13 Contract true up	1,028,833	433,098	0	0	595,735	0.0
R14 Convert contracts to FTE	45,546	-38,299	-20,718	239,666	-135,103	8.3
R15 Pharmacy pricing	-2,066,234	-470,433	-129,619	0	-1,466,182	0.0
R16 CF transfers & enterprise	0	-698,757	698,757	0	0	0.0
NP Equity Office realignment	74,921	74,921	0	0	0	0.0
NP CU School of Medicine	0	0	20,000,000	-20,000,000	0	0.0
Annualize prior year budget actions	59,837,169	30,392,444	-15,873,009	-41,569	45,359,303	-48.7
Centralized appropriations	7,997,947	835,699	2,320,305	-328,843	5,170,786	0.0
Transfers to other state agencies	6,328,970	2,725,669	47,820	0	3,555,481	0.0
Community First Choice	0	-49,248,106	0	0	49,248,106	0.0
Total	$17,397,096,105	$5,410,393,152	$1,956,787,771	$118,914,926	$9,911,000,256	844.8
Increase/-Decrease	$1,436,548,041	$422,158,179	$165,921,874	-$18,691,712	$867,159,700	0.3
Percentage Change	9.0%	8.5%	9.3%	-13.6%	9.6%	0.0

[1] Includes General Fund Exempt.

R1a Medical Services Premiums: The Department requests projected costs under current law and policy for Medical Services Premiums. The request costs $996.8 million total funds, including $338.7 million General Fund. Medical Services Premiums pays for physical health and long-term care. The request reflects projected changes in enrollment, utilization, and per capita costs.

R1b Health benefits for children lacking access due to immigration status: The Department requests projected costs under current law for health benefits for children lacking access due to their immigration status. The request costs $27.7 million General Fund. This is in addition to the originally estimated cost in the fiscal note for H.B. 22-1289. The JBC staff separates the amount from the rest of R1 because it funds a state program distinct from Medicaid.

R1b Health benefits for children lacking access due to immigration status	
Item	General Fund
FY 2024-25 Appropriation	$2,102,665
Annualization of H.B. 22-1289	$2,258,198
Subtotal - Original estimated cost	$4,360,863
Forecast increase in R1b	$27,714,743
Total projected program cost in FY 2025-26	$32,075,606

R2 Behavioral Health: The Department requests projected costs under current law and policy for Behavioral Health. The request costs $256.0 million total funds, including $51.3 million General Fund. Behavioral Health pays for mental health and substance use care. The request reflects projected changes in enrollment, utilization, and per capita costs.

R3 Child Health Plan Plus: The Department requests projected costs under current law and policy for the Child Health Plan Plus. The request costs $29.2 million total funds, including $6.1 million General Fund. The Child Health Plan Plus provides a health insurance option for children and pregnant women with low income. The request reflects projected changes in enrollment, utilization, and per capita costs.

R4 Medicare Modernization Act: The Department requests projected costs under current law and policy for the state obligation under the Medicare Modernization Act. The request costs $24.2 million General Fund. The Medicare Modernization Act requires state Medicaid programs to pay the federal government in lieu of covering drugs for people dually eligible for Medicaid and Medicare. The request reflects projected changes in enrollment and utilization.

R5 Office of Community Living: The Department requests projected costs under current law and policy for the Office of Community Living. The request costs $95.3 million total funds, including $38.1 million General Fund. The Office of Community Living provides services for people with intellectual and developmental disabilities. The request reflects projected changes in enrollment, utilization, and per capita costs.

R6 Accountable Care Collaborative: The Department requests a net decrease for Phase III of the Accountable Care Collaborative (ACC). The request saves a net $2.5 million total funds, including $1.3 million General fund. The ACC coordinates care for Medicaid members. The Department requests increased funding for the RAEs and various state-level costs to support the new duties of the RAEs. The Department projects offsetting savings from increased RAE support when members transition out of inpatient and residential settings and from member incentives for behavioral changes linked to better health outcomes.

R7 Eligibility administration: See the briefing for the Office of Community Living.

R8 Claims systems reprocurement: The Department requests funding for the increased complexity of using modular procurement strategies for information technology systems. The request costs $1.9 million total funds, including $343,562 General Fund, and 16.6 FTE. Federal regulations require states to use modular information technology systems. Breaking the information technology into modules theoretically allows upgrades of components when technology changes, or to address problems, without needing to replace everything. It reduces reliance on individual vendors. However, each module still needs careful design and oversight to ensure proper interaction with the other modules. More vendors mean more contracts for the Department to oversee and more responsibilities to coordinate communication and standards between the vendors. The Department is moving from 3 modules and vendors to 16 modules and at least 9 different vendors.

R9 Provider rates: The Department proposes decreasing rates above 95 percent of Medicare and for dental services and pediatric behavioral therapies. In addition, the Department proposes rebalancing rates for similar services that pay differently based on the waiver. The net impact decreases projected expenditures $74.6 million total funds, including $22.1 million General Fund.

R10 HAS Fee admin & refinance: The Department proposes repurposing unused HAS Fee to help address disproportionate funding for the existing administration and to increase administration for changes in federal requirements. The net impact would decrease appropriations $4.3 million total funds, including $2.2 million General Fund, and increase FTE by 6.4.

The unused HAS Fee is primarily due to ending the Hospital Outstationing program but includes a lower than expected disability determinations contract. The Hospital Outstationing program funded medical assistance sites within hospitals to facilitate eligibility determinations. Due to federal requirements for an onerous time survey to determine proper Medicaid reimbursement, program stakeholders decided to discontinue the program.

Funding for the Department's existing administration is not proportionate to the workload driven by the HAS Fee, because statutes limit the share of HAS Fee for administration to 3.0 percent. The General Fund makes up the difference. Expansion populations financed by the HAS Fee represent approximately 30 percent of the Medicaid population. The appropriations for Hospital Outstationing and the disability determination contract were using $3.4 million of the 3.0 percent for administration. The Department proposes applying $2.2 million of the savings toward addressing the disproportionate workload and decreasing the General Fund subsidy.

The Department proposes applying the remaining $1.2 million savings for additional staff to address increasing federal requirements related to the HAS Fee. Changes driving the increased workload include:

- new federal reporting, annual review, and approval processes for determining the upper payment limit
- in-progress audits of major components of the HAS Fee payment methodology
- revised federal policies in 2023 and 2024 on provider fee programs
- increased stakeholder challenges of payment categories and methodologies

R11 Long term care benefits: See the briefing for the Office of Community Living.

R12 BH and primary care integration: See the briefing for Behavioral Health.

R13 Contract increases: The Department requests funding to update appropriations for contract services. The request costs 1.0 million total funds, including $433,098 General Fund.

- The Department needs ongoing funding for actuarial rate analysis and program audits for the new health benefits for children and pregnant women lacking access due to immigration status authorized in H.B. 22-1289. The bill included funding for the initial rate development but not ongoing rate setting and auditing.
- The Department says low funding for screenings to ensure nursing residents receive appropriate care drives performance issues and threatens compliance with federal standards
- The Department needs to change the timing for quadrennial nursing facility appraisals that get used in rate setting due to a rate rebase in a prior year.

R14 Convert contracts to FTE: The Department proposes reducing contract services and transferring the duties to state FTE. Accounting for impacts on other departments the proposal saves $85,936 total funds, including $100,352 General Fund, statewide and adds 8.3 FTE. The specific contracts involve county expenditure reviews to ensure only allowable costs are charged to Medicaid and technical support and user acceptance testing for eligibility systems. The Department expects the changes to improve performance in addition to saving money.

R15 Pharmacy pricing: The Department proposes decreasing the rates paid for drugs with no acquisition cost data. Most pharmacy rates get indexed to measures of the average acquisition cost. Pharmacies voluntarily participate in quarterly rate surveys that determine average acquisition cost. When there is insufficient data to determine average acquisition cost, maybe because a drug is new and/or low volume, the Department indexes the rates to a measure of wholesale costs but applies a discount. The measure of wholesale costs overstates average acquisition costs but the amount varies by drug. The Department proposes increasing the discount applied to the wholesale costs. The Department anticipates the decreased reimbursement will primarily impact mail order pharmacy providers. The rates for drugs priced this way switch back to using the average acquisition cost if sufficient data becomes available.

R16 CF transfers & enterprise [requires legislation]: The Department requests:

- eliminating obsolete cash funds and using the balances to offset General Fund and
- moving the disability buy-in cash fund to an enterprise.

Using the cash fund balances saves $698,757 General Fund. Moving the disability buy-in cash fund to an enterprise allows General Fund revenues to increase an additional $6,660,761 under the TABOR limit.

The disability buy-in cash fund receives premiums from people with disabilities who elect to buy in to Medicaid. The Department suspended the premiums during the pandemic. The Department expects to begin collecting premiums again in FY 2026-27. The Healthcare Affordability and Sustainability (HAS) Fee pays the state share of service costs for the disability

buy-in program. The Department proposes that the premiums revenue go to the enterprise for the HAS Fee.

NP Equity Office realignment: See the briefing for the Department of Personnel.

NP CU School of Medicine: See the briefing for the Department of Higher Education.

Annualize prior year budget actions: The request includes adjustments for out-year impacts of prior year legislation and budget actions. In the table below the titles of the annualizations begin with either a bill number or the relevant fiscal year. For budget decisions made in the Long Bill, the title includes a reference to the priority number the Department used in that year for the initiative, if relevant. If there is no reference to a bill number or priority number, then the change was initiated by the Joint Budget Committee.

The largest increases include:

- *FY 23-24 BA7 Community-based access to services* primarily for the expected increase in utilization when long-term services and supports become available through the state plan, rather than through waivers with defined eligibility criteria. The General Fund increase is more than offset by an increase in the federal match. See the Community First Choice adjustment for the change in the federal match.
- *HB 22-1289 Health benefits children & pregnant people lacking access due to immigration status* primarily for the service costs associated with new eligibility
- *FY 24-25 R6 Provider rates* for provider rate increases. The legislature used one-time funding to pay part of the increase for Home- and Community-Based Services, explaining the large increase and General Fund and decrease in cash funds.

The largest decreases include:

- *FY 24-25 BA6 Public health emergency unwind* primarily for the phase-out of extra eligibility determination supports provided during the unwind.
- *HB 23-1228 Nursing facility rates* for a step down in the statutory nursing provider rate increases.
- *HB 24-1401 Denver Health funding* for the end of one-time funding provided to support Denver Health

Annualize prior year budget actions						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 23-24 BA7 Community-based access to services	$24,819,485	$6,817,473	$1,439,870	$0	$16,562,142	4.9
HB 22-1289 Health benefits children & pregnant people lacking access due to immigration status	15,675,769	6,115,251	7,056	0	9,553,462	-0.4
FY 24-25 R6 Provider rates	14,928,458	17,116,542	-11,777,349	0	9,589,265	0.0
HB 23-1300 Continuous eligibility	11,799,801	5,344,427	358,439	0	6,096,935	0.4
SB 23-002 Medicaid reimb community health	11,165,077	2,686,309	685,499	0	7,793,269	-0.4
FY 24-25 R10 Assessments for nursing svcs	8,394,005	2,098,501	0	0	6,295,504	0.0
HB 23-1038 High acuity crisis for children	6,276,503	3,138,252	0	0	3,138,251	0.1

Annualize prior year budget actions						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
HB 24-1045 Substance use disorder treatment	4,666,581	1,073,707	283,894	0	3,308,980	1.3
FY 24-25 New DD waiver enroll	4,063,792	2,031,895	0	0	2,031,897	0.0
SB 24-168 Remote monitoring	2,121,865	1,039,415	71,299	0	1,011,151	0.0
HB 23-1136 Prosthetic devices	1,535,399	1,687	154,127	0	1,379,585	0.0
SB 24-116 Discounted care for indigent patients	1,160,397	0	153,766	0	1,006,631	1.6
FY 24-25 BA8 Community-based access svcs	839,685	419,843	0	0	419,842	0.0
FY 2024-25 Step Plan	834,248	358,393	49,721	3,921	422,213	0.0
HB 22-1114 Transport svcs waiver clients	720,000	360,000	0	0	360,000	0.0
SB 24-175 Perinatal health	524,400	247,359	0	0	277,041	0.0
SB 24-110 Medicaid prior authorization	326,876	85,746	19,645	0	221,485	0.0
FY 24-25 R12 Administrative support	77,176	75,718	370	0	1,088	0.1
FY 24-25 NP CDPHE Medical facility oversight	69,632	31,334	0	0	38,298	0.0
FY 23-24 R12 BH Eligibility & claims	61,189	61,189	0	0	0	0.0
FY 24-25 Member correspondence	43,074	13,353	8,185	0	21,536	0.6
FY 24-25 R7 Behavioral health continuum	35,988	14,396	3,598	0	17,994	0.6
HB 22-1290 Wheelchair repairs	28,916	14,458	0	0	14,458	0.0
FY 23-24 R13 Case management redesign	22,190	2,219	0	0	19,971	0.0
FY 24-25 R8 Eligibility compliance	2,989	930	566	0	1,493	0.2
FY 23-24 R10 Children complex needs	0	884,714	-884,714	0	0	0.0
FY 24-25 BA6 Public health emergency unwind	-12,512,599	-3,173,550	-1,252,612	0	-8,086,437	-4.9
HB 23-1228 Nursing facility rates	-9,216,419	-4,608,209	0	0	-4,608,210	0.0
HB 24-1401 Denver Health funding	-5,000,000	-5,000,000	0	0	0	0.0
FY 24-25 BA11 ARPA HCBS adjustments	-4,608,068	0	-2,495,840	0	-2,112,228	-29.0
FY 24-25 Care & case management stabilization	-4,213,036	-2,104,850	0	0	-2,108,186	0.2
FY 23-24 BA8 ARPA HCBS adjustments	-3,225,336	0	-1,743,276	0	-1,482,060	-17.0
HB 22-1302 Health practice transformation	-2,967,943	-1,483,971	0	0	-1,483,972	-2.5
FY 24-25 Salary survey and step pay	-2,734,231	-1,174,586	-162,995	-12,853	-1,383,797	0.0
SB 21-038 Expand complementary & alt medicine	-1,769,323	-526,182	-358,479	0	-884,662	0.0
FY 24-25 BA7 Med transport credentials & reviews	-1,532,317	-459,695	-306,464	0	-766,158	-0.5
SB 19-197 Complementary & alt medicine	-823,855	-411,928	0	0	-411,927	-1.0
FY 23-24 BA6 Public health emergency funding	-636,287	-214,244	-103,898	0	-318,145	0.0
FY 23-24 R9 Birthing equity	-527,093	-264,260	0	0	-262,833	0.0
HB 22-1303 Residential behavioral health beds	-186,818	-93,409	0	0	-93,409	-2.0
FY 24-25 Eligibility appeals	-119,995	-37,199	-22,799	0	-59,997	-1.5
FY 23-24 NP Equity through technology	-93,460	-9,996	-714	0	-82,750	0.0
SB 24-047 Substance use disorder prevention	-75,000	-37,500	0	0	-37,500	0.0
HB 23-1197 Stakeholder oversight host homes	-75,000	-37,500	0	0	-37,500	0.0
FY 24-25 R13 Convert contractors to FTE	-31,915	228	96	-32,637	398	0.4
HB 24-1322 Medicaid housing & nutrition services	-6,670	-3,335	0	0	-3,335	0.0
FY 24-25 R9 Access to benefits	-961	-481	0	0	-480	0.1

Annualize prior year budget actions						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Total	$59,837,169	$30,392,444	-$15,873,009	-$41,569	$45,359,303	-48.7

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

Transfers to other state agencies: The Department requests funding for transfers to programs administered by other departments. The request costs $6.3 million total funds, including $2.7 million General Fund, primarily for programs administered by the Department of Human Services.

Community First Choice: The Department requests a change in fund sources to reflect the higher match rate for long-term services and supports under Community First Choice. The request saves $49.2 million General Fund. The General Assembly approved Community First Choice to move selected long-term services and supports from federal waivers that serve defined populations to the State Plan that serves all members. The Department will still use assessments to determine service needs. States that implement Community First Choice receive an additional federal match of six percentage points for the services.

Budget Reduction Options

The Executive Budget Request includes reductions of $7.3 million General Fund for the Department of Health Care Policy and Financing, representing 0.1% of the Department's General Fund appropriations. This issue brief reviews these proposals and additional options identified by staff.

Summary

- Converting nursing provider fees to an enterprise could allow the General Fund to grow another $65.2 million under TABOR. Also, it could allow an increase in fees to draw more federal funds for nursing homes.
- Using the Healthcare Affordability and Sustainability (HAS) Fee to offset General Fund could provide significant one-time General Fund relief. Negative impacts on hospitals could be mitigated by implementing a directed payment program to draw more federal funds for hospitals ongoing.
- Achieving significant further savings mostly requires reducing provider rates, limiting eligibility, or decreasing benefits. If the legislature does not want to entertain these types of changes, then it may need to look at other departments.
- There are several eligibility and benefit expansions the Department has not yet implemented, including a $32.1 million General Fund program for children lacking access to health benefits due to their immigration status.
    - There is no federal match.
    - The Fiscal Note significantly underestimated the cost.
    - If the program ended, the children could still access emergency services.

Discussion

Funding History FY 2018-19 to FY 2024-25

General Fund for the Department of Health Care Policy and Financing has increased/-decreased by 31.9 percent since FY 2018-19 after adjustments for inflation[6]. This is more than the statewide increase in General Fund appropriations of 11.3 percent over the same period after adjustments. Total funding increased 21.1 percent over the same period after adjustments.

[6] Fiscal year 2018-19 appropriations are adjusted for inflation, calculated based on the Legislative Council Staff September forecast, which reflects an increase in the Denver-Aurora-Lakewood consumer price index of 26.7 percent between FY 2018-19 and FY 2024-25.

FY 2018-19 to FY 2024-25 Appropriations Comparison - Adjusted for Inflation					
	FY 2018-19			Increase/ -Decrease after inflation adjustment	
Fund	Nominal	FY 24-25 Dollars	FY 2024-25	Amount	Percent
General Fund	$2,985,709,605	$3,781,511,176	$4,988,234,973	$1,206,723,797	31.9%
Total Funds	$10,403,998,605	$13,177,047,403	$15,960,548,064	$2,783,500,661	21.1%

Budget Requests for General Fund Relief

For this section of the budget, the budget request includes proposals for General Fund relief totaling $7.3 million, representing 0.1 percent of the General Fund appropriations. These reductions are offset by proposed increases, so that the Department/Division's total General Fund is requested to increase by 8.5 percent. The proposals for General Fund relief are summarized in the table below. Some of the proposals require statutory change.

Budget Requests for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
R16 CF Transfers & enterprise	$6,660,761	$0	Y	Make premiums for the buy-in program for people with disabilities exempt from TABOR
Statewide R1 Transfer CF interest to GF	622,220	-622,220	Y	Transfer CF interest to the GF. In HCPF the revenue is from the Nursing Home Penalty Cash Fund.
Subtotal - Revenue	$7,282,981	-$622,220		
Expenditure Reductions				
R6 Accountable Care Collaborative	-$1,254,288	-$1,211,422	N	Net of increased costs for Phase III and Dept. projected avoided costs
R9 Provider rates	-$22,148,958	-$52,408,122	N	Reduce provider rates for dental, pediatric behavioral therapies, and rates above 95 percent of Medicare
R10 HAS Fee admin & refinance	-$3,425,299	$3,425,299	N	Reallocate HAS Fee from hospital outstationing to offset General Fund. The request includes an increase in HAS administration that would reduce the General Fund savings, if approved.
R11 Long-term care benefits	-$837,083	-$720,006	N	Reductions associated with CHRP group respite services, Hospital Backup Unit eligibility expansion, and Alternative Care Facilities tiered rates
R15 Pharmacy pricing	-$470,433	-$1,595,801	N	Reduce rates for drugs lacking data to calculate the average acquisition cost
R16 CF Transfers & enterprise	-$698,757	$698,757	Y	Abolish obsolete cash funds and use balances to offset General Fund
Statewide R4 1% General Fund from program lines	-$313,581	$0	N	Combine and reduce personal services and operating lines by 1% General Fund
Statewide R5 Round to nearest $1,000	-36,973	-23,064	N	Round appropriations to the nearest $1,000. GF and CF always round down and FF always round up.

Budget Requests for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
Statewide R8 Boards & Commissions	0	0	Y	End the State Medical Assistance and Services Advisory Council. This portion of the statewide request does not save money, because federal law requires an advisory committee with slightly different requirements.
Subtotal - Expenditures	-$36,973	-$23,064		
Net General Fund Relief	$7,319,954			

To the extent the savings in "Statewide R5 Round to nearest $1,000" comes from line items with authority to overexpend, the savings is a mirage. The Department will spend what it needs to for the enrollment and utilization, regardless of the appropriation, so rounding down does not force any savings. That said, the appropriations for these lines are based on forecasts with significant margin for error. The General Assembly could safely round to a larger amount, such as the nearest $100,000 or million, and remain well within the margin of error.

Additional Options for JBC Consideration

The table below summarizes options identified by the JBC staff that the Committee could consider in addition to or instead of the options presented in the budget request.

A General Fund reduction of 5.0 percent would require a reduction of $270.5 million from the FY 2025-26 request. The FY 2025-26 request was used as the base in order to capture projected increases in expenditures under current law and policy based on enrollment and utilization trends.

The amounts listed below for eligibility and benefit changes include only differences in service costs. If the JBC adopts any of these changes, there will be some additional small savings on staff but also some one-time costs for programming, noticing, etc. The service cost savings assume the eligibility and benefit changes can be implemented for all of FY 2025-26. Ending some eligibility categories or benefits may require more time to navigate regulations, properly notice the changes, and implement needed programming updates. The JBC staff may need to refine the estimated savings as the Committee narrows the focus.

Additional Options for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
Enterprise nursing provider fees	$65,202,711	$0	Y	Convert nursing home provider fees to enterprises
Subtotal - Revenue	$65,202,711	$0		

Additional Options for General Fund Relief				
Option Expenditure Reductions	General Fund	Other Funds	Bill? Y/N	Description
Provider rates				
HAS Fee offset to General Fund	-100,000,000	0	Y	Redirect HAS Fee from supplemental payments for hospitals to instead offset General Fund
Nursing facility rates	-$5,234,773	-5,296,129	Y	Eliminate the statutory 1.5% increase for nursing
1% provider rate reduction	-$23,668,494	-$39,939,981	N	1% reduction in provider rates, excluding rates with a proposed targeted reduction
Reduce targeted rates	-$3,588,013	-$8,791,975	N	Reduce dental, pediatric behavioral therapies, and rates above 95% of Medicare by 1% instead of (or in addition to) the proposed targeted reductions
Eligibility/benefit changes				
Health benefits for children lacking access due to immigration status	-32,075,606	0	Y	Halt Medicaid and CHP+ look-alike for children lacking access due to immigration status, per H.B. 22-1289, scheduled to start 1/25
Continuous eligibility expansions	-5,613,712	-7,991,333	Y	Halt continuous coverage for children to age 3 and people to 1 year after incarceration, per H.B. 23-1300, scheduled to start 1/26
High acuity crisis for children[1]	-5,774,639	-5,774,639	Y	H.B. 24-1038 requires HCPF to expand CHRP eligibility and develop a system of care for high acuity youth. Repealing the bill would reduce General Fund in DHS by an additional $11.3 million.
Prenatal choline supplements	-247,359	-277,041	Y	Halt prenatal coverage of choline supplements without a prescription, per S.B. 24-175, scheduled to start 7/25
Antipsychotic drug prior authorization	-974,301	-2,739,898	Y	Reinstate prior authorization requirements (PARs) for antipsychotic drugs that were removed, per S.B. 24-110, in FY 24-25
Community health services	-2,729,115	-8,697,573	Y	Halt reimbursements for community health services, per S.B. 23-002, scheduled to start 7/25
Adult dental cap	-4,359,800	-18,300,284	N	Reinstate an annual cap on the adult dental benefit at $1,500 annually
Denture benefit	-2,909,548	-12,124,826	Y	Eliminate the adult denture benefit
Reproductive health for individuals not eligible for Medicaid	-3,614,490	0	Y	Eliminate (or cap) the benefit, which primarily pays for long acting reversible contraceptives for people ineligible for Medicaid due to immigration status
Telehealth remote monitoring reimbursement	-260,733	-322,821	Y	Halt reimbursements for remote patient monitoring, per S.B. 24-168, scheduled to start 7/25
Continuous glucose monitoring	-278,683	-759,628	Y	Halt coverage of continuous glucose monitors, per S.B. 24-168, scheduled to start 11/25
CHP+ children/pregnant 206-265% FPL	-43,108,681	-80,058,980	Y	Eliminate CHP+ coverage of children and pregnant women from 206%-265% FPL and repuprose the HAS Fee savings to offset GF
Comprehensive services for people with IDD[2]	-7,262,471	-7,262,470	N	Cap comprehensive services for adults with intellectual and developmental disabilities and don't fill positions that open through churn
Grants/special payments				
Telehealth Remote Monitoring Grant Program	-500,000	0	N	Halt rural grants for remote monitoring tech, per S.B. 24-168, scheduled for 7/25

Additional Options for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
SBIRT Training grants	-1,500,000	0	Y	Eliminate training grants for screening and interventions related to substance use and repurpose the MTCF to offset General Fund
Family medicine residencies	-4,520,085	-4,520,085	N	Eliminate GF and matching FF for family medicine residency training programs
Pediatric Specialty Hospital	-6,727,506	-6,727,506	N	Eliminate supplemental payments to Children's Hospital
Senior Dental Program	-3,962,510	-27,848	Y	Eliminate grants for dental care to seniors who do not qualify for Medicaid. There is no federal match.
Admin/other				
General Professional Services	-1,500,000	0	N	Reduce contract services based on reversions of $5.7 million General Fund in FY 2023-24 and $1.5 million General Fund in FY 2022-23.
Prepayment review	-5,604,621	-10,296,543	N	Increased prepayment reviews will likely decrease improper payments
Office of eHealth Innovations	-750,000	0	N	Reduce funding 20 percent for the Office of eHealth Innovations that provides technical support for technology to improve health information sharing
All-Payer Claims Database	-4,471,011	0	N	Eliminate subsidies for the All-Payer Claims Database that supports research using insurance claims
Subtotal - Expenditures	-$266,015,140	-$219,909,560		
Net General Fund Relief	$331,217,851			

[1] See the briefing for Behavioral Health

[2] See the briefing for the Office of Community Living

Revenue Enhancements

Enterprise nursing provider fees [requires legislation]

Converting the provider fees on nursing homes to enterprises could increase the General Fund the State may keep under the TABOR limit. The nursing provider fees match federal funds to support supplemental payments for nursing providers. They function similar to the fee on hospitals, called the Healthcare Affordability and Sustainability Fee (HAS Fee). There are separate provider fees for traditional nursing homes and those serving people with intellectual and developmental disabilities.

The same arguments used to make the HAS Fee an enterprise apply to the nursing provider fees. TABOR requires an adjustment to the spending limit for qualifications or disqualifications as an enterprise. However, the legislature determined that abolishing the hospital provider fee and creating a new HAS Fee enterprise to replace it did not trigger an adjustment to the spending limit.[7] A similar approach to the nursing home provider fees would allow the General Fund to grow an additional $65.2 million under the TABOR limit.

[7] Section 25.5-4-402.4 (3)(c)(I), C.R.S.

This strategy makes additional General Fund available only to the extent there is a TABOR surplus. The Legislative Council Staff and Office of State Planning and Budgeting project TABOR surpluses in FY 2025-26 of $747.3 million and $381.6 million respectively. Small decrease in the forecasts, or the accumulation of other policies that decrease TABOR revenues, could reduce or eliminate the budget balancing utility of this strategy.

In addition to saving General Fund, converting the nursing fees to an enterprise could allow the state to maximize the fees and draw an additional $28.5 million federal funds to support nursing homes. Under current law and revenue projections, increasing the fees to the federal maximum would increase the General Fund obligation for a TABOR refund. In an enterprise, the fees could be increased to the maximum with no TABOR impact. Federal law limits the nursing fees to 6.0 percent of net patient revenues. The current fees are 3.9 percent of net patient revenues.

Increasing the fees to the maximum would likely require six to twelve months for federal approval, plus whatever time the Department needs to redesign the fees and supplemental payments. Maximizing the federal funds would require removing a state statutory exemption for nursing providers with the Continuing Care Retirement Community designation. Also, the legislature would likely want to adjust the fee structure to mitigate the impacts on non-Medicaid providers who do not receive the benefits. The current supplemental payments prioritize behavioral health supports and quality incentives. If the legislature wants to change those priorities with an increase in supplemental payments, then that might add implementation time.

At least 20 states collect nursing fees over 5.5 percent of net patient revenues, according to a 2017 Kaiser Family Foundation report. This compares to Colorado's nursing fees equal to 3.9 percent of net patient revenues.

If nursing fees grow slower than the TABOR growth rate, then keeping the nursing fees in the TABOR base allows the state to retain more General Fund. Conversely, if nursing fees grow faster than the TABOR growth rate, then they crowd out General Fund.

The Department expects nursing rates will grow faster than TABOR but with low confidence due to changing consumer habits. State statute calculates the primary nursing fee by multiplying non-Medicare bed days by a per diem that increases annually by a federal nursing home inflation metric. This is similar, but not exactly the same, as the inflation metric used for TABOR. The other part of both the TABOR and nursing fee equations is population. From 2016 to 2020 the nursing population grew roughly 0 percent. In 2021 the patient population decreased 18.5 percent due to COVID. The patient population has grown slightly more than 1 percent per year since 2021. Looking forward, the State Demographer projects the population age 75+ will increase 5 percent per year, or 4-5 times faster than Colorado's overall population. However, the Department continues to see consumers choosing community-based services over nursing homes.

The state could potentially create other provider fees to increase federal funds for classes of providers, but this would not generate additional General Fund budget relief. Models exist in other states for ambulance service and managed care provider fees. Administering provider

fees can be time intensive and burdensome. The Department argues provider fees work best when applied to large, long-term, and stable organizations.

Provider rates

HAS Fee offset to General Fund [requires legislation]

The legislature could redirect the Healthcare Affordability and Sustainability Fee (HAS Fee) from hospital supplemental payments to instead offset General Fund for Medicaid. The HAS Fee is an assessment on hospitals. The revenue from the HAS Fee matches federal funds and gets used for: supplemental payments to increase hospital reimbursements; eligibility expansions; and associated administrative expenses. The General Assembly implemented similar one-time financing in the last two budget shortfalls. For example, in H.B. 20-1386 the General Assembly redirected $161 million from the HAS Fee to offset General Fund. The legislature could choose to do a larger or smaller offset than the $100 million included in the table.

The General Assembly could pair this budget balancing strategy with a directed payment program to generate a net increase for hospitals. A directed payment program could expand the allowable HAS Fee financing for hospitals. Federal limits constrain the current supplemental payments to hospitals. One constraint is the Upper Payment Limit (UPL) that caps what states can pay providers. The UPL represents what Medicare would have paid for the same services. The UPL calculation does not include managed care. Colorado has managed care contracts with Denver Health and Rocky Mountain Prime and for behavioral health services. States can implement a directed payment program for managed care. The federal government limits directed payment programs, too, but the limits align with average commercial pay, rather than the lower Medicare pay. A directed payment program would increase the amount Colorado could pay hospitals. The second constraint limits collections from provider fees to six percent of net patient revenue. A directed payment program would add hospital services delivered through managed care to the net patient revenue, increasing the amount of HAS Fee that could be collected. In addition, advocates argue that Denver Health could make an intergovernmental transfer that would not count against the six percent limit. If an intergovernmental transfer can go to the enterprise that manages the HAS Fee, it may not count against the TABOR limit.

Advocates argue a directed payment program could increase the federal funds available for hospitals by around $200 million. If the State implemented a directed payment program in FY 2025-26, it would occur in a year when the Governor is proposing either no increases or decreases in payments for other providers.

Nursing facility rates [requires legislation]

Eliminating the 1.5 percent increase in nursing home rates required in statute for FY 2025-26 would save $5.2 million General Fund. Historically, nursing home rates increased by 3.0 percent annually. House Bill 23-1228 changed the increases to:

- 10 percent in FY 2023-24
- 3 percent in FY 2024-25
- 1.5 percent in FY 2025-26

- a rate subject to available appropriations in subsequent years

This change might be more palatable to providers in combination with enterprising the nursing provider fees and increasing the nursing fees to draw additional federal funds.

1% Provider rate reduction

Each 1.0 percent across-the-board decrease in provider rates saves $23.7 million General Fund. This excludes rates where the Governor proposed a targeted rate reduction. The proposed targeted rate reductions apply to certain dental services, pediatric behavioral therapies, and rates above 95 percent of Medicare.

Reduce targeted rates

Reducing rates by 1.0 percent for certain dental services, pediatric behavioral therapies, and rates above 95 percent of Medicare saves $3.6 million General Fund. This could be instead of the targeted rate reductions the Governor proposed or in addition to those targeted rate reductions.

Eligibility/benefit changes

Health benefits for children lacking access due to immigration status [requires legislation]

Halting the new health benefits for children lacking access due to immigration status would save $32.1 million General Fund. House Bill 22-1289 authorized the program. The benefits mirror Medicaid and CHP+. The eligibility criteria include children or pregnant women who would otherwise qualify for Medicaid or CHP+ except for their immigration status.

This new program is still ramping up. The Department expects to offer benefits beginning in January 2025.

The Department projects that the original Fiscal Note significantly understated the cost. The Department increased enrollment projections based on uptake rates for a similar program in Oregon and enrollment trends to date. In advance of the January 2025 implementation, the Department began passively enrolling people who qualified for emergency services under Medicaid within the last year who would not qualify for standard Medicaid or CHP+ due to immigration status. The Department passively enrolled 7,153 children to date, compared to 1,344 children assumed in the Fiscal Note. The Department decreased the expected per capita costs compared to the Fiscal Note but not nearly enough to offset the higher projected enrollment. Would the legislature have made different choices about the program if the Fiscal Note had been 7.5 times higher?

HB 22-1289 Service Costs for Children		
Item	FY 2024-25	FY 2025-26
Fiscal Note	$2,102,664	$4,360,863
November 2024 Projection	$16,037,803	$32,075,606
Difference	$13,935,139	$27,714,743

There is no federal match for the program. Costs are paid entirely from the General Fund.

The lower income end of the population would still qualify for emergency services under Medicaid but wouldn't get government support for primary and non-emergent specialty care. Without this program, the population might go without care, seek charity care through safety net providers, or maybe get care through an employer.

There is significant uncertainty about service costs. The Department lacks traditional demographic and expenditure data for projections due to the immigration status of the population. Recent political developments may change the population entering the United States and where they move. Statute requires the Department to pay the cost of the program, regardless of the original appropriation, and provides overexpenditure authority if enrollment or utilization is higher than the projection. Eliminating or capping the program would reduce uncertainty in expenditures.

An alternative to elimination would cap the program. To keep costs similar to the original fiscal note would require capping the program at approximately 1,709 children. That would put an estimated 10,861 children on a waitlist for services. The legislature could consider a higher cap with a smaller waitlist and correspondingly smaller savings.

In addition to services for children, H.B. 22-1289 expanded coverage for pregnant and postpartum women. The Department received a federal waiver to include the pregnant and postpartum women on Medicaid. The Department projects a net savings from reduced emergency services for the newly covered pregnant and postpartum women. Therefore, this list of budget balancing options does not include a reduction to the new eligibility for pregnant and postpartum women.

Continuous eligibility expansions [requires legislation]

Halting continuous eligibility for children to age 3 and people to 1 year after incarceration would save $5.6 million General Fund. House Bill 23-1300 authorized the eligibility expansions. During continuous eligibility clients do not need to reapply for services. They remain eligible even with a change in income or family status.

This new eligibility has not yet been implemented. The Department expects to implement it January 2026. The projected service costs double in FY 2026-27.

Without this eligibility change, people who qualify for Medicaid or CHP+ could still get services but would need to complete the application. People not qualifying for Medicaid or CHP+ would have higher income. They may have access to insurance through an employer. People with income up to 400 percent of the federal poverty guidelines could get tax credits to purchase insurance through the exchange.

Children already receive continuous eligibility for one year.

Eligibility interruptions may disrupt preventive care or reduce adherence to treatment, leading to lower health outcomes. For example, children might miss immunizations or developmental screenings. Adults after incarceration might skip treatments for behavioral health or for chronic conditions.

Prenatal choline supplements [requires legislation]

Halting prenatal coverage of choline supplements without a prescription would save $257,359 General Fund. Senate Bill 24-175 authorized the new benefit.

This new benefit has not yet been implemented. The Department expects to implement it in July 2025.

Without this benefit, clients could still get coverage of choline supplements with a prescription or pay over-the-counter.

Advocates argue that requiring a prescription for coverage creates a barrier to access and reduces health outcomes. Writing a prescription when recommending choline supplements is not standard clinical practice. The supplements are available over-the-counter. Requiring a prescription causes confusion for physicians and pharmacists.

Antipsychotic drug prior authorization [requires legislation]

Allowing the Department to reinstate prior authorization requirements (PARs) for antipsychotic drugs would save an estimated $974,301 General Fund. Insurance companies use PARs to ensure services are medically necessary. Senate Bill 24-110 prohibited PARs for antipsychotic drugs beginning in FY 2024-25. Reinstating the PARs would reduce projected expenditures by requiring clients to fail on two preferred antipsychotic drugs before receiving coverage for a more expensive non-preferred drug.

The Department uses available research on best medical practices to develop PARs. For pharmaceutical PARs a federally mandated Drug Utilization Review (DUR) board composed of healthcare professionals reviews any PARs. PARs get reviewed at least annually to ensure the criteria is up to date with clinical best practices. The Department coordinates with the Skaggs School of Pharmacy for drug utilization review analyses. The Department must submit an annual report to the federal Centers for Medicare and Medicaid Services on PARs and other drug use interventions.

If someone disagrees with a PAR they do not need to go to the legislature. The DUR board takes written and verbal comments on policies. Members can appeal individual PAR decisions.

There might be other PARs that could save money, but it would be extraordinary for the General Assembly to direct specific PARs for budget savings. This option stood out because the legislature prohibited a PAR. Normally, the legislature delegates PARs to the Department's expertise, although there are some other examples of legislative restrictions on the Department's ability to implement PARs.

Community health services [requires legislation]

Halting reimbursements for community health services would save $2.7 million General Fund. Senate Bill 23-002 authorized the reimbursements and delegated authority to the Department to determine the specific covered services and required credentials. The bill defines a community health worker as a liaison between health and social service providers and community members to facilitate access and improve the quality and cultural responsiveness of

service delivery. At a minimum, the Department must seek federal approval to reimburse for preventive services, group and individual health education and health coaching, health navigation, transitions of care supports, screenings and assessments for nonclinical and social needs, and individual support and health advocacy.

According to the Department's web site, community health workers provide health system navigation to help people engage with providers, adhere to treatment plans, self-manage chronic conditions, understand and access benefits, mitigate health barriers, and improve social determinants of health. They offer health promotion and coaching that trains people in setting health goals and creating action plans. They provide health education and training to raise awareness of research-supported methods for avoiding illness and lessening its effects.

This new reimbursement has not yet been implemented. The Department expects to implement it in July 2025.

Service costs are expected to increase in future years. The Fiscal Note assumes demand exceeds the supply of providers. Also, the Fiscal Note assumes more people will get credentialed to provide services as the program becomes established. The Fiscal Note projects General Fund costs will increase to $3.2 million in FY 2026-27 and continue increasing in future years.

Without this reimbursement the availability of services is not expected to increase and it may decrease. To the extent the services are currently available, it is usually through volunteering, charity, or grant funding, including time-limited federal grants available during the pandemic.

Adult dental cap

Reinstating a $1,500 annual cap on the adult dental benefit would reduce the projected General Fund obligation for a TABOR refund by $4.4 million. The adult dental benefit is financed with transfers from the Unclaimed Property Trust Fund (UPTF). The UPTF is exempt from TABOR, but transfers to support the adult dental benefit cross the TABOR boundary.

Colorado previously had an annual cap of $1,500 and before that $1,000. Dental services for children to age 21 and emergency dental services for adults would still be covered, because these are required benefits.

An annual cap on the dental benefit restrains expenditures but some of the savings come from people spreading costs over multiple years. Deferred dental care reduces overall health and may lead to higher costs for other medical services and emergency dental services.

Federal regulations do not require dental coverage, but any dental coverage offered must meet sufficiency standards. Indiana recently lost a court case with an annual dental cap of $1,000.

Denture benefit [requires legislation]

Eliminating the denture benefit would save $2.9 million General Fund, mostly by reducing the General Fund obligation for a TABOR refund. The denture benefit is financed with transfers from the Unclaimed Property Trust Fund (UPTF) and a small amount of General Fund for people with intellectual and developmental disabilities. The UPTF is exempt from TABOR, but transfers to support the denture benefit cross the TABOR boundary. The denture benefit was added by

H.B. 14-1336. Emergency services and services for children would still be covered, because they are required benefits.

Reproductive health for individuals not eligible for Medicaid [requires legislation]

Eliminating the reproductive health benefit for people not eligible for Medicaid due to their immigration status would save $3.6 million General Fund. The money primarily pays for Long Acting Reversible Contraceptives (LARCs). In FY 2023-24 there were 4,206 distinct utilizers. There is no federal match for the program.

Eliminating the program may increase Medicaid expenditures for unwanted pregnancies.

There is a cushion between the appropriations and expenditures that could be removed with a change in statute. Utilization is trending up, but the Department underspent the appropriation by $2,257,563 in FY 2023-24. The benefits and eligibility are defined in statute with no clear means for the Department to manage costs within the appropriation. If the statute allowed cost containment measures, such as caps, or provided overexpenditure authority for the line item, then the legislature could appropriate to the expected expenditure and not maintain a cushion.

Without a change in statute, staff believes the appropriation could still be reduced by $1.0 million General Fund with a low probability that utilization would exhaust the buffer.

Telehealth remote monitoring [requires legislation]

Halting reimbursements to outpatient facilities for remote patient monitoring would save $260,733 General Fund. Senate Bill 24-168 authorized the new payments. Projected costs for the bill increase to $336,293 General Fund in FY 2026-27.

The Department has not yet implemented the new payments. The Department expects to begin reimbursements in July 2025.

The bill authorized a related grant program (described below) but the legislature could choose to stop one without stopping the other.

Without this funding, members would need to travel for care. Changes in health status could not be checked in real time. Adherence to treatment and health outcomes might decline.

Continuous glucose monitoring [requires legislation]

Halting the expanded coverage of continuous glucose monitors would save $278,683 General Fund. Senate Bill 24-168 authorized the expanded coverage of continuous glucose monitors.

The Department has not yet implemented the expanded benefit. The Department expects to implement it in November 2025.

Projected General Fund costs increase to $836,008 in FY 2026-27 and on-going.

While this is an expanded benefit that has not yet been implemented, the expansion is consistent with changes in treatment standards. There might be savings from pharmacy rebates and improved condition management from keeping the benefit.

CHP+ children/pregnant 206-265% [requires legislation]

Eliminate coverage under the Child Health Plan Plus (CHP+) for children and pregnant women with income from 206 percent to 265 percent of the federal poverty guidelines and repurpose the savings in the Healthcare Affordability and Sustainability Fee (HAS Fee) to offset General Fund. In a family of three, the change would impact people with annual income from $53,189 to $68,423. The change would remove coverage for a projected 37,762 children and 1,094 pregnant women.

Outside of the buy-in program for people with disabilities, this is the highest income population served by the Department's health programs. The population is relatively healthier with lower medical needs than the typical Medicaid population, due to age and income. Federal tax credits can help people in this income range purchase private insurance through the individual market.

Grants/special payments

Telehealth Remote Monitoring Grant Program

Halting rural grants for remote monitoring technology would save $500,000 General Fund. The grants were authorized by S.B. 24-168. The Department expects to begin making five grants of $100,000 each in July 2025.

There is no federal match for the discretionary grant program.

The bill authorized a related new reimbursement for remote patient monitoring (described above) but the legislature could choose to stop one without stopping the other.

Without this funding, the supply of providers offering telehealth remote monitoring might grow more slowly.

SBIRT Training grants [requires legislation]

Eliminating grants that train providers in Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use would save $1.5 million from the Marijuana Tax Cash Fund that could offset General Fund. This is a grant program and it supports training, rather than direct services. There is no federal match. Medicaid would continue to cover services.

Family medicine residencies

Eliminating funding for the family medicine residencies would save $4.5 million General Fund. The Commission on Family Medicine organizes and financially supports family medicine residencies, particularly in rural and underserved areas.

Eliminating or reducing this funding affects teaching and development of the provider network, rather than direct services. Impacts on access to care and health, life, and safety would be indirect and in the future.

Residents increase provider capacity during their training. A high portion end up practicing where they train.

Pediatric Specialty Hospital

Eliminating the Pediatric Specialty Hospital payments would save $6.7 million General Fund. These payments go to Children's Hospital. There is a 50 percent federal match. Of the total funds, $11.5 million supports outpatient behavioral health services, $1.5 million goes to an alternative educational placement for children with complex medical needs, and $0.5 million supports the KidStreet childcare program for children 6 weeks to 3 years with complex medical needs. The legislature could reduce the funding, rather than eliminating it.

These are narrowly targeted supplemental payments above and beyond the standard Medicaid reimbursement for services.

The funding for outpatient behavioral health increases provider reimbursement for services otherwise covered under Medicaid. Children's Hospital argues the standard Medicaid reimbursement is insufficient. This supplemental payment allows the hospital to maintain and expand outpatient behavioral health services.

Without the alternative educational placement, school districts would need to make other accommodations for children with complex medical needs. School district costs would increase and the alternatives might not be as robust as this established program.

Children's Hospital argues that the KidStreet program reduces utilization of more expensive private duty nursing, provides therapies that would be covered under Medicaid, and allows parents to work.

Senior Dental Program [requires legislation]

Eliminate funding for the grant program that supports dental care for seniors who do not qualify for Medicaid would save $4.0 million General Fund. This is a grant program above and beyond the Department's core services. There is no federal match. Eliminating the program would require a bill but reducing the program would not.

Admin/Other

General Professional Services

The Department reverted $5.7 million General Fund in FY 2023-24 and $1.5 million General Fund in FY 2022-23. That was 39 percent and 17 percent of the General Fund appropriations respectively.

The Department says it needs the entire appropriation in FY 2025-26 to support initiatives approved by the General Assembly and to satisfy federal requirements. According to the Department, any reduction in General Professional Services would need to be coupled with eliminating or reducing the programs supported by the contract services.

The Department did not explain why FY 2025-26 would be so different from the actual experience with contract services in FY 2024-25 and FY 2023-24.

The table below shows the Department's projected expenditures from the General Professional Services line item in FY 2025-26.

General Professional Services Projection FY 2025-26	
Description	Expenditure
Cover All Coloradoans	$10,678,371
Primary Care Alternative Payment Model (APM)	5,099,840
Special Financing Projects	2,411,250
Third Party Assessments-PDN / LTHH	1,938,600
Actuarial Review of HMO, PACE and MH Rates	1,652,370
SUD Patient Placement and Benefit Waiver	1,430,744
Import Prescription Drugs from Canada	1,296,160
Community Based Access to Services	1,206,700
Cost Allocation Vendor Consolidation	1,067,842
Medicaid Payment Reform Pilot Program (ACC)	650,000
Asset Verification Program (AVP)	648,256
Health-Care Practice Transformation	378,750
Member Experience and Testing	329,304
Drug Cost Containment Initiatives	300,500
Pharmacy Technical & Pricing Efficiencies (SMAC)	300,000
County Administration, Oversight and Accountability	269,304
Federal Managed Care Services	253,750
Periodic Review of Provider Rates (MPRRAC)	250,000
Access to Benefits	250,000
Continuous Eligibility	180,000
HCBS Final Rule Review	179,550
Behavioral Health Administration	169,000
Advancing Birthing Equity	165,000
CUSOM - UPL	162,000
Clinical Evidence Advisory Committee (CEAC)	150,000
Medicaid Recovery & Third-Party Liability (TPL)	120,000
Access to Managed Care Covered Services	101,500
CLAG and HCBS Final Rule Review	100,000
Medicaid Ombudsman Contract	100,000
Medicaid Buy-in Age 65 and Older	100,000
Comprehensive Primary Care Initiatives	75,000
Senior Dental Grant Program	75,000
Nursing Home Fees & Order of Payments	60,000
Inpatient Hospital DRG (FQHC & RHC)	60,000
Assignment of Rights and Eligibility Determinations	50,000
Unemployment Insurance	30,000
Alternative Language Services	30,000
Total	$32,318,791
General Fund	11,685,822
Cash Funds	2,393,115
Reappropriated Funds	81,000
Federal Funds	18,158,854

Prepayment review

Additional resources for prepayment reviews would likely reduce expenditures by preventing improper billing and fraud. The scenario in the table adds $3.5 million total funds for contract services and some state FTE in order to generate net savings of $5.6 million General Fund.

This approach may reject some legitimate payments for nit-pickey technical errors, driving increased workload for providers to correct errors, or decisions by providers to accept losses.

The savings are not guaranteed. The estimated savings in the table below are based on prepayment reviews of transportation services. There were large known fraud issues with transportation services. There might be fewer improper billing issues in other service areas, reducing the potential savings. On the other hand, the Department says this savings estimate is lower than the return on investment described by the federal Centers for Medicare and Medicaid Services (CMS) based on similar programs.

Prepayment Review					
Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Prepayment review contract	$3,500,000	$1,517,950	$232,050	$1,750,000	0.0
Compliance FTE	198,836	86,235	13,183	99,418	1.0
Potential savings	-19,600,000	-7,208,806	-927,940	-11,463,254	0.0
Total	-$15,901,164	-$5,604,621	-$682,707	-$9,613,836	1.0

Office of eHealth Innovations

Reducing the General Fund for the Office of eHealth Innovations (OeHI) by 20 percent would save $750,000. Some of the OeHI activities qualify for matching federal funds but the match rates vary, so the decrease in federal funds would depend on how the executive branch implements a decrease in funding.

The OeHI provides technical support and maintenance for technology initiatives to improve health information sharing. The OeHI supports the rural connectivity program that attempts to address gaps in state health information exchange networks by providing affordable technology connection options to rural critical access hospitals and certified rural health clinics. The rural connectivity program capital construction project received $11.0 million total funds, including $5.5 million General Fund. Also, the OeHI supports the Colorado Social Health Information Exchange (CoSHIE) that is building interoperability between existing systems to ensure providers have access to the information they need to serve clients in their preferred system of record. The CoSHIE capital construction project received $11.0 million total funds, including $1.5 million General Fund.

The Department says a 20 percent reduction in funding would mean a decrease in personnel and state innovation efforts and scaling back the rural connectivity program. This is a vague description from the executive branch of the consequences of a 20 percent reduction in funding. A little less state innovation and scaling back (but continuing) the rural connectivity program might be an acceptable policy outcome for the legislature in a budget reducing environment.

All-Payer Claims Database operations

Eliminating funding for the All-Payer Claims Database (APCD) would save $4.5 million General Fund. Alternatively, the General Assembly could reduce funding. The APCD collects claims data from insurers operating in Colorado and provides custom reports and analysis to support

research and address policy questions. The APCD is operated by a nonprofit that charges fees for reports and analysis. This appropriation supplements the inadequate fee revenue.

During COVID the General Assembly temporarily eliminated the $500,000 scholarship grant program that supports researcher access to the All-Payer Claims Database (APCD) and reduced the remaining operating fund for the APCD 25 percent.

This funding supports data collection and research, rather than direct services.

The scholarship program supports the operations of the APCD by bringing in more research requests than might otherwise happen. The scholarship grants typically do not cover the full cost of research. Entities receiving the scholarships still pay 20-25 percent of the project fees.

The potential for increased fee revenue to offset a reduction in operating funds is minimal. The majority of the APCD work occurs for state agencies. The fees are already high enough that they restrain private utilization, driving the need for the scholarship grant program. To the extent the APCD could increase fees, the revenue would go to the nonprofit and not increase state TABOR revenue.

State programs increasingly rely on data from the APCD. For example, the Colorado Option sets rate caps using a Reference Based Price derived from the APCD and the Department uses the APCD to determine provider eligibility for performance based payments. Analysis of the APCD informs work on the reinsurance program, the Prescription Drug Affordability Board, and disease surveillance. The APCD has always been used to answer policy questions about subjects such as utilization, access to care, and drug rebates and expenditures.

Forecasting Medicaid & CHP+

This issue brief discusses the sustainability of Medicaid funding, the process for forecasting, and the Department's November forecast.

Discussion

Sustainability

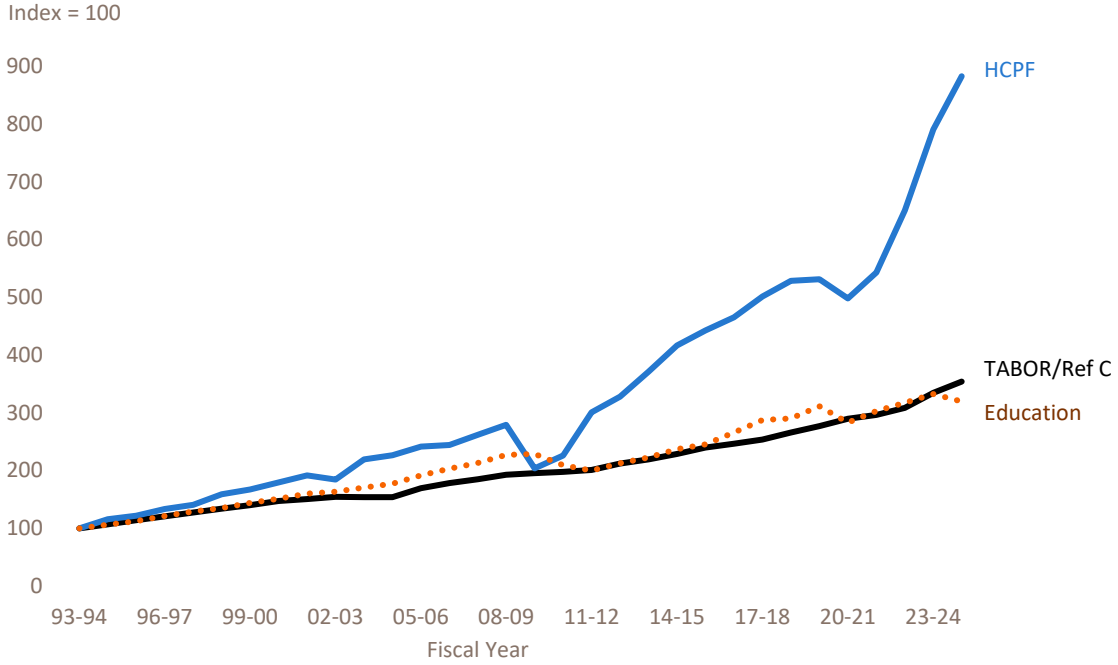
Over the interim, Representative Bird asked whether the legislature can sustain the growth of Health Care Policy and Financing (HCPF).

The General Assembly continues to provide significant General Fund increases for the Department. Also, the General Assembly has identified creative ways to increase the available funding, such as creating the provider fee on hospitals to increase reimbursements for hospitals and expand eligibility and then converting the fee to an enterprise to free up room under the TABOR limit.

Whether the legislature can sustain the growth of the Department depends on decisions in other areas of the budget. The Department's growth exceeds the growth of the TABOR limit. This puts pressure on the legislature to contain costs in other areas of the budget, or to identify ways to relieve the constraints of the TABOR limit. Policies like the budget stabilization factor in education or the rapid tuition growth in higher education could be attributed indirectly to HCPF growing faster than the TABOR limit.

The graph below indexes the TABOR limit and General Fund appropriations for HCPF and Education to 100 in FY 1993-94 and then shows the growth of each through FY 2024-25. Both the Department of Health Care Policy and Financing and the TABOR limit began in FY 1993-94. The three dips in the trend line for HCPF all correspond with federal policies that temporarily increased the federal match rate for Medicaid to provide budget relief to states during economic downturns.

General Fund appropriations for Health Care Policy and Financing (HCPF) are growing faster than the TABOR/Referendum C limit



Forecast process

The Department produces forecasts of the Medicaid and CHP+ enrollment and expenditures in November and mid-February each year. The November forecast is based on data through June and informs the Governor's request. The mid-February forecast uses data through December and informs the legislature's budget balancing.

The mid-February forecast comes out after the statutory deadlines for the Governor to submit supplemental requests or budget amendments. Historically, governors have not submitted formal proposals for how to rebalance the budget to account for the mid-February forecast. Sometimes governors provide informal feedback to the Joint Budget Committee.

FY 2023-24 overexpenditure

During the pandemic, the Department consistently over-forecasted the General Fund in the November forecast. The JBC staff heard complaints that the Department's forecast was too conservative, crowding out other priorities. In reality, the Department's forecast was chasing changes in federal policy. The federal government kept extending the duration of the enhanced federal match for a few months at a time. The General Fund relief from extensions of the enhanced federal match masked other changes to the forecast. Comparisons of the forecasts to actual expenditures over time provides no reason to believe the forecasts contain a bias to over or under project. Nevertheless, a contingent of legislators became accustomed to mid-year decreases in the forecast for Medicaid and knew nothing different.

In FY 2023-24 the Department's forecast came up tails. Flipping heads several times in a row has no bearing on the odds of coming up heads on the next flip.

Actual expenditures exceeded the FY 2023-24 forecast by $123.8 million General Fund. That represents a forecast error of 2.9 percent.

FY 2023-24					
	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Appropriation					
Medical Services Premiums	$11,093,263,887	$3,166,608,078	$1,242,432,371	$99,768,814	$6,584,454,624
Behavioral Health	1,138,399,137	283,497,693	86,656,628	0	768,244,816
Children's Basic Health Plan	201,217,687	27,643,724	42,202,063	0	131,371,900
Medicare Modernization Act	245,388,980	245,388,980	0	0	0
Office of Community Living	1,057,939,133	514,973,247	20,486,175	0	522,479,711
Total - Appropriation	$13,736,208,824	$4,238,111,722	$1,391,777,237	$99,768,814	$8,006,551,051
Actual					
Medical Services Premiums	$11,386,151,835	$3,314,226,326	$1,314,296,704	$99,207,497	$6,658,421,308
Behavioral Health	1,039,484,586	260,258,218	76,375,406	0	702,850,962
Children's Basic Health Plan	186,607,736	22,943,724	41,320,991	0	122,343,021
Medicare Modernization Act	244,361,309	244,361,309	0	0	0
Office of Community Living	1,068,626,397	520,164,613	20,896,615	0	527,565,169
Total - Actual	$13,925,231,863	$4,361,954,190	$1,452,889,716	$99,207,497	$8,011,180,460
Actual Higher/-Lower than Appropriation					
Medical Services Premiums	$292,887,948	$147,618,248	$71,864,333	-$561,317	$73,966,684
Behavioral Health	-98,914,551	-23,239,475	-10,281,222	0	-65,393,854
Children's Basic Health Plan	-14,609,951	-4,700,000	-881,072	0	-9,028,879
Medicare Modernization Act	-1,027,671	-1,027,671	0	0	0
Office of Community Living	10,687,264	5,191,366	410,440	0	5,085,458
Total - Difference	$189,023,039	$123,842,468	$61,112,479	-$561,317	$4,629,409
Percent Difference					
Medical Services Premiums	2.6%	4.7%	5.8%	-0.6%	1.1%
Behavioral Health	-8.7%	-8.2%	-11.9%	n/a	-8.5%
Children's Basic Health Plan	-7.3%	-17.0%	-2.1%	n/a	-6.9%
Medicare Modernization Act	-0.4%	-0.4%	n/a	n/a	n/a
Office of Community Living	1.0%	1.0%	2.0%	n/a	1.0%
Total - Percent Change	1.4%	2.9%	4.4%	-0.6%	0.1%

This time the JBC staff heard rumors that the Department played with the forecast to free up room in the budget to accomplish things the Department wanted. Now the legislature had to clean up the mess.

The main reason for the forecast error was under projecting per capita costs for acute care. The Department spent a lot of time looking for a "silver bullet" explanation of some change in utilization but did not identify anything. The Department knew that enrollment would decrease due to the end of continuous eligibility. The Department's enrollment forecast was very close to the actual enrollment. Also, the Department knew that the people on continuous eligibility

were relatively healthier and had lower utilization than the standard Medicaid population. The Department dramatically increased the forecast of per capita expenditures to account for the removal of low utilizers. However, the pandemic disrupted normal utilization trends. The Department had to make assumptions about the baseline per capita costs without the continuous eligibility.

In hindsight, the Department consistently underestimated the per capita costs for nearly every service line. There was not one particular population or set of services driving the increase in per capita costs. Forecasts depend on prior history to project the future. Major disruptions to the trends, such as COVID and the continuous eligibility policy, introduce more guesswork to the forecast. The major increases in per capita costs that the Department projected were a little less than the actual increases in almost every case.

Incentives

The JBC staff believes the incentives for a continuing Governor and department director encourage the Department to get the forecast exactly right. If the Department forecasts too high, money gets tied up needlessly and at the expense of other priorities of the Governor. If the Department forecasts too low, then there will be a hole in the budget the next year. The Department will spend what the benefits cost regardless of the forecast. Maybe a department director, as opposed to the Governor, might see a hole in the next year's budget as somebody else's problem, but this seems unlikely and short-sighted when the Department represents nearly a third of the General Fund. Potentially the incentives change in the last year for a Governor or department director, but the JBC staff has seen no pattern to suggest it.

Career civil service employees put together the forecast, rather than political appointees. Each analyst forecasts assigned lines of services. The Department harmonizes the forecasts to use internally consistent assumptions. The forecasts for lines of service get peer reviewed and aggregated into the total forecast. Sometimes the peer review results in changes to correct errors or due to differences of opinion, experience, or available information. An individual analyst may not agree with the changes. The JBC staff has seen no evidence of politically-motivated changes.

The forecast gets presented and defended to political appointees, including the department director. This review occasionally identifies inconsistent logic or incomplete information. The Department's directors may know about developments impacting the projection that eluded the forecasting staff, such as information technology problems or a new federal policy or an eligibility processing backlog. According to the Department, any changes get made by the forecasting staff and not at the direction of political appointees to hit a target number.

Creating an alternative forecast

Some legislators propose that Legislative Council Staff (LCS) produce a forecast separate from the Department's. LCS already produces separate forecasts for revenues and some populations, like K12 enrollment and prisoners. An alternate forecast might increase accountability and the confidence of policy makers in the projection.

LCS estimates it would need 2.0 FTE and $260,000 General Fund, to compete with the Department's forecasting capacity. In addition, the Department would need increased resources to supply the necessary information for LCS to produce a forecast.

The Department currently uses approximately 6.0 analysts and 2.0 managers to produce the forecast. These staff work intensively on the forecast for about two months leading up to each forecast. The rest of the year they help develop, monitor, and manage the Department's budget.

The LCS cost estimate assumes one forecast per year in February, since there is no need for an alternate to the November forecast. The Department's 8 people for 2 months translates to 1.3 FTE. LCS could not hire 8 people for 2 months. LCS assumes it could produce a forecast with 2.0 additional staff and hours beyond a normal workday during peak periods. The rest of the year the staff would monitor Medicaid and CHP+, improve forecast models, build subject matter expertise on Medicaid and health issues, write fiscal notes, staff interim committees, and support ballot measure analyses ("Blue Book").

An alternate forecast introduces complexity and the potential for cost estimates based on different assumptions. For example, a fiscal note might need to get repriced to match the assumptions used in the selected forecast. There is no guarantee that the legislature could identify the most accurate forecast or that the legislature would select it versus the most advantageous forecast.

An LCS forecast would depend highly on information from the Department. Federal law requires a single state agency administer Medicaid. The Department would learn about things that could influence the forecast well in advance of LCS, like changes in federal policy, the status of state plan amendments, or audit findings. Communication breakdowns could cause forecast errors. Also, the Department staff are closer to internal factors that might impact the forecast, such as an information technology change causing a temporary payment delay.

Forecasting Medicaid requires specialized knowledge that LCS would need to develop. For example, forecasters need to understand the strengths, limitations, and quirks of the Department's data systems. LCS estimates it would take years of building subject knowledge and refining the forecasting methods to produce a forecast with a comparable or lower error rate than the 2.9 percent in HCPF's FY 2023-24 projection.

LCS estimates a more limited forecast of just Medicaid enrollment would require half the resources. However, the JBC staff questions the utility of a limited approach. Most of the complexity and variability associated with the Medicaid forecast involves projecting costs and fund sources, rather than enrollment. The legislature would need to pair a forecast of just enrolment with expenditure assumptions. A limited forecast of enrollment would be less effective at increasing confidence in the projected costs for Medicaid than a full projection.

In the 1990s LCS forecasted Medicaid enrollment but not expenditures. In the 2000s, the JBC staff produced a forecast of Medicaid and CHP+ expenditures. The JBC staff's forecast was not nearly as well documented or defended as the Department's. It was put together by one person in a very condensed time and depended heavily on the Department's February forecast. However, it had the advantage of an additional month or two of data over the Department's

forecast. For the JBC staff to produce a forecast with similar rigor to the Department's forecast would require additional resources in line with the LCS estimate.

Previous Joint Budget Committees considered an alternate forecast and decided not to pursue it.

Rather than creating a competing forecast, LCS offered that the legislature could create an oversight group to review and interrogate the Department's forecast. It is difficult for the JBC staff to imagine how the timing might work with the current budget schedule or how the legislature might use the end product from such a review. It might increase confidence in the Department's forecast with less cost and fewer complications than asking LCS to produce a competing forecast.

November Forecast

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. In FY 2025-26, the combined forecast requests account for more than 100 percent of the General Fund adjustments proposed by the Department (the Department proposes some offsetting reductions). It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy. The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2024. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2024. The mid-February forecasts come after deadlines for the Governor to submit supplemental budget requests and budget amendments. Typically, governors do not submit official revised requests based on the mid-February forecasts, neither do they submit official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the mid-February forecast for the budget, because it is the most recent data available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2024-25 expenditures. The requests for changes in FY 2024-25 will be officially submitted in January. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2024-25 is the change from the appropriation and not the change from FY 2023-24.

FY 2024-25					
	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 24-25 Appropriation					
Medical Services Premiums	$11,931,356,051	$3,573,779,779	$1,321,506,284	$120,304,766	$6,915,765,222
Health Benefits for Children	2,102,665	2,102,665	0	0	0
Behavioral Health	1,040,269,703	275,847,686	79,656,824	0	684,765,193
Children's Basic Health Plan	269,980,786	43,885,585	50,672,690	0	175,422,511
Medicare Modernization Act	244,659,612	244,659,612	0	0	0
Office of Community Living	1,205,855,916	602,226,632	12,246,759	0	591,382,525
Total - Appropriation	$14,694,224,733	$4,742,501,959	$1,464,082,557	$120,304,766	$8,367,335,451
FY 24-25 Projection (Nov)					
Medical Services Premiums	$12,082,260,328	$3,629,701,056	$1,392,532,728	$119,588,730	$6,940,437,814
Health Benefits for Children	16,037,803	16,037,803	0	0	0
Behavioral Health	1,133,889,296	288,454,166	94,797,864	0	750,637,266
Children's Basic Health Plan	281,345,428	45,117,765	53,418,135	0	182,809,528
Medicare Modernization Act	241,755,970	241,755,970	0	0	0
Office of Community Living	1,249,355,664	611,486,124	24,665,342	0	613,204,198
Total - Actual	$15,004,644,489	$4,832,552,884	$1,565,414,069	$119,588,730	$8,487,088,806
Projection Higher/-Lower than Appropriation					
Medical Services Premiums	$150,904,277	$55,921,277	$71,026,444	-$716,036	$24,672,592
Health Benefits for Children	13,935,138	13,935,138	0	0	0
Behavioral Health	93,619,593	12,606,480	15,141,040	0	65,872,073
Children's Basic Health Plan	11,364,642	1,232,180	2,745,445	0	7,387,017
Medicare Modernization Act	-2,903,642	-2,903,642	0	0	0
Office of Community Living	43,499,748	9,259,492	12,418,583	0	21,821,673
Total - Difference	$310,419,756	$90,050,925	$101,331,512	-$716,036	$119,753,355
Percent Change					
Medical Services Premiums	1.3%	1.6%	5.4%	-0.6%	0.4%
Health Benefits for Children	662.7%	662.7%	n/a	n/a	n/a
Behavioral Health	9.0%	4.6%	19.0%	n/a	9.6%
Children's Basic Health Plan	4.2%	2.8%	5.4%	n/a	4.2%
Medicare Modernization Act	-1.2%	-1.2%	n/a	n/a	n/a
Office of Community Living	3.6%	1.5%	101.4%	n/a	3.7%
Total - Percent Change	2.1%	1.9%	6.9%	-0.6%	1.4%

FY 2025-26					
	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2024-25 Projection (Nov)					
Medical Services Premiums	$12,082,260,328	$3,629,701,056	$1,392,532,728	$119,588,730	$6,940,437,814
Health Benefits for Children	16,037,803	16,037,803	0	0	0
Behavioral Health	1,133,889,296	288,454,166	94,797,864	0	750,637,266
Children's Basic Health Plan	281,345,428	45,117,765	53,418,135	0	182,809,528
Medicare Modernization Act	241,755,970	241,755,970	0	0	0
Office of Community Living	1,249,355,664	611,486,124	24,665,342	0	613,204,198
Total - Appropriation	$15,004,644,489	$4,832,552,884	$1,565,414,069	$119,588,730	$8,487,088,806

FY 2025-26					
	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2025-26 Projection (Nov)					
Medical Services Premiums	$12,978,805,284	$3,872,415,144	$1,436,840,921	$119,588,730	$7,549,960,489
Health Benefits for Children	32,075,606	32,075,606	0	0	0
Behavioral Health	1,299,826,326	328,620,082	99,097,340	0	872,108,904
Children's Basic Health Plan	305,600,642	50,712,851	56,312,374	0	198,575,417
Medicare Modernization Act	268,891,377	268,891,377	0	0	0
Office of Community Living	1,316,681,401	647,294,950	22,597,041	0	646,789,410
Total - Actual	$16,201,880,636	$5,200,010,010	$1,614,847,676	$119,588,730	$9,267,434,220
FY 2025-26 Higher/-Lower than FY 2024-25					
Medical Services Premiums	$896,544,956	$242,714,088	$44,308,193	$0	$609,522,675
Health Benefits for Children	16,037,803	16,037,803	0	0	0
Behavioral Health	165,937,030	40,165,916	4,299,476	0	121,471,638
Children's Basic Health Plan	24,255,214	5,595,086	2,894,239	0	15,765,889
Medicare Modernization Act	27,135,407	27,135,407	0	0	0
Office of Community Living	67,325,737	35,808,826	-2,068,301	0	33,585,212
Total - Difference	$1,197,236,147	$367,457,126	$49,433,607	$0	$780,345,414
Percent Change					
Medical Services Premiums	7.4%	6.7%	3.2%	0.0%	8.8%
Health Benefits for Children	100.0%	100.0%	n/a	n/a	n/a
Behavioral Health	14.6%	13.9%	4.5%	n/a	16.2%
Children's Basic Health Plan	8.6%	12.4%	5.4%	n/a	8.6%
Medicare Modernization Act	11.2%	11.2%	n/a	n/a	n/a
Office of Community Living	5.4%	5.9%	-8.4%	n/a	5.5%
Total - Percent Change	8.0%	7.6%	3.2%	0.0%	9.2%

R6 Accountable Care Collaborative Phase III

This issue brief provides an overview of the Department's request for care coordination resources through the Accountable Care Collaborative.

Summary

- The Department requests increases of $33.1 million total funds, including $10.5 million General Fund, for new duties of the Regional Accountable Entities (RAEs) and associated support costs.
- The Department projects these increased costs will be offset by savings of $35.6 million total funds, including $11.7 million General Fund, primarily due to additional Transitions of Care services when members leave an inpatient or residential setting.

Discussion

The Accountable Care Collaborative coordinates care for Medicaid members. Regional Accountable Entities (RAEs):

1. develop the provider network
2. connect members to services
3. conduct outreach for difficult to reach members
4. address client and provider complaints
5. track outcomes
6. promote preventive care
7. design interventions and population strategies for high utilizers

The Department is reprocuring the care coordination services. The table below summarizes changes driving increased costs. The request includes projected savings, primarily related to Transitions of Care services.

R6 Accountable Care Collaborative Phase III				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
Increase payments to RAEs for new duties	29,654,734	9,548,825	1,186,189	18,919,720
Member incentives	431,613	203,937	0	227,676
Centralize credentialing	650,000	40,950	33,800	575,250
Enrollment mailer	2,100,000	649,635	400,365	1,050,000
Increase sampling for CAHPS survey	0	0	0	0
Expand western slope managed care to include children	0	0	0	0
Give RAEs access to Care and Case Management System	300,000	18,900	15,600	265,500
Transitions of Care savings	-34,480,577	-11,186,626	-1,360,374	-21,933,577
Member incentives savings	-1,121,500	-529,909	0	-591,591
Total - FY 2025-26	-$2,465,730	-$1,254,288	$275,580	-$1,487,022
FY 2026-27				

R6 Accountable Care Collaborative Phase III				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
Increase payments to RAEs for new duties	32,717,585	10,535,063	1,308,703	20,873,819
Member incentives	431,613	203,937	0	227,676
Centralize credentialing	0	0	0	0
Enrollment mailer	0	0	0	0
Increase sampling for CAHPS survey	0	0	0	0
Expand western slope managed care to include children	3,476,470	1,738,235	0	1,738,235
Give RAEs access to Care and Case Management System	250,000	15,750	13,000	221,250
Transitions of Care savings	-34,480,577	-11,186,626	-1,360,374	-21,933,577
Member incentives savings	-1,121,500	-529,909	0	-591,591
Total - FY 2026-27	$1,273,591	$776,450	-$38,671	$535,812

Increase payments to RAEs for new duties: The Department proposes increasing contractual responsibilities of the Regional Accountable Entities, driving an increase in costs for:

- Licensing requirements
- Care coordination and condition management
- Transitions of care
- Provider communication and complaint resolution
- Social health information exchange reporting
- Practice transformation supports and monitoring

Member incentives: The Department proposes three programs that provide incentives for pregnant and post-partum members to change behaviors.

- Baby and Me Tobacco Free provides diaper vouchers to participants in a tobacco cessation program who test nicotine free. The estimated average cost per member is $781.
- Substance use treatment adherence provides cash for meeting treatment goals as part of an evidence-based behavioral therapy called contingency management. Estimated incentives per member would be $500.
- Prenatal Early-Entry-To-Care provides $50 vouchers to people who engage in the first trimester with education, high-risk screening, or referrals for case management.

Centralize credentialing: The Department proposes one-time system changes to centralize credentialing for behavioral health providers. This would eliminate cumbersome requirements for providers to navigate different credentialing procedures at multiple RAEs.

Increase sampling for CAHPS survey: The Department proposes increasing sampling for the federally-required Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey measures consumer satisfaction on topics from the communication skills of providers to the accessibility of services. Response rates hover in the range of 4-7 percent and are typically not sufficient for statistically sound conclusions. The Department hopes additional sampling will produce more responses to inform decision making. The Department proposes the additional sampling begin in FY 2027-28 due to current budget constraints.

Expand Western Slope managed care to include children: The Department proposes adding children to the Western Slope managed care organization that currently covers adults. The

Department argues this will reduce confusion when children and their parents are enrolled in different programs. Managed care rates are higher than fee-for-service rates and include costs for greater care coordination responsibilities, driving an increase in costs. The Department is planning for the change as part of ACC Phase III, but it would not occur until FY 2026-27.

Give RAEs access to Care and Case Management system: The Department requests funding for licenses and one-time programming costs to give the RAEs access to the Care and Case Management System. The Department argues this will improve communication and reduce duplication of effort between the RAEs and Case Management Agencies.

Transitions of Care savings: The expanded responsibilities of the RAEs would include increased care management during transitions from inpatient and residential facilities. The additional cost for the care management is included in the "Increase payments to RAEs for new duties" above.

The Department projects a 10 percent decrease in adult hospital readmissions as a result of the Transitions of Care. The savings estimate for adults is based on a study[8] of similar interventions in North Carolina that reduced readmissions 20 percent.

The study of North Carolina looked at the impact of an entire Transitions of Care program and not at the incremental increases to an existing program that the Department is proposing. The largest decreases in readmissions occurred a year after entering the North Carolina program. The Department projects savings in the same year. Current responsibilities of the RAEs overlap with the North Carolina system, including data management, care coordination, and local support networks. The primary staples of both the Colorado and North Carolina models are similar, which may suggest that the savings reflected in this study have already been realized.

The Department projects a 25 percent reduction in readmissions for children in RAEs 1, 2, and 4 serving the Western Slope and Eastern Plains. The savings estimate for children is based on an observational study of Children's Hospitals in Minnesota that found a 31 percent reduction from similar interventions.[9] The Department expects the biggest percentage changes in readmissions in rural areas with the least amount of existing care coordination.

The current contracts include a requirement for RAEs to “provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems." According to the Department, RAEs have the infrastructure to support members through most of the transitions, but transitions from hospital settings have not been a focus historically.

With the requested funding the new contracts will:

- Require RAEs to provide transitions of care for all members and not just the highest cost or most complex members

[8] Transitional Care Cut Hospital Readmissions for North Carolina Medicaid Patients with Complex Chronic Conditions

[9] Pediatric Inpatient Readmissions in an Accountable Care Organization

- Provide financial rewards when members receive outpatient behavioral health care within 7 days and outpatient physical health care within 30 days of discharge
- Require RAEs to have a documented plan for identifying and intervening with members who overutilize emergency room services

Providers, especially behavioral health providers, tell the JBC staff that they lack timely notifications of when clients enter or leave hospital settings. According to the Department, many providers operate on electronic health record systems that are not connected to the Health Information Exchange (HIE) and therefore don't receive data feeds. In Phase III the RAEs will establish value-based payments with safety net providers to incentivize connection to the HIE. Where providers are unable to connect, the RAEs must establish manual workarounds.

Member incentives savings: The Department expects the three incentive programs for members described above to improve health outcomes and reduce expenditures long term. However, the Department only included projected savings associated with the Baby and Me Tobacco Free (BMTF) proposal.

Member Incentives				
Item	Clients	Total Funds	General Fund	Federal Funds
Incentives				
Baby and Me Tobacco Free expenditures	273	$213,213	$100,743	$112,470
Substance use treatment adherence	296	148,200	70,024	78,176
Prenatal Early-Entry-To-Care	1,404	70,200	33,170	37,030
Subtotal - Incentives		$431,613	$203,937	$227,676
Savings - Baby and Me Tobacco Free		-$1,121,500	-$529,910	-$591,590
Net Cost - Member Incentives		-$689,887	-$325,973	-$363,914

R9 Provider rates

This issue brief provides an overview of the Department's request to decrease provider rates by $74.6 million total funds, including $22.1 million General Fund.

Summary

- The Department proposes decreasing rates above 95 percent of Medicare to 95 percent to save $6.3 million General Fund
- The Department proposes decreasing the increase provided last year for dental services by 43.6 percent to save $6.3 million General Fund
- The Department proposes decreasing pediatric behavioral therapies to a benchmark that excludes Nebraska to save $9.7 million General Fund

Discussion

The Department proposes the following adjustments to provider rates.

R9 Provider rates				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
Rates above 95% of Medicare	-$21,103,833	-$6,268,202	-$1,016,240	-$13,819,391
Dental services	-34,219,469	-6,248,476	-5,167,140	-22,803,853
Pediatric behavioral therapies	-19,490,302	-9,745,151	0	-9,745,151
Community First Choice rebalance	256,524	112,871	0	143,653
Total - FY 2025-26	-$74,557,080	-$22,148,958	-$6,183,380	-$46,224,742
FY 2026-27				
Rates above 95% of Medicare	-$23,022,363	-$6,838,038	-$1,108,625	-$15,075,700
Dental services	-37,330,331	-6,816,519	-5,636,879	-24,876,933
Pediatric behavioral therapies	-21,262,146	-10,631,073	0	-10,631,073
Community First Choice rebalance	279,844	123,131	0	156,713
Total - FY 2026-27	-$81,334,996	-$24,162,499	-$6,745,504	-$50,426,993

Rates above 95% of Medicare

The Department proposes reducing rates above 95 percent of Medicare to 95 percent. The reduction saves $21.1 million total funds, including $6.3 million General Fund. The proposed reduction applies only to rates normally reviewed by the MPRRAC where the selected benchmark is Medicare. It includes rates reviewed in prior years and is not limited to only the rates in this year's MPRRAC review cycle. The proposed reductions are based on the differences between today's Medicare and Medicaid rates and not the Medicare rates at the point in time of the most recent MPRRAC review.

If a different benchmark than Medicare was selected by the MPRRAC, no reduction was proposed. Typically, a different benchmark is only selected when there is no Medicare equivalent. This happens most often with rates for Home- and Community-Based Services.

Medicare sets rates using methods intended to reimburse providers at cost.

The table below summarizes the projected impact on total payments by broad service category, sorted by the largest percentage reductions.

Rate Reduction to 95% of Medicare				
Service Category	Current Projection	With Rate Reduction	Difference	Percent
Physician - Sleep Study	$3,598,376	$2,778,607	-$819,769	-22.8%
Physician - EEG Ambulatory Monitoring	2,521,971	2,067,046	-454,925	-18.0%
Anesthesia	26,869,606	24,639,600	-2,230,006	-8.3%
Behavioral Health Fee For Service	17,500,713	16,174,389	-1,326,324	-7.6%
Maternity	37,612,153	35,543,891	-2,068,262	-5.5%
Durable Medical Equipment	33,234,849	31,641,409	-1,593,440	-4.8%
Laboratory and Pathology Services	74,960,263	71,590,081	-3,370,182	-4.5%
Surgery	110,531,109	107,246,713	-3,284,396	-3.0%
Injections and other Miscellaneous J-Codes	1,366,913	1,334,747	-32,167	-2.4%
Physician	488,618,362	480,841,812	-7,776,549	-1.6%
Dialysis and Nephrology Services	1,243,583	1,238,471	-5,113	-0.4%
Eyeglasses and Vision	25,091,931	25,030,700	-61,231	-0.2%
Total	$823,149,829	$800,127,466	-$23,022,364	-2.8%

Over the last few years the General Assembly has approved several funding adjustments to move Medicaid rates closer to Medicare. Typical adjustments rebalanced the rates to within a band, such as 80 percent to 100 percent of Medicare.

Despite the progress of the General Assembly, not all Medicaid rates are a similar distance from Medicare. Due to budget constraints, the legislature sometimes expanded the band, such as 70 percent to 100 percent, or settled for smaller progress than a full rebalance, as with transportation rates. Also, the Medicare rates are a moving target, so after rebalancing the Medicaid rates can become out of sync with Medicare again.

The Department views the request as preferable to an across-the-board reduction that would penalize providers with low rates relative to Medicare. The Department's proposal aims to reduce rates at the high end relative to Medicare, with no adjustments to rates at the low end. The impacts are different by service category. Not all providers start with the same adequacy of rates. The providers best compensated relative to Medicare would see the largest reductions.

The table below shows the percent of Medicaid billing codes with rates above 95 percent and below 80 percent of Medicare. The table does not adjust for the volume of billing associated with each code or the price per unit. As a result, it may not reflect how the overall payments compare to Medicare.

Medicaid Billing Codes with Rates Above or Below Medicare		
Service Category	Above 95%	Below 80%
Anesthesia	100.0%	0.0%
Maternity	100.0%	0.0%
Laboratory and Pathology	88.0%	3.0%

Medicaid Billing Codes with Rates Above or Below Medicare		
Service Category	Above 95%	Below 80%
Physician Services - EEG Ambulatory Monitoring	68.0%	26.0%
Physician Services - Vaccines and Immunizations	60.0%	0.0%
Physician Services - Vascular	60.0%	0.0%
Physician Services - Sleep Studies	59.0%	19.0%
Physician Services - Cardiology	46.0%	3.0%
Physician Services - Respiratory	44.0%	29.0%
Physician Services - Radiology	43.0%	1.0%
Physician Services - Ophthalmology	41.0%	8.0%
Surgery - Cardiovascular System	32.0%	2.0%
FFS Behavioral Health	31.0%	3.0%
Physician Services - Other Physician Services	31.0%	12.0%
Surgery - Respiratory System	30.0%	0.5%
Durable Medical Equipment (DME)	26.0%	21.0%
Surgery - Eye & Auditory System	19.0%	1.0%
Physician Services - Women's Health and Family Planning Services	18.0%	3.0%
Surgery - Integumentary System	18.0%	3.0%
Surgery - Other Surgeries	18.0%	14.0%
Physician Services - Ear, Nose, and Throat	13.0%	16.0%
Dialysis	11.0%	0.0%
Prosthetics, Orthotics, and Supplies (POS)	7.0%	62.0%
Physician Services -Gastroenterology	4.0%	0.0%
Surgery - Digestive System	3.0%	2.0%
Vision	2.0%	73.0%
Ambulatory Surgical Center (ASC)	0.0%	0.0%
Physician Services - Health Education	0.0%	0.0%
Surgery - Musculoskeletal System	0.0%	21.0%
Emergency Medical Transportation (EMT)	0.0%	100.0%
Non-emergent Medical Transportation (NEMT)	0.0%	100.0%

Some of the Medicaid rates are above 95 percent of Medicare to encourage "high value" services where increased utilization may decrease costlier emergency services. Last year the General Assembly approved the MPRRAC recommendation to increase high value maternity rates to 100 percent of the benchmark. In FY 2023-24, the General Assembly approved the Department's request to exempt high value vaccine and immunization services from reductions to 100 percent of the benchmark. For these services, the request would undo intentional investments by the General Assembly in preventive care.

Dental services

The Department proposes scaling back an increase in dental rates approved last year. The request saves $34.2 million total funds, including $6.2 million General Fund. Also, it reduces transfers from the Unclaimed Property Trust Fund to the Adult Dental Fund by $3.7 million. Transfers from the Unclaimed Property Trust Fund to the Adult Dental Fund count as TABOR revenue. If there is a TABOR refund in FY 2026-27, the reduction to the Adult Dental Fund will increase the General Fund the State can retain.

Last year the legislature approved the Department's request to increase 28 dental service rates. Of the 28 rates, 24 were identified by the Colorado Dental Association as critical and recommended in order to have the most immediate impact. The 24 codes represent 44.6 percent of dental utilization. In addition to the 24 codes, the legislature increased another 4 highly used preventive codes that together represent 12 percent of utilization, including 3 codes related to sealants and 1 code for silver diamine fluoride to arrest decay. These preventive services could reduce costlier utilization. Preventive, endodontic, and periodontic codes increased to 100 percent of the benchmark and diagnostic services increased to 70 percent of the benchmark.

The benchmark was an American Dental Association (ADA) 2020 survey. The JBC staff raised concerns that the ADA survey includes average fees from all payers, including both public and private. The Department compares most rates to Medicare. The Medicare rates attempt to pay at cost and are typically lower than private insurance. When Medicare rates are not available, the Department usually uses other state Medicaid program rates as the benchmark. There are no comparable Medicare rates and the Department decided to use the ADA survey instead of comparing to other states primarily due to time. A more recent ADA 2022 survey was available, but the Department's request used the ADA 2020 survey due to a technical error. The legislature approved the Department's request, rather than updating for the 2022 survey, for budget balancing reasons.

The increase for dental services was the second largest targeted rate increase approved by the legislature last year. At $78.5 million it was only slightly smaller than the $79.0 million approved for wages for Home- and Community-Based Services workers.

The request would decrease the increase for dental services by 43.6 percent. The percentage reduction was selected based on the amount needed to balance the Governor's budget. The Department notes that dental providers would hold onto a significant remaining increase over the FY 2023-24 rates.

Dental Services					
Item	Total Funds	General Fund	HAS Fee	Adult Dental	Federal Funds
FY 2024-25 Rate increase	$78,485,021	$14,331,366	$3,257,128	$8,594,110	$52,302,417
Reduction percent	43.6%	43.6%	43.6%	43.6%	43.6%
Reduction amount	$34,219,469	$6,248,476	$1,420,108	$3,747,032	$22,803,853

Pediatric behavioral therapies

The Department proposes scaling back an increase in rates for pediatric behavioral therapies approved last year. The request saves $19.5 million total funds, including $9.7 million General Fund. Pediatric behavioral therapies help children with developmental, emotional, or behavioral challenges. Children with autism use the most services.

Last year the legislature approved the recommendation from the Medicaid Provider Rate Review Advisory Committee (MPRRAC) to rebalance rates to 100 percent of a benchmark of other state Medicaid rates that included Nebraska.

The Department proposes using a benchmark that excludes Nebraska. The Department considers Nebraska's rates an outlier. The request for FY 2025-26 is consistent with what the Department requested (and the legislature rejected) in FY 2024-25.

Community First Choice rebalance

The Department proposes rebalancing rates for long-term service and supports to implement Community First Choice. The request costs $256,524 total funds, including $112,871 General Fund.

The General Assembly approved Community First Choice to move selected long-term services and supports from federal waivers that serve defined populations to the State Plan that serves all members. States that implement Community First Choice receive an additional federal match of six percentage points for the services.

Under Community First Choice the Department must pay the same rates for the same services regardless of the population served. The Department currently pays different rates for different waivers.

The Department selected new rates with the goal of keeping aggregate costs the same. Some rates will increase and some will decrease.

Footnotes and Requests for Information

Update on Long Bill Footnotes

The General Assembly includes footnotes in the annual Long Bill to: (a) set forth purposes, conditions, or limitations on an item of appropriation; (b) explain assumptions used in determining a specific amount of an appropriation; or (c) express legislative intent relating to any appropriation. Footnotes to the 2024 Long Bill (H.B. 24-1430) can be found at the end of each departmental section of the bill at https://leg.colorado.gov/bills/HB24-1430 The Long Bill footnotes relevant to this document are listed below.

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

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

24 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses; Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2025-26 state fiscal year.

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

24a Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- This appropriation includes $12,676 total funds, including $6,338 General Fund, for the purpose of increasing provider rates for maternal care to $800 for billing code S0199, $1,000 for billing code 59840, and $1,600 for billing code 59841.

Comment: This footnote explains the purpose of the appropriation to increase provider rates for certain maternal care codes. The Department is complying with the footnote.

25 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs -- It is the General

Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Medicaid Programs.

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

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

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

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

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

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

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

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

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

30 Department of Health Care Policy and Financing, Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $900,000 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $107,671,715, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $107,671,715 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

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

Update on Requests for Information

The Joint Budget Committee annually submits requests for information (RFIs) to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2024-25 Report):
https://leg.colorado.gov/sites/default/files/fy24-25apprept.pdf

The RFIs relevant to this document are listed below.

Requests Affecting Multiple Departments

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

Comment: The Department submitted the report, FY23-24 CUSOM Interagency Agreement, as requested. Through the agreement, the Department uses General Fund appropriated to the Department of Higher Education for the University of Colorado School of Medicine (CUSOM) to match federal funds and increase Medicaid payments to CUSOM providers. In FY 2023-24, the agreement drew $112.4 million federal funds that would not otherwise have been available.

The number of Medicaid members seen by CUSOM providers increased 30.6 percent since the beginning of the agreement in FY 2017-18, excluding emergency department claims. Medicaid enrollment decreased 5.7 percent over the same time. It appears that CUSOM is seeing a greater share of Medicaid patients. That was one of the primary goals of the agreement. It is unknown what would have happened without the agreement.

The report highlights the following accomplishments with the additional federal funds:

- Telemedicine grew 12 percent and eConsults 16.5 percent
- Behavioral health services delivered grew 3 percent
- Specialty care visits grew 20 percent

4 Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of

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

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

5 Department of Health Care Policy and Financing and Department of Human Services, Behavioral Health Administration -- The departments are requested to provide the following updates regarding the implementation of the Non-Medicaid Behavioral Health Eligibility and Claims System by November 1, 2024: (1) the specific non-Medicaid programs that are utilizing the system for eligibility and/or claims purposes, including the specific uses for each program; (2) the number and percentage of clients and claims for which each program is using the system; (3) the number and percentage of providers that are using the system for each program; (4) the Departments' plans to expand the utilization to other programs (including programs housed outside of the BHA) and other providers through FY 2024-25 and in subsequent years; and (5) any efficiencies or payment issues identified through the use of the system thus far.

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

Department of Health Care Policy and Financing

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

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

2 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by November 1, 2024, discussing member utilization of capitated behavioral health services in FY 2022-23 and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year 2023, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

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

3 Department of Health Care Policy and Financing, Office of Community Living -- The Department is requested to provide progress updates by July 15, 2024, and September 15, 2024, on care and case management stabilization.

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

4 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each

year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

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

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

5 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to submit a report by January 2, 2025 regarding the implementation of the FY 2023-24 mid-year capitated payment increase in response to the end of the public health emergency. The report should include how the increase was spent by managed care entities and how funds were utilized to support providers and clinical services in a manner that is compliant with federal regulations.

Comment: This report is not due until January 2, 2025.

Department Annual Performance Report

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

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2025-26 budget request, the FY 2023-24 Annual Performance Report and the FY 2024-25 Performance Plan can be found at the following link:

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

Appendix A: Numbers Pages

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