JOINT BUDGET COMMITTEE

STAFF BUDGET BALANCING FY 2019-20 & FY 2020-21

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

PREPARED BY:
ERIC KURTZ, CHRISTINA BEISEL, AND ROBIN SMART, JBC STAFF
APRIL 21, 2020

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

CONTENTS

HOW TO USE THIS DOCUMENT

The **first section** of this document includes a summary table showing:

- Committee action on Long Bill appropriations through March 16, 2020; and
- Staff recommended changes to Long Bill amounts, assuming General Fund appropriations in FY 2020-21 must be kept at approximately the same level as FY 2019-20 to bring the budget into balance. This recommendation is based on revenue approximately consistent with the March 16, 2020 forecast.

The table is followed by descriptions of each of the changes recommended by staff.

A **second section** of the document (if applicable) summarizes staff recommendations that require statutory change. This may include appropriations reductions that cannot be implemented without a statutory change, changes that affect General Fund revenue (e.g., a transfer from a cash fund), or any other items that are not captured in the Long Bill appropriations table. The recommendations in the second section are also based on the assumption that General Fund appropriations in FY 2020-21 must be kept at approximately the level of FY 2019-20 to bring the budget into balance.

A **third section** of the document includes additional staff recommendations and options for the Committee to consider if deeper cuts are required. For purposes of this section, staff has assumed an additional 10.0 to 20.0 percent reduction to General Fund appropriations and transfers may be required to bring the budget into balance in FY 2020-21.

SUMMARY OF STAFF BUDGET BALANCING RECOMMENDATIONS FOR LONG BILL

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20 APPROPRIATION						
SB 19-207 (Long Bill)	$10,657,855,447	$3,136,842,180	$1,385,028,692	$93,615,672	$6,042,368,903	532.8
Other legislation	89,900,170	57,356,683	43,051,424	0	(10,507,937)	11.8
Long Bill Supplemental	102,700,267	(7,753,857)	292,314	93,850	110,067,960	0.0
Subtotal - JBC Action as of 3/16/20	**$10,850,455,884**	**$3,186,445,006**	**$1,428,372,430**	**$93,709,522**	**$6,141,928,926**	**544.6**
Higher federal match	(12,109,670)	(184,837,580)	(49,140,923)	0	221,868,833	0.0
Electronic health records-reduce	(650,000)	(325,000)	0	0	(325,000)	0.0
SUD benefit-delay	(80,000)	(26,400)	(13,600)	0	(40,000)	0.0
FY 2019-20 APPROPRIATION	**$10,837,616,214**	**$3,001,256,026**	**$1,379,217,907**	**$93,709,522**	**$6,363,432,759**	**544.6**
FY 2020-21 RECOMMENDED APPROPRIATION						
FY 2019-20 Appropriation	$10,837,616,214	$3,001,256,026	$1,379,217,907	$93,709,522	$6,363,432,759	544.6
Enrollment/utilization trends						
R1 Medical Services Premiums	267,097,163	102,811,292	87,227,920	(4,871)	77,062,822	0.0
R2 Behavioral Health	24,799,754	6,024,500	7,006,619	0	11,768,635	0.0
R3 Child Health Plan Plus	9,308,822	16,506,435	7,977,221	0	(15,174,834)	0.0
R4 Medicare Modernization Act	8,903,173	8,903,173	0	0	0	0.0
R5 Office of Community Living	45,979,567	23,167,613	75,410	0	22,736,544	0.0
BA9 School health services forecast	6,235,449	0	3,117,725	0	3,117,724	0.0
Subtotal - Enrollment/utilization trends	*362,323,928*	*157,413,013*	*105,404,895*	*(4,871)*	*99,510,891*	*0.0*
Provider rates						
R7 a) Pharmacy pricing	235,835	52,853	31,643	0	151,339	0.9
R9 Bundled payments	739,313	61,979	67,671	0	609,663	1.8
R10 Community provider rate	91,312,005	33,586,261	4,061,979	0	53,663,765	0.0
R10 Targeted rate adjustments	12,959,087	6,695,538	(54,735)	0	6,318,284	0.0
R18 School health services expansion	75,000	0	0	0	75,000	0.0
Subtotal - Provider rates	*105,321,240*	*40,396,631*	*4,106,558*	*0*	*60,818,051*	*2.7*
R6 Customer service	3,411,940	1,041,444	549,986	8	1,820,502	4.0
R7 b) Pharmacy tech and admin	3,216,874	943,192	512,415	0	1,761,267	2.7
R8 Accountability and compliance resources	2,884,625	546,870	199,760	0	2,137,995	9.0
R11 Substance use disorder patient placement and benefit implementation	88,116,960	17,470,056	5,947,927	0	64,698,977	0.0
R12 Work number verification	(22,577,733)	(3,791,252)	(1,436,052)	0	(17,350,429)	0.0
R13 Long-term care utilization management	1,492,690	369,441	3,732	0	1,119,517	0.0
R14 High cost condition management	315,818	104,220	53,689	0	157,909	0.0
R15 Recoveries and 3rd party liability	(12,634,022)	(3,378,089)	1,917,676	0	(11,173,609)	4.5
R16 Case management and state-only programs	0	(367,759)	0	0	367,759	0.0
R17 Program capacity for older adults	554,060	182,835	94,192	0	277,033	0.9
R19 Leased space	60,862	25,234	5,197	0	30,431	0.0
R20 Safety net provider payments	0	0	0	0	0	0.0
BA11 Convert contractors to FTE	(652,899)	(67,630)	(54,774)	0	(530,495)	10.8
Nursing home closure	(1,398,325)	0	(1,398,325)	0	0	0.0
Annualize provider rates	22,619,833	10,765,734	148,624	0	11,705,475	0.0
Annualize prior year budget actions	4,248,572	4,762,914	(946,359)	117,389	314,628	0.0
Human Services programs	2,965,556	1,482,762	0	0	1,482,794	0.0
Transfers to other state agencies	199,072	(7,146)	0	49,482	156,736	0.0
Centrally appropriated items	4,386,521	2,246,314	592,851	(221,153)	1,768,509	0.0
Other	(3,112,069)	1,617	(3,146,492)	2	32,804	0.0
Subtotal - JBC Action as of 3/16/20	**$561,743,503**	**$230,140,401**	**$112,555,500**	**($59,143)**	**$219,106,745**	**34.6**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R7 a) Pharmacy pricing-revise	(7,597,384)	(1,789,425)	(533,353)	0	(5,274,606)	(0.9)
R9 Bundled payments-undo	(739,313)	(61,979)	(67,671)	0	(609,663)	(1.8)
R10 Community provider rate-undo	(91,312,005)	(33,586,261)	(4,061,979)	0	(53,663,765)	0.0
R10 Targeted rate adjustments-revise	(17,796,067)	(7,652,912)	(324,130)	0	(9,819,025)	0.0
Local minimum wage adjustment	6,590,967	3,295,484	0	0	3,295,483	0.0
R6 Customer service-undo	(3,411,940)	(1,041,444)	(549,986)	(8)	(1,820,502)	(4.0)
R7 b) Pharmacy tech and admin-revise	(738,004)	(133,540)	(82,632)	0	(521,832)	(2.7)
R8 Accountability and compliance-undo	(708,501)	(217,555)	(113,166)	0	(377,780)	(9.0)
R11 SUD benefit-delay	(88,332,034)	(17,540,713)	(5,984,807)	0	(64,806,514)	0.0
R13 Long-term care IHSS-assume savings	(2,642,395)	(1,307,985)	(13,212)	0	(1,321,198)	0.0
R13 Long-term care CDASS-assume savings	(1,214,909)	(657,496)	(13,418)	0	(543,995)	0.0
R14 High cost condition management-undo	(315,818)	(104,220)	(53,689)	0	(157,909)	0.0
R17 Program capacity for older adults-undo	(554,060)	(182,835)	(94,192)	0	(277,033)	(0.9)
Pediatric hospital supplement-eliminate	(13,455,012)	(6,727,506)	0	0	(6,727,506)	0.0
IDD Services cash fund-refinance	0	(6,727,431)	6,727,431	0	0	0.0
Annualize prior budget actions-stop selected	(12,894,853)	(4,764,128)	(655,919)	0	(7,474,806)	(1.4)
APCD Grants for access-eliminate	(500,000)	(500,000)	0	0	0	0.0
APCD State only support-eliminate	(2,838,619)	(2,838,619)	0	0	0	0.0
PACE-freeze new enrollment	(5,875,559)	(2,937,779)	0	0	(2,937,780)	0.0
Member copays-increase	(8,809,862)	(2,136,757)	(733,663)	0	(5,939,442)	0.0
Commission on Family Medicine-reduce	(4,000,000)	(2,000,000)	0	0	(2,000,000)	0.0
Teaching hospital supplement-eliminate	(4,436,698)	(1,993,349)	0	(225,000)	(2,218,349)	0.0
Healthy Communities outreach-reduce	(2,000,000)	(1,000,000)	0	0	(1,000,000)	0.0
Clinic based indigent care-reduce	(2,000,000)	(1,000,000)	0	0	(1,000,000)	0.0
Senior dental program-reduce	(1,000,000)	(1,000,000)	0	0	0	0.0
TOTAL	**$11,132,777,651**	**$3,136,789,977**	**$1,485,219,021**	**$93,425,371**	**$6,417,343,282**	**558.5**
INCREASE/(DECREASE)	**$295,161,437**	**$135,533,951**	**$106,001,114**	**($284,151)**	**$53,910,523**	**13.9**
Percentage Change	2.7%	4.5%	7.7%	(0.3%)	0.8%	2.6%

Note: Changes to staff recommendations for common policy items, including salary survey and provider rates, will be addressed in statewide policy packets.

FY 2019-20

➔ HIGHER FEDERAL MATCH

JBC ACTION AS OF 3/16/20: The JBC assumed a 50.0 percent standard federal match rate for Medicaid for state FY 2019-20.

RECOMMENDATION: Staff recommends assuming a 56.2 percent standard federal match rate for Medicaid for January 2020 through June 2020, reducing the estimated General Fund required for the state fiscal year by $184.8 million General Fund.

The higher assumption about the federal match is based on the federal Families First Coronavirus Relief Act that temporarily increases the standard federal match by 6.2 percent from January 1, 2020 through the last quarter when a disaster is declared by the federal Secretary of Health and Human Services. The higher match only applies to services and not administrative expenses. There is an indirect impact on the federal match for some populations and services where the federal match is determined using a formula based on the standard federal match, like CHP+.

To receive the higher federal match a state may not reduce Medicaid eligibility or increase Medicaid premiums, and may not charge copays for any testing or treatment related to COVID-19. States must also provide continuous eligibility and may not reduce benefits for people enrolled in Medicaid on or after March 18, 2020, through the last month a federal emergency is declared.

If the Medicaid and CHP+ forecasts change, then the amount of savings attributable to the change in the federal match rate will change in proportion to the forecast changes. While the higher federal match decreases General Fund, the requirement that states may not end periods of Medicaid eligibility until after the disaster declaration ends will increase enrollment, offsetting some of the General Fund savings. The Department is still estimating the impact on enrollment.

Key Considerations: This is a change that will happen with or without General Assembly approval for the duration of the federal emergency declaration, if Colorado meets the criteria to qualify for the higher federal match.

➔ ELECTRONIC HEALTH RECORDS - REDUCE

JBC ACTION AS OF 3/16/20: For FY 2019-20, the Committee approved an appropriation of $680,382 total funds, including $340,191 General Fund, to the Office of Information Technology Services line item in the Department of Human Services Medicaid-funded Programs subdivision. The funding is for implementation of the Regional Centers Electronic Health Record System.

RECOMMENDATION: Staff recommends a one-time reduction in the appropriation to Office of Information Technology Services line item of $650,000 total funds, including $325,000 General Fund.

KEY CONSIDERATIONS: The Department of Human Services has indicated that if the appropriation is not reduced, it will revert $650,000 reappropriated funds, including $325,000 Medicaid General Fund, because the system will not be fully operational until FY 2020-21.

➔ SUD BENEFIT - DELAY

JBC ACTION AS OF 3/16/20: For FY 2019-20, the Committee approved an appropriation of $80,000 total funds, including $26,400 General Fund, for the development of a patient placement tool related to expansion of the substance use disorder (SUD) benefit required by H.B. 18-1136 (Substance Use Disorder Treatment).

RECOMMENDATION: As discussed in the FY 2020-21 section of the document, staff is recommending a delay of the SUD benefit by one fiscal year (until FY 2021-22). For FY 2019-20, staff recommends a reduction of $80,000 total funds to delay the development of the patient placement tool until FY 2021-22, as well.

Key Considerations: New program (not yet fully implemented or new proposal for FY 2020-21)

Additional Background:
House Bill 18-1136, which was recommended by the Opioid and Other Substance Use Disorders Interim Study Committee, adds residential and inpatient substance use disorder (SUD) treatment and

medical detoxification services as a benefit under the Colorado Medicaid Program. This expansion is conditional upon federal approval and the receipt of federal financial participation for the costs of the new services. The act limits these new services to persons who meet nationally recognized, evidence-based, level of care criteria for residential and inpatient SUD treatment and medical detoxification services.

The Department submitted the Section 1115 waiver application to the Centers for Medicare and Medicaid (CMS) in October 2019. While the application is under review, the Department is in the process of mapping SUD treatment capacity across the state according to the American Society of Addiction Medicine (ASAM) levels, as well as demand for services.

The Department must submit an implementation plan to CMS that outlines how providers would place patients in SUD treatment based on evidence-based, SUD-specific criteria. CMS requires that:

- "Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM (American Society of Addiction Medicine) Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines," and
- "Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings."

This can be done by either a centralized, uniform decision support system or by requiring each Medicaid provider to develop their own system to justify patient placement decisions.

The Committee approved $80,000 total funds, including $26,400 General Fund, in FY 2019-20 and $1,368,000 total funds, including $451,440 General Fund, in FY 2020-21 to contract for a centralized patient placement tool for use by SUD providers.

For FY 2019-20, the $80,000 total funds request would cover the costs of implementation and training.

In FY 2020-21 and beyond, the appropriation would cover ongoing system support costs, as well as software subscriptions for providers. The request is based on the assumption that licenses will be needed for 2,500 users, based on implementation of a similar system in Arizona (which has a comparable system and number of enrollees to Colorado).

FY 2020-21

➔ R7 A) PHARMACY PRICING - REVISE

JBC ACTION AS OF 3/16/20: The JBC approved an increase of $235,835 total funds, including $52,853 General Fund, and 0.9 FTE to implement different methodologies for pricing (1) newly covered drugs and (2) physician administered drugs.

RECOMMENDATION: Staff recommends:

- Assuming savings of $7.5 million total funds, including $1.8 million General Fund, associated with the change in pricing for newly covered drugs. The Department previously anticipated that developing the pricing plan would take a year and did not presuppose any savings to let discussions and negotiations with stakeholders play out organically. However, at least one vendor has a pricing plan from other states that could largely be cut and pasted into Colorado for implementation beginning in October 2020 to accelerate the anticipated savings.
- Reducing the currently approved amount by another $97,835 total funds, including $32,281 General Fund, and 0.9 FTE for administration of the pricing methodology for newly covered drugs. In the current budget environment, it is reasonable to expect the Department to implement the change within existing resources. The lack of FTE may slow future updates to the pricing methodology.

Of the amount previously approved, the recommendation leaves $138,000 total funds, including $20,572 General Fund, for contract services to perform the surveys necessary to determine the average acquisition cost for physician administered drugs. This proposed pricing methodology is expected to more accurately reflect costs, which is the standard used for other pharmacy rates. While the rates for individual drugs might be higher or lower, the Department expects that in aggregate the new pricing methodology will reduce pharmacy expenditures beginning in FY 2021-22. This is an investment intended to achieve savings in a future year and could be delayed, but it is a strategy with a very high probability of delivering the savings and making rates for physician administered drugs more consistent with rates for other drugs and so the JBC staff recommends retaining the funding.

KEY CONSIDERATIONS: The recommendation includes new assumed savings and reducing a new FTE. The assumed savings is based on cutting and pasting a rate methodology from other states. The Department could implement the change within existing staff. The reductions would have no immediate negative health, life, or safety impact.

➔ R9 BUNDLED PAYMENTS - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $739,313 total funds, including $61,979 General Fund, and 1.8 FTE for administrative costs to implement bundled payments for episodes of care. Initially, the Department plans to target maternity care, but the funding would allow the Department to explore bundled payments for other episodes of care in future years. The net cost in FY 2020-21 includes an estimated savings of $138,736 total funds ($69,368 General Fund) that grows to $277,472 total funds ($138,736 General Fund) in the second year.

RECOMMENDATION: Staff recommends eliminating the increase of $739,313 total funds, including $61,979 General Fund, and 1.8 FTE. Bundled payments are a strategy for changing provider behavior and offering financial incentives for the practices that are most cost effective and achieve the best health outcomes. In a pandemic it will be difficult to get providers to focus on cost saving changes in behavior as opposed to changes in behavior focused on transmission mitigation. Furthermore, bundled payments are administratively intense strategies for both the providers and the department. For these reasons, the staff recommendation is to put off investing in bundled payment initiatives that bet on uncertain future cost savings from behavioral changes by providers.

KEY CONSIDERATIONS: The recommended reductions are to new FTE and a new initiative. Eliminating this increase would have no immediate negative health, life, or safety impact. The intended outcome of long-term reductions in costs is unlikely to occur in the current environment.

➔ R10 COMMUNITY PROVIDER RATE - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $91.3 million total funds, including $33.6 million General Fund, for a 1.9 percent common policy increase in community provider rates.

RECOMMENDATION: Staff recommends no common policy community provider rate increase, saving $91.3 million total funds, including $33.6 million General Fund.

KEY CONSIDERATIONS: Eliminating this increase would have no immediate negative health, life, or safety impact.

➔ R10 TARGETED RATE ADJUSTMENTS - REVISE

JBC ACTION AS OF 3/16/20: The JBC approved several targeted rate adjustments totaling $13.0 million total funds, including $6.7 million General Fund, with annualized costs in FY 2021-22 of $21.2 million total funds, including $10.8 million General Fund.

RECOMMENDATION: Staff recommends the adjustments summarized in the table below.

R10 TARGETED RATE ADJUSTMENTS				
RATE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
JBC Action as of 3/16/20				
Personal Care and Homemaker	$4,534,519	$2,267,259	$0	$2,267,260
Alternative care facility	3,693,258	1,846,629	0	1,846,629
Adult day programs	3,444,422	1,722,211	0	1,722,211
Behavioral health fee-for-service (mostly impacts RCCFs)	1,586,971	875,964	(20,264)	731,271
Habilitation in Residential Child Care Facilities	532,362	266,181	0	266,181
Family planning	97,092	9,709	0	87,383
Ambulatory surgical centers	0	0	0	0
Anesthesia	0	0	0	0
In-home dialysis	(929,537)	(292,415)	(34,471)	(602,651)
Durable medical equipment	0	0	0	0
TOTAL - JBC Action as of 3/16/20	**$12,959,087**	**$6,695,538**	**($54,735)**	**$6,318,284**
Revised Recommendation				
Personal Care and Homemaker	$0	$0	$0	$0
Alternative care facility	0	0	0	0
Adult day programs	0	0	0	0
Behavioral health fee-for-service (mostly impacts RCCFs)	1,586,971	875,964	(20,264)	731,271
Habilitation in Residential Child Care Facilities	532,362	266,181	0	266,181
Family planning	0	0	0	0
Ambulatory surgical centers	0	0	0	0
Anesthesia	(5,977,532)	(1,789,672)	(320,397)	(3,867,463)
In-home dialysis	(929,537)	(292,415)	(34,471)	(602,651)
Durable medical equipment	(49,244)	(17,432)	(3,733)	(28,079)
TOTAL - Recommendation	**($4,836,980)**	**($957,374)**	**($378,865)**	**($3,500,741)**
Revised Rec. Higher/(Lower) than JBC Action				
Personal Care and Homemaker	($4,534,519)	($2,267,259)	$0	($2,267,260)
Alternative care facility	(3,693,258)	(1,846,629)	0	(1,846,629)
Adult day programs	(3,444,422)	(1,722,211)	0	(1,722,211)
Behavioral health fee-for-service (mostly impacts RCCFs)	0	0	0	0
Habilitation in Residential Child Care Facilities	0	0	0	0
Family planning	(97,092)	(9,709)	0	(87,383)
Ambulatory surgical centers	0	0	0	0
Anesthesia	(5,977,532)	(1,789,672)	(320,397)	(3,867,463)
In-home dialysis	0	0	0	0
Durable medical equipment	(49,244)	(17,432)	(3,733)	(28,079)
TOTAL – Difference from JBC Action	**($17,796,067)**	**($7,652,912)**	**($324,130)**	**($9,819,025)**

- Personal Care and Homemaker – The JBC approved a 2.75 percent increase. These are non-medical services that help people with disabilities in performing activities of daily living, such as personal hygiene, cooking, and house cleaning. The primary argument for the increase was to keep pace with rising wages and to attract a quality workforce. The fiscal impact is for a half year assuming implementation January 1, 2021.

  While it is important to keep pace with rising wages, the statewide wage outlook has changed dramatically since the JBC's original action. Most providers will not be required to pay employees more based on an increase in the minimum wage. Senate Bill 19-238 set a statewide minimum wage for personal care and homemaker services of $12.41 per hour and included funding for the cost to providers in FY 2019-20. The S.B. 19-238 industry-specific minimum wage does not

increase annually. The statewide minimum wage does adjust annually by inflation, but it is unlikely to overtake the industry-specific minimum wage set in S.B. 19-238 during FY 2020-21[1].

The exception is providers in Denver, where the minimum wage went from $11.10 in calendar year 2019 to $12.85 in calendar year 2020 with an additional increase scheduled for calendar year 2021 to $14.77. The recommendation on a local minimum wage adjustment is addressed separately.

Although the staff recommendation is for flat funding in FY 2020-21, the Department is investigating and may implement temporary emergency rate increases for providers with significant increased costs related to the coronavirus response, such as hazard pay, increased staffing to account for employees who are sick or otherwise unable to work, and higher costs for cleaning supplies and personal protective equipment. Those temporary emergency increases may benefit this class of providers for the duration of the emergency, but as of the drafting of this document the Department was still determining which providers were most impacted and in need of emergency temporary funding.

- Alternative Care Facility and Adult Day Programs– The JBC approved (1) a 6.4 percent increase for Alternative Care Facilities that provide assisted living services for the elderly and people with disabilities, including 24-hour protective oversight, daily living skills assistance, personal care services, and homemaker services and (2) a 19.0 percent increase in rates for Adult Day Programs that include social and recreational services, assistance with daily activities like eating, dressing, and bathing, emergency services, nutrition services, health monitoring, and medication supervision. For both services the rationale was the same. The Department has a new rate setting methodology, approved by the federal Centers for Medicare and Medicaid Services, for the Home- and Community-Based Services waivers that identifies expected costs for salaries, facilities, administration, capital, and potentially other inputs identified through the stakeholder process. The Department then applies a budget neutrality factor to prevent adjustments from current rates to the expected costs. The Department identified the rates for Alternative Care Facilities and Adult Day Programs as having some of the largest budget neutrality factors. Also, the Department says stakeholders focused on rates for Alternative Care Facilities and Adult Day Programs as among those most in need of adjustment. The Department proposes reducing the budget neutrality factor for Alternative Care Facilities by 18 percent and for Adult Day Programs by 25.0 percent.

  The recommendation assumes revenues will not be sufficient to support rate increases, or protect rates for classes of providers from decreases. If that assumption is incorrect these rates would be among the top priorities for the JBC staff.

  Although the staff recommendation is for flat funding in FY 2020-21, the Department is investigating and may implement temporary emergency rate increases for providers with significant increased costs related to the coronavirus response, such as hazard pay, increased staffing to account for employees who are sick or otherwise unable to work, and higher costs for cleaning supplies and personal protective equipment. Those temporary emergency increases may benefit alternative care facility providers for the duration of the emergency, but as of the drafting

[1] The Department of Labor and Employment has not yet determined what time period they will use for measuring inflation for the annual adjustment to the statewide minimum wage required by the Constitution. For calendar year 2020 the statewide minimum wage is $12.00.

of this document the Department was still determining which providers were most impacted and in need of emergency temporary funding.

- Behavioral Health Fee-for-service and Habilitation in Residential Child Care Facilities – The JBC approved rebalancing behavioral health fee-for-services rates to within 80-100 percent of equivalent Medicare rates. Some rates would increase and some decrease. The changes mostly impact Residential Child Care Facilities (RCCFs) and will provide a net increase for these providers. RCCFs offer individualized behavioral health services, such as psychological testing, psychotherapy, and medication management, for children in a residential facility.

  In addition, the JBC approved increasing rates for habilitation services provided through Residential Child Care Facilities (RCCFs) based on the support level needed by clients. Habilitation services include training in emergency assistance, independent living, and self-advocacy, supports for cognition, communication, and personal care, and costs for travel and supervision. Currently, the Department pays the same for habilitation services in a group home or RCCF. However, RCCFs offer intensive therapeutic supports for extreme behavioral needs that are not available in group homes. According to the Department, the current RCCF rates for habilitation are below cost and the proposed new rates would be more consistent with those paid to RCCFs by the Department of Human Services for children in child welfare out-of-home placement. The new rates would distinguish based on the level of need for the client.

  For these two targeted rate adjustments the staff recommendation is to preserve the amount approved by the JBC in order to increase the number of providers in Colorado. In 2018, the JBC sponsored H.B. 18-1328 expanding the Children's Habilitation Residential Program (CHRP) Medicaid waiver for children placed in out-of-home settings through child welfare, and who are dually diagnosed with IDD and intense behavioral health needs, to include children who are dually diagnosed and not in the custody of child welfare. A shortage of providers in Colorado, however, results in an underutilization of the CHRP waiver and perpetuates the need for parents to relinquish custodial rights in order for the child to obtain services. Because services must be provided to children in the custody of child welfare, if an in-state provider is not available, children are placed in higher cost out-of-state settings and counties bear the burden of the out-of-state placements from fixed child welfare block grant funding. Costs for out-of-state placements are reported to be seven to ten times higher than the current daily rate for RCCFs. Higher reimbursement rates may encourage more in-state providers and/or preserve the current provider network.

- Family planning -- The JBC approved increasing two evaluation and management codes with a family planning modifier. Setting higher rates for codes with the family planning modifier provides a financial incentive to offer family planning services and to bill with the specific modifier code rather than generically. When providers bill with the specific modifier the Department can claim a 90 percent federal match. The financial incentive may encourage proper coding and actually decrease General Fund expenditures, but the likelihood this will occur is uncertain. It is difficult to justify these rate increases on the potential that they might decrease expenditures when the recommendation for other rates is mostly flat.

- Ambulatory surgical centers – The JBC approved adding clinically appropriate procedures for reimbursement in Ambulatory Surgical Centers that would otherwise be performed in an

outpatient hospital setting. Expanding where people can receive services could increase access and utilization, but at a less expensive rate. The Department projects the changes would be budget neutral and the staff recommendation is to stick with the JBC's original decision to approve the change.

- Anesthesia – The Department requested, but the JBC did not approve, reducing anesthesia rates to Medicare. Last year the JBC reduced anesthesia rates to 120 percent of Medicare as a compromise between the Department's request and current rates.

  Based on the forecast and the available revenue, staff recommends the requested reduction to align Medicaid anesthesia rates with Medicare rates and save $6.0 million total funds, including $1.8 million General Fund. The reduction will not likely impact access to care, because patient panels are determined by the hospital and anesthesiologists do not deny based on insufficient rates paid by particular insurance carriers.

- In-home dialysis – The JBC approved changing the way in-home dialysis is billed to align with Medicare practices. Staff recommends adhering to the JBC's original action to save $929,537 total funds, including $292,415 General Fund.

- Durable medical equipment – The Department requested, but the JBC did not approve, rebalancing rates for durable medical equipment to within 80-100 percent of Medicare. The proposed change only applies to rates that are not subject to the federal Upper Payment Limit established by Section 1903(i)(27) of the Social Security Act.

  Staff recommends the rebalancing requested by the Department to save $49,244 total funds, including $17,432 General Fund.

KEY CONSIDERATIONS: The recommendation would stop increases that have not yet been implemented and in some cases make decreases but not below Medicare reimbursement rates. The recommendation will not decrease access to care or negatively impact health, life, and safety from current standards, but it will leave areas unaddressed where the Department has concerns about the current access to care.

➔ LOCAL MINIMUM WAGE ADJUSTMENT

JBC ACTION AS OF 3/16/20: The JBC tabled a decision on the JBC staff recommendation for an increase of $6.6 million total funds, including $3.3 million General Fund. The increase would cover supplemental payments to nursing homes required by H.B. 19-1210, plus provide discretionary increases for select Home- and Community- Based Services that will be challenged by increases in the local minimum wage.

LOCAL MINIMUM WAGE ADJUSTMENT			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
FY 2020-21			
Required by H.B. 19-1210			
Nursing home adjustment	$1,209,024	$604,512	$604,512
Recommended by Department pursuant to H.B. 19-1210			
Personal Care	$3,526,412	$1,763,206	$1,763,206
Homemaker	695,663	347,832	347,831
Health Maintenance Activities	145,757	72,879	72,878
CDASS	123,903	61,952	61,951
Residential Habilitation	890,208	445,104	445,104
Subtotal - Recommended	*$5,381,943*	*$2,690,973*	*$2,690,970*
TOTAL - FY 20-21 Local Minimum Wage Adjustment	**$6,590,967**	**$3,295,485**	**$3,295,482**
FY 2021-22			
Required by H.B. 19-1210			
Nursing home adjustment	$3,940,668	$1,970,334	$1,970,334
Recommended by Department pursuant to H.B. 19-1210			
Personal Care	$8,594,588	$4,297,294	$4,297,294
Homemaker	1,707,558	853,779	853,779
Health Maintenance Activities	300,464	150,232	150,232
CDASS	480,821	240,411	240,410
Residential Habilitation	2,486,291	1,243,146	1,243,145
Subtotal - Recommended	*$13,569,722*	*$6,784,862*	*$6,784,860*
TOTAL - FY 21-22 Local Minimum Wage Adjustment	**$17,510,390**	**$8,755,196**	**$8,755,194**

RECOMMENDATION: Staff recommends that the JBC approve the original staff recommendation. These providers pay near the minimum wage and describe competition for workers with other employers who are paying minimum wage for less challenging work. In the current economic environment the providers of these services might be able to find people willing to work for less, but in Denver they could not pay them less than the minimum wage. Without a rate increase, the higher local minimum wage will provide a challenge for these providers to maintain operations.

The staff recommendation for a local minimum wage adjustment is especially important in the context of the previous staff recommendation to not provide targeted increases for these classes of providers. The original calculations of the amounts needed for a local minimum wage adjustment assumed approval of the targeted rate increases. Without the targeted rate increases, the amounts recommended here for the local minimum wage adjustment will not be entirely sufficient to cover the increase in costs for Denver providers, but they will mitigate the impact.

As an alternative to the staff recommendation, the JBC could consider repealing or somehow modifying H.B. 19-1210 that authorized local minimum wages to eliminate or push out the impacts. It is also possible that Denver may revisit their local minimum wage action and delay or reduce the impact, which would change the need for this funding.

KEY CONSIDERATIONS: Without the funding providers in Denver will be challenged to continue services and there might be negative impacts on access to care and health, life, and safety.

➔ R6 CUSTOMER SERVICE - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $3.4 million total funds, including $1.0 million General Fund, and 4.0 FTE for additional technology, staff, and consulting services for the Member Contact Center that handles customer service calls and chats.

RECOMMENDATION: Staff recommends eliminating the increase of $3.4 million total funds, including $1.0 million General Fund, and 4.0 FTE. The technology and consulting services are strategic investments designed to achieve operation improvements in future years with no immediate impact. In the current budget environment they could be delayed for more short-term priorities. The FTE are to address current existing excessive call response times, which may get longer if calls increase as a result of increased enrollment during the economic downturn. The FTE cost $272,289 total funds, including $89,836 General Fund, and the JBC may want to consider preserving the FTE. If there are increased costs for the Member Contact Center related to responding to the coronavirus, then these additional costs might be an acceptable use of the Coronavirus Relief Fund.

KEY CONSIDERATIONS: The recommended reductions are to new FTE and new technology initiatives. The impact of the new technology initiatives will not be felt until future years. The FTE are more critical for addressing immediate needs, but expenditures for the FTE may qualify as an acceptable use of the federal Coronavirus Relief Fund.

➔ R7 B) PHARMACY TECH AND ADMIN - REVISE

JBC ACTION AS OF 3/16/20: The JBC approved $3.2 million total funds, including $943,192 General Fund, and 2.7 FTE for initiatives to ensure appropriate utilization of drugs and to control pharmacy and physician administered drug expenditures.

RECOMMENDATION: Staff recommends eliminating the portion of the increase for pharmacy administration resources and for connecting the prescriber tool to the Joint Agency Interoperability project, saving $738,004 total funds, including $133,540 General Fund, and 2.7 FTE. The administrative resources would address needs for more pharmacy clinical expertise, a backlog of pharmacy appeals, and general support for the pharmacy program. In the current budget environment it is reasonable to expect the Department to continue managing the workload with the existing staff. Connecting the prescriber tool to the Joint Agency Interoperability (JAI) project would give physicians access to information about other public benefits that might improve a member's health and well-being. This connection to the JAI might add a marginal benefit to the prescriber tool, but none of the projected cost savings associated with the prescriber tool are dependent on this enhancement.

The staff recommendation leaves an increase of $2.5 million total funds, including $809,652 General Fund, for higher than expected costs related to the prescriber tool that will help providers identify the most cost effective medications based on diagnosis information. The prescriber tool is required by S.B. 18-266[2], which was sponsored by the JBC, and the February forecast assumes savings of $5.3 million total funds, including $1.4 million General Fund, associated with the implementation of the prescriber tool. Without funding for the higher than expected costs, the savings will not be realized.

[2] Pursuant to Section 25.5-4-422 (2)(b), C.R.S., "The state department shall provide information regarding Medicaid expenditures and the quality of available pharmaceuticals prescribed by providers participating in the Medicaid program to providers participating in the Accountable Care Collaborative pursuant to Section 25.5-5-419."

Key Considerations: The recommended reductions are to new FTE and new IT features proposed for FY 2020-21. Eliminating these increases would have no immediate negative health, life, or safety impact.

➔ R8 ACCOUNTABILITY AND COMPLIANCE - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $2.9 million total funds, including $546,870 General Fund, and 9.0 FTE to address operational compliance and oversight deficiencies, ensure quality, and improve benefit management.

RECOMMENDATION: Staff recommends eliminating the increase. These are positions related to fiscal management and compliance with federal regulations, including:

- two positions related to long-term services and supports to help with case management oversight and provider enrollment and claims research
- two positions to improve cost allocation reporting related to federal regulations
- administrative support for state plan amendments, rule drafting, and regulator research
- a position related to county performance on eligibility determinations
- a position and resources for provider rate reviews
- a position for negotiating and forecasting prices for contract services
- resources to configure changes to the billing system and address a backlog of changes
- two positions to improve operations and performance of CHP+

Eliminating these positions and resources would not directly impact client health, life, or safety, but there might be indirect impacts due to less oversight. The closest connection between the request and client safety and experience is probably the case management agency oversight and that would be the priority for the JBC staff if any of the positions are maintained.

Key Considerations: The recommended reductions are to new FTE and new initiatives proposed for FY 2020-21. Eliminating these increases would have no immediate negative health, life, or safety impact.

➔ R11 SUD BENEFIT - DELAY

JBC ACTION AS OF 3/16/20: For FY 2020-21, the Committee approved an appropriation of $88.2 total funds, including $17.5 General Fund, for the expansion of the SUD benefit required by H.B. 18-1136 (Substance Use Disorder Treatment). This includes $1.4 million total funds, including $451,440 General Fund, for the creation of a patient placement tool, which will guide placement in the appropriate level of SUD treatment.

RECOMMENDATION: Staff recommends delaying implementation of the SUD benefit for one fiscal year. The staff recommendation includes delaying the implementation of the patient placement tool, as described in the FY 2019-20 section. The recommendation would reduce General Fund appropriations by $17.5 million General Fund.

Key Considerations: New program (not yet fully implemented or new proposal for FY 2020-21)/Affects a vulnerable population

Other Items of Note: The Department has already delayed the benefit by 6 months (until January 2021). This reduction reduces expected General Fund expenditures by $8.5 million.

Additional Background:
H.B. 18-1136 (Substance Use Disorder Treatment), which was recommended by the Opioid and Other Substance Use Disorders Interim Study Committee, adds residential and inpatient SUD treatment and medical detoxification services as a benefit under the Colorado Medicaid Program. This expansion is conditional upon federal approval and the receipt of federal financial participation for the costs of the new services. The act limits these new services to persons who meet nationally recognized, evidence-based, level of care criteria for residential and inpatient SUD treatment and medical detoxification services.

The act requires HCPF, no later than October 1, 2018, to seek federal authorization to provide residential and inpatient substance use disorder treatment and medical detoxification services with full federal financial participation. Prior to seeking federal approval, the act requires HCPF to seek input from relevant stakeholders regarding:

- The coordination of benefits with managed service organizations and the office of behavioral health in the department of human services;
- The most appropriate entity for administration of the benefit;
- The provision of wraparound services needed during treatment and the provision of required services following treatment that may not be covered through the medical assistance program;
- The authorization process for approval of services; and
- The development of a reimbursement rate methodology to ensure sustainability that considers a provider's cost of providing care including lower-volume providers in rural areas.

Finally, the act requires HCPF to prepare and submit a performance review report no later than January 15, 2022, to the Joint Budget Committee and the relevant committees of reference concerning the expanded SUD benefits.

Funding
The final Legislative Council Staff fiscal note for the act identified the following fiscal impact:

Table 1
State Fiscal Impacts Under HB 18-1136

		FY 2018-19	FY 2019-20	FY 2020-21
Revenue		-	-	-
Expenditures	General Fund	$155,193	$148,745	$34,243,205
	Cash Funds	$81,634	$78,242	$11,554,286
	Federal Funds	$236,828	$226,987	$128,359,478
	Centrally Appropriated	$20,326	$27,101	$27,101
	Total	**$493,981**	**$481,075**	**$174,184,070**
	Total FTE	**1.5 FTE**	**2.0 FTE**	**2.0 FTE**
Transfers	**Total**	-	-	-

The above fiscal impact was based on the assumption that HCPF will require two years to seek federal authorization and design the new benefit, so the new services will become available on July 1, 2020. The $174.2 million cost estimate for FY 2020-21 includes some ongoing administrative expenses for

2.0 FTE, contractor/actuarial expenses, and facility licensing, but the figure primarily reflects the estimated cost of the new services. The fiscal note does indicate that to the extent inpatient and residential treatment are more effective than existing treatment options for certain clients, then Medicaid may have costs savings. For example, if persons enter and stay in recovery from substance use disorders, then Medicaid will spend less on repeat instances of substance use treatment, emergency care associated with overdose, and long-term medical costs associated with substance use disorders. However, these potential savings could not be quantified.

The fiscal note also indicated that the expanded Medicaid benefit should reduce expenditures by the DHS' Office of Behavioral Health. However, given the overall demand for services and provider funding, it is assumed that any such savings will be reprioritized toward other eligible purposes.

Status of Implementing an Expanded Benefit
The Department submitted the Section 1115 waiver application to the Centers for Medicare and Medicaid (CMS) in October 2019. While the application is under review, the Department is in the process of mapping SUD treatment capacity across the state according to the American Society of Addiction Medicine (ASAM) levels, as well as demand for services. The Department will host a series of Regional Capacity Meetings from December 2019 through February 2020 in order to receive input about capacity and demand from communities and stakeholders. CMS approval is expected prior to July 1, 2020, when the benefit is expected to go into effect.

In mid-April, the Department announced that it will be delaying implementation of the benefit until January 2021.[3]

FY 2020-21 November 1 Request
The FY 2020-21 request included three components related to the SUD benefit:

- An increase of $173.9 million total funds, including $34.1 million General Fund, to reflect the final FY 2020-21 cost included in the fiscal note for H.B. 18-1136;
- A request to reduce that amount by $86.9 million total funds, including $17.1 million General Fund; and
- An increase of $1.4 million total funds, including $451,440 General Fund, for the implementation of a patient placement tool.

The Department anticipates that the cost of the benefit will be significantly less than the projected fiscal impact of H.B. 18-1136 due to a lower estimated caseload associated with a lack of treatment capacity. The fiscal note used assumptions from a report authored by the Colorado Health Institute (CHI) that estimated the cost of the expanded benefit based on the assumption that 17,000 enrollees would utilize the new treatment options each year. New estimates from CHI indicate that provider capacity will result in less than half of the expected utilization. In other words, the reduction is based on a lack of capacity, not a reduction in the number of people needing the service.

As a result, the Department submitted a request to reduce the appropriation for FY 2020-21 by 50.0 percent, which the Committee approved. The Department believes this is a conservative reduction,

[3] https://www.colorado.gov/pacific/sites/default/files/Special%20Update%20Concerning%20Coronavirus%20(COVID-19)%20and%20Substance%20Use%20Disorder%20(SUD)%20Benefits%204-7-2020.pdf

and it is likely that actual expenditures will be lower. However, much like Medicaid expansion, it will take some time for numbers to settle.

The Committee approved the Department's supplemental request for the patient placement tool contract for a centralized patient placement tool for use by SUD providers. Staff recommended approval of the FY 2020-21 request to continue funding.

For FY 2019-20, the $80,000 total funds were anticipated to cover the costs of implementation and training. In FY 2020-21 and beyond, the appropriation would cover ongoing system support costs, as well as software subscriptions for providers. The request is based on the assumption that licenses will be needed for 2,500 users, based on implementation of a similar system in Arizona (which has a comparable system and number of enrollees to Colorado).

ESTIMATED COSTS IN FY 2020-21 FOR 2,500 USERS	
ASSUMPTIONS	TOTAL FUNDS
Licensing ($420 per user)	$1,050,000
Direct Technical Support ($120 per user)	300,000
System-Wide Support	18,000
Total	**$1,368,000**

As noted in the FY 2019-20 section, staff is recommending an FY 2019-20 reduction of $80,000 total funds in order to delay development of the patient placement tool to align with the recommended delay in the benefit.

➔ R13 LONG-TERM CARE IHSS - ASSUME SAVINGS

JBC ACTION AS OF 3/16/20: The JBC approved $1.5 million total funds, including $369,441 General Fund, to expand a contract for utilization management to include reviews of in-home skilled care authorizations within In-Home Support Services (IHSS).

RECOMMENDATION: Staff recommends assuming savings of $2.6 million total funds, including $1.3 million General Fund, associated with the utilization management. The theory is that case managers currently authorizing health maintenance activities do not have the health credentials to properly evaluate the need for these medical and skilled services and there are incentives for them to overauthorize services to minimize conflict with clients and workload. Therefore, consistent, centralized application of "evidence based" evaluation criteria will result in lower authorizations of care in aggregate.

There are potential problems with assuming savings from this initiative. The criteria for the utilization management has not yet been determined and there is no way to compare it to current practice to accurately estimate the potential savings, or cost (it could actually increase costs). Also, assuming savings appears to set a target or quota for reductions and may undermine confidence that the criteria is truly "evidence based" and objectively reflects the medical needs of clients, as opposed to reflecting budget and cost cutting necessities.

In the current budget environment the JBC staff is less concerned about the appearance or reality of setting an advance target for savings than would be the case in a neutral or growing budget. Utilization management is a strategy that targets resources to those most in need. The staff recommendation is

based on a rough estimate provided by the Department that implementation of utilization management would reduce expenditures by at least 1.0 percent, after accounting for substitution with lower cost services, which is a relatively conservative estimate of what is possible through this strategy.

Key Considerations: The recommended reduction is based on a strategy to ensure high cost services are targeted to those most in need.

➔ R13 LONG-TERM CARE CDASS - ASSUME SAVINGS

JBC ACTION AS OF 3/16/20: The JBC approved utilization management only for in-home skilled care authorizations within In-Home Support Services (IHSS), although the Department proposed also applying it to Consumer Directed Attendant Support Services (CDASS).

RECOMMENDATION: Staff recommends applying utilization management to CDASS as well as IHSS, and assuming savings associated with the strategy, for a net reduction of $1.2 million total funds, including $657,496 General Fund.

From a policy perspective, the JBC staff does not see a reason to treat CDASS differently than all other authorizations of medical services. Including CDASS would moderately increase administrative costs for the contract vendor doing the utilization management review. The federal government provides incentives for utilization management with a 75 percent federal match for administrative costs. Including CDASS would also increase the projected savings achieved at a 50 percent federal match.

Key Considerations: The recommended reduction is based on a strategy to ensure high cost services are targeted to those most in need.

➔ R14 HIGH COST CONDITION MANAGEMENT - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $112,648 total funds, including $37,169 General Fund, for interactive web and mobile software designed to help people manage chronic pain, anxiety, or depression.

RECOMMENDATION: Staff recommends eliminating the funding for this new technology, saving $315,818 total funds, including $104,220 General Fund. The technology is more convenient to access than traditional psychotherapy and the software license is only $2.50 per client. It may allow people to access help where they could or would not before, or increase the frequency they receive help, potentially improving health outcomes. Also, there might be some substitution of high cost care by low cost care. Due to the low cost per client, the technology would not need to make much of a difference to pay for itself. However, this is a new initiative and the JBC staff has relatively low confidence that the technology will make a difference. Also, as way to reduce exposure to the coronavirus, this might be an allowable use of the federal Coronavirus Relief Fund. Finally, this could be an activity eligible for a direct federal grant for telehealth.

Key Considerations: The recommended reduction is to a new informational technology initiative proposed for FY 2020-21. The initiative might be an allowable use of the federal Coronavirus Relief Fund and/or quality for a direct federal grant for telehealth.

➔ R17 PROGRAM CAPACITY FOR OLDER ADULTS - UNDO

JBC ACTION AS OF 3/16/20: The JBC approved $554,060 total funds, including $182,835 General Fund, and 0.9 FTE for oversight of the Program for All-Inclusive Care for the Elderly (PACE) and a study of nursing home rates.

RECOMMENDATION: Staff recommends eliminating the increase, saving $554,060 total funds, including $182,835 General Fund, and 0.9 FTE. The staff and resources for PACE oversight are related to fiscal management and performance. The nursing home rate study is a long term strategy that might justify a reduction in nursing home rates in a future year, but could be delayed in the current budget environment. Eliminating the funding would have no direct impacts on client health, life, or safety, but there might be indirect impacts due to less oversight of PACE.

Key Considerations: The recommended reduction is to new FTE and new initiatives proposed for FY 2020-21. Eliminating the increase would have no immediate negative health, life, or safety impact.

➔ PEDIATRIC HOSPITAL SUPPLEMENT - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $13.5 million total funds, including $6.7 million General Fund, for the Pediatric Specialty Hospital line item that funds payments to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients.

RECOMMENDATION: Staff recommends eliminating the appropriation, saving $13.5 million total funds, including $6.7 million General Fund. The Department has other ways of reimbursing hospitals that serve a large number of indigent clients, including the supplemental payments financed with the Healthcare Affordability and Sustainability (HAS) fee and the safety net provider payments under the federal Disproportionate Share Hospital (DSH) program. Also, hospitals are receiving significant funding through the federal CARES Act and scheduled reductions for Medicare sequestration and Medicaid DSH payments have been delayed. The CARES Act provides $100 billion to hospitals and other entities and of that amount the federal government has announced plans for how the first $30 billion will be distributed, with $360.9 million going to hospitals in Colorado.

KEY CONSIDERATIONS: This is a supplemental payment above and beyond the Department's core operations. It reimburses a hospital for uncompensated and undercompensated care they would otherwise provide and does no directly impact access to care or health, life and safety. To the extent the reduction undermines the financial viability of Children's Hospital, it may indirectly impact access to care and health, life, and safety in the future. The Department has other mechanisms for reimbursing hospitals that serve a large number of indigent clients. Increased federal funds for hospitals may offset some of the lost revenue.

➔ IDD SERVICES CASH FUND - REFINANCE

JBC ACTION AS OF 3/16/20: The JBC approved an appropriation to the Adult Comprehensive Services line item of $541,604,266 total funds, including $269,988,100 General Fund and $814,032 cash funds from the Intellectual and Developmental Disabilities Services (IDD Services) Cash Fund.

RECOMMENDATION: Staff recommends a refinancing of $6,727,431 million General Fund in the Adult Comprehensive Services line item in the Office of Community Living with cash funds from the IDD Services Cash Fund.

As of April 13, 2020, the IDD Services Cash Fund has an available cash balance of $12,801,809. Given the FY 2019-20 appropriations from the fund and the expectation that there will be 2½ months of additional expenditures charged to the fund, JBC Staff estimates that $12.0 million of the cash fund balance is available for appropriation in FY 2020-21. JBC action as of March 16, 2020, included appropriations to various line items from the cash fund of $5,272,569. The remaining estimated balance of $6,727,431 is available for appropriation.

KEY CONSIDERATIONS: The recommendation would have no negative health, life, or safety impact. The savings are one-time.

➔ ANNUALIZE PRIOR BUDGET ACTIONS – STOP SELECTED

JBC ACTION AS OF 3/16/20: The JBC approved annualizations of prior year budget actions that can be grouped into those related to prior year provider rate changes ($22.6 million total funds, including $10.8 million General Fund) and those related to other prior year budget actions (a net $4.2 million total funds, including an increase of $4.8 million General Fund).

The annualizations for prior year provider rate changes are due to the lag between when services are delivered and billed/paid and in some cases due to mid-year implementation of the rate changes. The annualizations for prior year provider rate changes cannot really be stopped, although the JBC could implement new policies to reduce provider rates going forward

Many of the annualizations not related to provider rates could be stopped.

RECOMMENDATION: Staff recommends three modifications to the annualizations to save $12.9 million total funds, including $4.8 million General Fund. The tables below summarize the annualizations attributable to provider rates and to other prior year budget actions and the staff recommended modifications.

ANNUALIZE PROVIDER RATES						
	TOTAL	GF	CF	RF	FF	FTE
FY 19-20 R13 Provider rates	7,647,178	3,248,157	148,624	0	4,250,397	0.0
SB 19-238 Wages and accountability home care	7,178,000	3,620,249	0	0	3,557,751	0.0
FY 19-20 Participant directed personal care and homemaker rates	6,454,701	3,227,351	0	0	3,227,350	0.0
SB 19-209 PACE Program funding methodology	1,339,954	669,977	0	0	669,977	0.0
TOTAL	**$22,619,833**	**$10,765,734**	**$148,624**	**$0**	**$11,705,475**	**0.0**

ANNUALIZE PRIOR YEAR BUDGET ACTIONS						
	TOTAL	GF	CF	RF	FF	FTE
FY 19-20 R12 Medicaid enterprise operations	$6,563,485	$2,399,407	$513,326	$0	$3,650,752	0.2
FY 19-20 NP OeHI operating	4,507,691	2,411,350	0	0	2,096,341	0.3
FY 19-20 R6 Local administration transformation	3,806,273	1,207,420	365,141	111,939	2,121,773	0.5
SB 19-005 Import prescription drugs from Canada	985,162	985,162	0	0	0	0.9
FY 19-20 NP CBMS-PEAK	364,321	59,446	294,318	669	9,888	0.0
FY 19-20 R15 Operational compliance and oversight	355,986	56,240	106,506	0	193,240	0.5
FY 19-20 Breast and cervical cancer cash fund	350,530	0	118,775	0	231,755	0.0
SB 15-011/SB 19-197 Pilot spinal cord alternate medicine	324,817	164,025	0	0	160,792	0.0
HB 19-1210 Local government minimum wage	297,875	148,938	0	0	148,937	0.9
SB 18-200 PERA	238,348	88,747	18,117	5,441	126,043	0.0
FY 19-20 R11 APCD True up	135,422	135,422	0	0	0	0.0
FY 18-19 12 Month contraceptive supply	118,809	2,868	42,729	0	73,212	0.0
SB 19-195 Child and youth behavioral health system	98,676	58,008	0	0	40,668	1.1
FY 19-20 NP Transfer home modification child waiver	14,231	7,116	0	0	7,115	0.0
FY 18-19 R18 Cost allocation vendor consolidation	7,475	2,449	1,288	0	3,738	0.0
HB 19-1287 Treatment opioids and substance use disorder	7,064	2,403	1,129	0	3,532	0.2
FY 19-20 R8 Benefits and tech advisory committee	2,276	842	296	0	1,138	0.2
FY 19-20 R16 Employment first initiatives	2,079	(289,618)	291,697	0	0	0.2
SB 16-192/FY 18-19 R17 Single assessment tool	(3,199,999)	(1,600,000)	0	0	(1,599,999)	0.0
HB 18-1326 Transition from institutional setting	(2,881,664)	(1,440,829)	0	0	(1,440,835)	0.0
FY 20-21 S6 Pharmacy pricing and technology	(1,799,357)	0	0	0	(1,799,357)	0.0
FY 19-20 Comprehensive waiver enrollments	(1,770,579)	2,114,711	(3,000,000)	0	(885,290)	0.0
FY 19-20 R10 Customer experience	(993,724)	(321,867)	(174,995)	0	(496,862)	0.2
FY 19-20 NP CO Choice Transitions	(443,850)	(221,925)	0	0	(221,925)	0.0
FY 19-20 R7 Payment reform hospitals	(400,150)	21,643	11,382	0	(433,175)	0.2
HB 19-1302 Cancer treatment license plate surcharge	(350,530)	0	(118,775)	0	(231,755)	0.0
FY 19-20 R14 Office of Community Living governance	(349,011)	(93,679)	0	0	(255,332)	0.1
FY 18-19 R8 Medicaid savings initiatives	(238,891)	(393,731)	666,416	(660)	(510,916)	0.0
FY 19-20 State Innovation Model	(202,434)	(202,434)	0	0	0	(1.5)
HB 19-1269 Mental health parity insurance	(188,109)	(63,957)	(30,097)	0	(94,055)	(1.0)
FY 18-19 R19 IDD Waiver consolidation	(177,000)	(88,500)	0	0	(88,500)	0.0
FY 17-18 R10/BA9 Pueblo Regional Center corrective action	(235,361)	(117,680)	0	0	(117,681)	(3.0)
HB 19-1004 Affordable health coverage option	(150,000)	(150,000)	0	0	0	0.0
SB 19-222 Individuals at risk of institutionalization	(150,000)	(51,000)	(24,000)	0	(75,000)	0.0
FY 19-20 R7 Adult LTHH/PDN clinical assessment tool	(149,920)	(74,960)	0	0	(74,960)	0.0
HB 19-1038 Dental services for pregnant women on CHP+	(149,786)	44,883	(18,806)	0	(175,863)	0.0
FY 18-19 R10 Drug cost containment	(71,710)	(22,206)	(11,649)	0	(37,855)	0.0
HB 18-1328 Redesign residential child health care waiver	(29,500)	(14,750)	0	0	(14,750)	0.0
Prior year salary survey	(373)	(1,030)	843	0	(186)	0.0
JBC Action as of 3/16/20	**$4,248,572**	**$4,762,914**	**($946,359)**	**$117,389**	**$314,628**	**0.0**
Recommended changes						
FY 19-20 R12 Medicaid enterprise operations	($7,402,000)	($1,367,616)	($655,919)	$0	($5,378,465)	(0.2)
FY 19-20 NP OeHI operating	(4,507,691)	(2,411,350)	0	0	(2,096,341)	(0.3)
SB 19-005 Import prescription drugs from Canada	(985,162)	(985,162)	0	0	0	(0.9)
Subtotal - Recommended changes	**($12,894,853)**	**($4,764,128)**	**($655,919)**	**$0**	**($7,474,806)**	**(1.4)**
Revised Total Annualizations	**($8,646,281)**	**($1,214)**	**($1,602,278)**	**$117,389**	**($7,160,178)**	**(1.4)**

- FY 19-20 R12 Medicaid enterprise operations – Stopping the annualization may delay reprocurement of the Medicaid Management Information System (MMIS) that handles billing for the department. Most of the General Fund in the annualization is for a contract to develop, implement, and secure interfaces between modules. This may not be the most logical portion of the project to stop, but the Department has flexibility within the appropriation to do other things

to absorb the reduction. The primary effect of stopping the annualization is to reduce the total funding for the MMIS by 7.8 percent from the $82.0 million previously approved by the JBC. This reduction will negatively impact operations, but like most major capital construction and information technology projects, there are ways the Department could phase the work and push costs out to future years to absorb the decrease in funding. The staff recommendation keeps some negative annualizations for one-time operating expenses and payments to OIT as well as a $1.2 million shift from federal funds to General Fund for the end of enhanced federal funds for development work related to the single assessment tool.

- FY 19-20 NP OeHI operating – The Office of eHealth Innovation is a relatively new initiative created by executive order to implement the Colorado Health IT Roadmap. Stopping the annualization would delay implementation of related capital construction and the implementation of the Colorado Health IT Roadmap. The recommendation would leave roughly $2.0 million total funds, including $1.0 million General Fund, and 2.7 FTE for the office to continue work at a slower pace.
- SB 19-005 Import prescription drugs from Canada – Most of the annualization is for contract services to prepare for implementation by July 1, 2021. The staff recommendation assumes the Department will NOT receive federal approval by December 2020 and therefore will not need to ramp up for implementation. The assumption is that the federal Centers for Medicare and Medicaid Services (CMS) has different priorities at the moment and may take longer to review the request. Portions of the proposal are also contingent on cooperation from Canada. However, if the staff assumption is wrong, then the Department would need the resources to meet the statutory deadlines. If federal approval is received, then the only way to stop or delay the implementation would be legislation to change the statutory timelines. The Department is required to submit a request for approval by September 1, 2020, and to implement the program within six months of federal approval. If federal approval is provided, the JBC could run legislation in the next session to delay or stop implementation.

➔ ALL PAYER CLAIMS DATABASE (APCD) GRANTS FOR ACCESS - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $500,000 General Fund for these grants that provide academics, nonprofits, and government entities (except the Department) with free access to the All Payer Claims Database (APCD) for research. The criteria for the grants is developed by the APCD advisory committee.

RECOMMENDATION: Staff recommends eliminating the General Fund grant program, saving $500,000 General Fund. The grants pay for research of claims data that happened several months in the past with applications for improving the health care system that are generally several years into the future.

KEY CONSIDERATIONS: Eliminating the increase would have no immediate negative health, life, or safety impact. To the extent any research of claims data is related to COVID-19 there might be federal funds available, depending on the entity performing the analysis and the nature of the work.

➔ ALL PAYER CLAIMS DATABASE STATE ONLY SUPPORT - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved $4.5 million total funds, including $3.7 million General Fund to continue state operating support for the All Payer Claims Database (APCD), not including the grant program.

RECOMMENDATION: Staff recommends eliminating state only support for the APCD, saving $2.8 million General Fund. This would leave $1.7 million total funds for the program, including $833,267 General Fund and $833,267 matching federal funds, based on Medicaid's share of the data in the APCD. The JBC could also consider eliminating all funding for this discretionary program.

Prior to FY 2018-19 the APCD was funded entirely by gifts, grants, donations, and earned revenue. The goals of the APCD are aligned with those of many private philanthropic organizations, such as the Colorado Health Foundation or the Kaiser Family Foundation. Also, the APCD charges fees for reports and datasets. The authorizing legislation made the creation of the APCD contingent on the receipt of gifts, grants, and donations. Appropriations from the General Fund were specifically prohibited. House Bill 18-1327, sponsored by the JBC, changed the statute to allow General Fund appropriations and provided state funding in FY 2018-19 followed by an increase in FY 2019-20, such that the majority of funding for the APCD now comes from state sources.

Some examples of the uses of the APCD include:

- Best practices -- The APCD can provide quality indicators like the rates of hospitalization for patients that received certain billed preventive interventions. A number of statewide initiatives to improve care, including the Comprehensive Primary Care Plus (CPC+), the Multi-payer Collaborative, and the State Innovation Model (SIM), use the APCD in ways like this to facilitate performance-based payments and encourage practice transformation. The Department uses the APCD to calculate utilization of potentially avoidable procedures by hospital for use in the development of hospital report cards. The Network for Regional Healthcare Improvement used the APCD to provide reports to provider groups comparing their costs and efficiency to broader averages.
- Access to care -- The Department uses data from the APCD to compare utilization by payer to help determine whether Medicaid rates and practices allow Medicaid patients to access care consistent with patients insured by other payers, as required by federal law.
- Rate setting -- The Department uses the APCD to identify appropriate benchmarks and measure Medicaid rates against those benchmarks.
- Cost of care by payer -- The Department uses analysis from the APCD to calculate total cost of care by payer group: Medicare, Medicaid, and commercial. The National Bureau of Economic Research is using the APCD to explore how Medicare rates affect commercial insurance rates.
- Cost of care by region -- For the Colorado Commission on Affordable Health Care, the Department and the Division of Insurance used the APCD to analyze the current nine geographic regions that determine insurance rates against other potential configurations, and to analyze factors driving variations in health care costs by region.

KEY CONSIDERATIONS: The recommended reduction is to a relatively new information technology initiative. Eliminating the increase would have no immediate negative health, life, or safety impact.

➔ PACE – FREEZE NEW ENROLLMENT

JBC ACTION AS OF 3/16/20: The JBC approved $248.0 million total funds, including $124.0 million General Fund, for the Program for All-inclusive Care for the Elderly (PACE) based on the February 2020 forecast. PACE is a comprehensive managed care program for people 55 years and older who meet nursing facility level of care standards. Benefits include standard medical costs, behavioral health, and long-term services and supports. For each PACE client, providers receive a capitated payment from both Medicare and Medicaid in proportion to the services those programs would expect to cover for similar clients with dual eligibility who are not enrolled in PACE.

RECOMMENDATION: Staff recommends freezing new PACE enrollment to save $5.9 million total funds, including $2.9 million General Fund. Clients would still have access to needed services. The services just would not be coordinated through the PACE delivery model.

This strategy pushes costs out to future years. The state pays PACE providers a monthly capitated rate based on the expected costs for clients over their lifetime in the program. When a person first enrolls in PACE the rate is higher than expected costs, but the rate stays constant over time as the person ages and expected costs increase. Freezing new PACE enrollment reduces the projected expenditures to those for younger clients, but in future years as those clients age and need more services the state would pick up the higher cost.

Utilization of many of the PACE services, especially for younger clients, is expected to decrease with stay-at-home orders. For example, utilization of non-emergency transportation, day programs, primary care visits, and behavioral health are all down. However, the capitated payment for PACE providers is not changing. Because they are receiving a fixed capitated rate and experiencing a decrease in client utilization, PACE providers are likely to come out significantly ahead this year, with or without a freeze on new enrollments.

Freezing new enrollments would limit access to a popular service delivery method, but clients would still have access to all the same services through standard Medicaid. If they need to see a doctor, visit a behavioral health specialist, or receive long-term services and supports, they will have access to all those services, just not through a PACE organization.

KEY CONSIDERATIONS: Freezing PACE enrollment would not reduce access to care or harm health, life, or safety. It would reduce business growth for PACE providers who are likely to make significant money this year, with or without a freeze on enrollment, due to receiving a fixed capitated payment when client service utilization is decreasing.

➔ MEMBER COPAYS – INCREASE

JBC ACTION AS OF 3/16/20: The JBC approved funding based on the February 2020 forecast assuming that current policies regarding member copayment requirements would continue.

RECOMMENDATION: Staff recommends the JBC increase existing Medicaid member copays to the federal maximum, saving $8.8 million total funds, including $2.1 million General Fund.

The JBC could also consider adding new copays for long-term services and supports, but this is not part of the staff recommendation. Adding copays at the federal maximum for long-term services and supports would save up to $3.6 million total funds, including $1.8 million General Fund.

MEMBER COPAYS - INCREASE

	EXISTING COPAY	FED MAX	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Pharmacy	$3.00	$4.00	$2,264,303	$443,736	$137,683	$1,682,884
Physician Services	$2.00	$4.00	1,598,686	313,294	97,210	1,188,182
Federally Qualified Health Centers	$2.00	$4.00	350,540	68,695	21,315	260,530
Rural Health Centers	$2.00	$4.00	61,416	12,036	3,734	45,646
Inpatient Services	$27.05	$75.00	213,713	41,881	12,995	158,837
Outpatient Services	$4.00	$4.00	0	0	0	0
Durable Medical Equipment	$1.00	$4.00	439,314	86,092	26,713	326,509
Lab and X-Ray	$1.00	$4.00	117,666	23,059	7,155	87,452
Anesthesia	$0.00	$4.00	308,788	79,082	18,168	211,538
NEMT	$0.00	$4.00	2,266,280	795,828	337,312	1,133,140
Dental	$0.00	$4.00	1,189,156	273,054	71,378	844,724
Recommend - Increase existing copays			**$8,809,862**	**$2,136,757**	**$733,663**	**$5,939,442**
Home Health	$0.00	$4.00	816,032	408,016	0	408,016
Private Duty Nursing	$0.00	$4.00	21,548	10,774	0	10,774
BI Waiver	$0.00	$4.00	30,744	15,372	0	15,372
CMHS Waiver	$0.00	$4.00	194,356	97,178	0	97,178
DD Waiver	$0.00	$4.00	583,116	291,558	0	291,558
EBD Waiver	$0.00	$4.00	1,651,744	825,872	0	825,872
SCI Waiver	$0.00	$4.00	18,016	9,008	0	9,008
SLS Waiver	$0.00	$4.00	*311,468*	*155,734*	*0*	*155,734*
Not recommended - Add new copays			**$3,627,024**	**$1,813,512**	**$0**	**$1,813,512**

Federal regulations exempt certain populations and services from out-of-pocket expenses and cap cost sharing at 5 percent of family income. For example, children, pregnant women, and Native Americans, are exempted, and emergency services are exempted.

The Department identified studies showing that even very small increases in copays of $1-$5 can impact utilization of services, such as vaccinations, prescription drugs, mental health visits, preventive and primary care.

In particular, the Department expressed concerns about the potential for copays on long-term services and supports (LTSS) to decrease utilization of services that can prevent more costly hospitalization and institutionalization. The Department noted that LTSS providers do not currently have procedures to collect copays and no other state has implemented copays for LTSS. For these reasons, the staff recommendation is limited to increasing existing copays and does not include new copays for LTSS.

When the JBC has considered increasing copays in the past, providers have complained that they are unable to collect copays consistently and efficiently from Medicaid clients. Trying to collect after the fact from a client that does not pay is not worth the marginal value of the copay. As a result, the providers argue, increasing copays is effectively a provider rate reduction.

Key Considerations: Impacts on health, life, and safety are indirect and proportional to how much increased copays change client behavior and utilization of preventive or necessary services. Some of the fiscal impact will be on providers who either choose not to charge copays or are unable to charge or collect copays from very low income Medicaid clients.

➔ COMMISSION ON FAMILY MEDICINE - REDUCE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $8.2 million total funds, including $4.1 million General Fund, for payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians

RECOMMENDATION: Staff recommends a reduction of $4.0 million total funds, including $2.0 million General Fund, or roughly 50 percent. The Commission on Family Medicine plays an important role in developing the primary care provider network, particularly in rural and underserved areas, but this is teaching rather than direct services and therefore a lower priority than preserving eligibility and benefits. The JBC could consider removing the full funding for FY 2020-21.

KEY CONSIDERATIONS: The recommended reduction impacts teaching and development of the provider network, rather than direct services. Impacts on access to care and health, life, and safety are indirect and in the future.

➔ TEACHING HOSPITAL SUPPLEMENT - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $2.8 million total funds, including $1.4 million General Fund, for Denver Health and $1.6 million total funds, including $590,992 for the University of Colorado. These appropriations pay for graduate medical education.

RECOMMENDATION: Staff recommends eliminating these supplemental payments to save $4.4 million total funds, including $2.0 million General Fund. These are expenditures for education, rather than direct services, and therefore a lower priority than preserving eligibility and benefits. Graduate medical education will continue, but these providers would not receive special supplemental payments to offset their costs. Also, hospitals are receiving significant funding through the federal CARES Act and scheduled reductions for Medicare sequestration and Medicaid Disproportionate Share Hospital (DSH) payments have been delayed. The CARES Act provides $100 billion to hospitals and other entities and of that amount the federal government has announced plans for how the first $30 billion will be distributed, with $360.9 million going to hospitals in Colorado.

KEY CONSIDERATIONS: The reduction would not directly impact access to care or health, life, and safety. Increased federal funds may offset some of the lost revenue to hospitals.

➔ HEALTHY COMMUNITIES OUTREACH - REDUCE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding for the Healthy Communities program that provides outreach and health education to recently eligible children, young adults, and pregnant women at no cost to families. Examples of services include assistance with completing applications for medical assistance, navigating health care systems, understanding coverage and benefits, referrals to community resources and providers, reenrollment, and preventing gaps in coverage. The program also follows up to ensure families meet recommended well-child visits. The program is part of the Department's strategy for meeting federal goals for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits.

RECOMMENDATION: Staff recommends reducing the funding by $2.0 million total funds, including $1.0 million General Fund, or about 75 percent. The program overlaps with orientation and outreach work performed by HealthColorado and the Regional Accountable Entities. By shifting responsibilities the Department could absorb a reduction while still performing activities aimed at meeting federal goals for EPSDT.

KEY CONSIDERATIONS: The recommended reduction may reduce adherence to recommended well child visits and the successful navigation by new clients of the health care system and benefits, thereby moderately impacting health, life, and safety. These potential impacts are mitigated by overlapping functions of HealthColorado and the Regional Accountable Entities.

➔ CLINIC BASED INDIGENT CARE-REDUCE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $6.1 million, including $3.0 million General Fund, for clinic based indigent care. This line item partially reimburses clinics for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people with income up to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is not an insurance program. Providers may choose what services beyond emergency care that they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

The available funding is distributed based on each participating clinic's share of estimated write-off costs compared to all participating clinics. This line item existed prior to the creation of the provider fee on hospitals, and so using the Healthcare Affordability and Sustainability Fee to match the federal funds might be viewed as supplanting existing General Fund, which is currently prohibited by statute, but that could be changed.

RECOMMENDATION: Staff recommends a reduction of $2.0 total funds, including $1.0 General Fund, or approximately 33 percent for FY 2020-21.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are receiving significant federal support, including to date $24.1 million in CARES Act Supplemental Funding Awards and another $1.7 million in Coronavirus Preparedness and Response Supplemental Funding for Colorado providers. The FQHCs and RHCs may be eligible for future distributions that have not yet been announced from the $100 billion nationwide in the CARES Act for the Public Health and

Social Services Emergency Fund. In addition, FQHCs and RHCs are eligible for increased flexibility to bill for telehealth services, telehealth grants, grants for rural community health, funds for detection, treatment, prevention and diagnosis of COVID-19, and loans.

The CICP serves people who are not eligible for Medicaid or CHP+, which includes people who are marginally less vulnerable due to higher income levels. However, the CICP also serves vulnerable populations who are ineligible for reasons other than income, such as citizens and legal immigrants who have been in the U.S. for less than five years. The staff recommendation for a partial reduction is intended to preserve funds for the lowest income populations.

According to the most recent annual report, in FY 2018-19 clinics served approximately 25,000 people through the CICP and received reimbursement through this line item for 37.5 percent of their indigent care costs. Providing indigent care is part of the mission of these clinics and the appropriation defrays, but does no eliminate, their charitable care costs.

KEY CONSIDERATIONS: The recommended reduction may impact access to care and health, life, and safety for vulnerable populations, to the extent the providers decrease offered services to CICP clients due to lower funding. Additional federal funds available to FQHCs and RHCs may offset some lost CICP revenue. Most CICP clients have income levels higher than Medicaid.

➔ SENIOR DENTAL PROGRAM - REDUCE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $4.0 million General Fund for the Senior Dental Program that makes grants to providers who serve low-income seniors who do not otherwise have access to dental care through Medicaid, the Old Age Pension Health and Medical Program, or private insurance. There is no federal match.

RECOMMENDATION: Staff recommends reducing the program by $1.0 million General Fund. This is a grant program above and beyond the Department's core functions and there is no federal match. The General Assembly approved a $1.0 million increase in FY 2019-20. The JBC could consider a larger reduction or eliminating the funding, but eliminating the funding would be best accomplished through a bill, since statute requires the Department to implement a grant program and there is no explicit language about the grant program being subject to annual appropriation.

Of the recommended reductions, this is among the lowest priorities for the JBC staff, due to the negative impacts on access to care and health, life, and safety.

KEY CONSIDERATIONS: The recommended decrease would reduce access to care and health, life, and safety, but this is a grant program above and beyond the Department's core functions and there is no federal match. This is a lower priority than eligibility or benefit reductions for core Medicaid and CHP+ functions that leverage federal funding.

SUMMARY OF RECOMMENDATIONS REQUIRING STATUTORY CHANGE

INCREASE GENERAL FUND REVENUE - STATUTORY CHANGE REQUIRED			
FY 2020-21 REVENUE	NET GF IMPACT	OTHER FUNDS	TOTAL FUNDS
Reinsurance-stop 2nd year	**$59,660,395**	**($174,000,000)**	**($114,339,605)**

REDUCE GENERAL FUND EXPENDITURES - STATUTORY CHANGE REQUIRED				
FY 2019-20 EXPENSE	NET GF IMPACT	OTHER FUNDS	TOTAL FUNDS	FTE
Higher federal match-capture cash fund savings	**($27,390,079)**	**$27,390,079**	**$0**	**0.0**

REDUCE GENERAL FUND EXPENDITURE - STATUTORY CHANGE REQUIRED				
FY 2020-21 EXPENSE	NET GF IMPACT	OTHER FUNDS	TOTAL FUNDS	FTE
HAS Fee-offset General Fund	(40,000,000)	0	(40,000,000)	0.0
Nursing provider rates-suspend	(9,483,914)	(9,483,914)	(18,967,828)	0.0
Higher federal match-capture cash fund savings	(5,495,973)	5,495,973	0	0.0
Comprehensive waiver list-remove approved bill	(5,500,000)	(5,500,000)	(11,000,000)	0.0
SBIRT grants-eliminate	(1,500,000)	1,500,000	0	0.0
Community First Choice-remove approved bill	(270,126)	(1,324,677)	(1,594,803)	(3.6)
TOTAL	**($62,250,013)**	**($9,312,618)**	**($71,562,631)**	**(3.6)**

➔ REINSURANCE – STOP SECOND YEAR

JBC ACTION AS OF 3/16/20: Under current law the reinsurance program would receive an estimated $59.7 million General Fund in FY 2020-21 and $19.7 million in FY 2021-22 for reinsurance payments. There is also another $1.0 million per year for administrative costs.

The JBC tabled a staff recommendation to sponsor legislation making several changes to the reinsurance program, including increasing the General Fund by $8.5 million in FY 2020-21 and decreasing the General Fund by $11.7 million in FY 2021-22 for a net reduction of $3.3 million General Fund.

RECOMMENDATION: In light of the new revenue forecast, the revised staff recommendation is to sponsor legislation eliminating the second year of the program in calendar year 2021 and stopping all scheduled transfers of state funds to the program, saving $59.7 million General Fund in FY 2020-21 and $19.7 million General Fund in FY 2021-22 compared to current law. The legislation would need to adjust the hospital fee collection schedule to bring in an additional $26.0 million in FY 2021-22 to avoid negative cash flow, but the hospitals would not need to pay anything in FY 2022-23, reducing the overall burden on hospitals to support the program by $14.0 million. The recommendation would reduce federal funds flowing through the state by $160.0 million, but the money would still come to Colorado in the form of federal tax credits to people buying insurance on the individual market.

Reinsurance Cash Flow					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Cumulative
Current Law					
Beginning Balance	$0	$184,000,000	$403,660,395	$213,320,790	
Revenue					
General Fund transfers	$15,000,000	$40,000,000	$0	$0	$55,000,000
Insurance premium taxes	0	19,660,395	19,660,395	0	39,320,790
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	0	3,000,568
Subtotal - State Grants	***$15,836,200***	***$60,742,579***	***$20,742,579***	***$0***	***$97,321,358***
Hospital special fee	0	0	40,000,000	40,000,000	80,000,000
Federal Funds	169,000,000	160,000,000	0	0	329,000,000
Revenue - Current Law	$184,836,200	$220,742,579	$60,742,579	$40,000,000	$506,321,358
Expenditures					
Reinsurance payments	0	0	250,000,000	250,000,000	500,000,000
Administration	836,200	1,082,184	1,082,184	0	3,000,568
Expenditures - Current Law	$836,200	$1,082,184	$251,082,184	$250,000,000	$503,000,568
Ending Balance	$184,000,000	$403,660,395	$213,320,790	$3,320,790	
Recommendation-revised					
Beginning Balance	$0	$184,000,000	$184,000,000	$0	
Revenue					
General Fund transfers	$15,000,000	$0	$0	$0	$15,000,000
Insurance premium taxes	0	0	0	0	0
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	0	3,000,568
Subtotal - State Grants	***$15,836,200***	***$1,082,184***	***$1,082,184***	***$0***	***$18,000,568***
Hospital special fee	0	0	66,000,000	0	66,000,000
Federal Funds	169,000,000	0	0	0	169,000,000
Revenue - Rec.	$184,836,200	$1,082,184	$67,082,184	$0	$253,000,568
Expenditures					
Reinsurance payments	$0	$0	$250,000,000	$0	$250,000,000
Administration	836,200	1,082,184	1,082,184	0	3,000,568
Expenditures - Rec.	$836,200	$1,082,184	$251,082,184	$0	$253,000,568
Ending Balance	$184,000,000	$184,000,000	$0	$0	
Rec Higher/(Lower) than Current Law					
Revenue					
State Grants[1]	**$0**	**($59,660,395)**	**($19,660,395)**	**$0**	**($79,320,790)**
Hospital special fee	0	0	26,000,000	(40,000,000)	(14,000,000)
Federal Funds	0	(160,000,000)	0	0	(160,000,000)
Subtotal - Revenue	$0	($219,660,395)	$6,339,605	($40,000,000)	($253,320,790)
Expenditures	$0	$0	$0	($250,000,000)	($250,000,000)

[1] This is revenue to the reinsurance program. A negative state grant revenue to reinsurance is an increase in General Fund revenue to the state budget.

Reinsurance is a program that benefits only the population that buys insurance on the individual market and within that subgroup mostly people with income over 400 percent of the federal poverty guidelines. For people with income below 400 percent of the federal poverty guidelines the benefit is largely canceled out by changes in federal tax credits.

KEY CONSIDERATIONS: Actual data has not yet been released by the Division of Insurance (DOI), but prior to implementation the DOI projected reinsurance would increase enrollment in the individual market by 6,378 people. For these people stopping the reinsurance program would reduce access to care and impact health, life, and safety. The remainder of the population affected by the reinsurance program would presumably continue purchasing insurance on the individual market and maintain access to care, but would pay significantly more for that insurance.

The reinsurance program benefits a relatively less vulnerable population (with income above 400 percent of the federal poverty guidelines) than either Medicaid or CHP+, making it a relatively lower priority to preserve eligibility and benefits. Reinsurance is a new program that began in 2020 and was time-limited from the beginning by the legislature.

➔ HIGHER FEDERAL MATCH – CAPTURE CASH FUND SAVINGS

JBC ACTION AS OF 3/16/20: The JBC assumed a 50.0 percent standard federal match rate for Medicaid for state FY 2019-20.

RECOMMENDATION: Staff recommends that the JBC run legislation to allow the General Fund to receive the benefit that accrues to cash funds from the higher federal match provided by the federal Families First Coronavirus Relief Act. This is similar to what the General Assembly did in S.B. 09-264 when Colorado received a temporary higher federal match through the federal American Recovery and Reinvestment Act (ARRA). Some of the fiscal impact will be in FY 2020-21, due to delays between when certified public expenditures occur and when the Department reimburses for them.

The table below summarizes the estimated offset to the General Fund and where it would originate. Absent the recommended legislation, the entities listed in the source column would receive the benefit from the higher federal match, rather than the General Fund. The figures in the table assume the higher federal match is in effect from January 2020 through June 2020, but not for any quarters in FY 2020-21.

Federal Match Related Transfers to General Fund

Source	FY 2019-20	FY 2020-21
Provider fee on hospitals (HAS fee)	$21,132,815	$0
Provider fee on nursing homes	3,601,130	0
CHP+ Trust	2,656,134	0
CU School of Medicine	0	4,835,886
Denver Health	0	568,374
Home Health Agencies	0	57,357
UCHealth Memorial Hospital	0	34,355
TOTAL	**$27,390,079**	**$5,495,973**

Key Considerations: The recommendation would not reduce the net benefit to any of the providers from current appropriations. The transfers capture the benefit that would otherwise accrue to these providers from the higher federal match rate and instead allocate that benefit to the General Fund.

➔ HAS FEE – OFFSET GENERAL FUND

JBC ACTION AS OF 3/16/20: The JBC approved $629.3 million in supplemental payments to hospitals financed with the Healthcare Affordability and Sustainability (HAS) Fee based on the February 2020 forecast. This is the net aggregate benefit to the hospitals after accounting for the portion of the total supplemental payments that comes from the HAS Fee.

RECOMMENDATION: Staff recommends the JBC sponsor legislation to temporarily use $40 million from the HAS Fee to offset General Fund for Medical Services Premiums. For an amount up to $40 million the Department could increase the HAS Fee and not have to decrease supplemental payments.

For amounts over $40 million the Department would need to decrease supplemental payments to the hospitals, due to federal limits on how much the state can collect from hospitals. In a more than $40 million scenario the lost funding for the hospitals might be moderately compounded, if there is a higher federal match available through the Families First Coronavirus Response Act for any quarter in FY 2020-21. For this reason, the staff recommendation is to use $40 million to offset General Fund, but the JBC could choose to target more.

The General Assembly took similar measures in the previous economic downturn. For example, S.B. 11-212 temporarily allowed $50.0 million in FY 2011-12 and $25.0 million in FY 2012-13 from the provider fee on hospitals to be used on Medical Services Premiums without changing the status of the assessment on hospitals as a fee, rather than a tax. An ongoing, rather than time-limited, General Fund offset from the HAS fee might be more problematic.

Hospitals are receiving significant funding through the federal CARES Act and scheduled reductions for Medicare sequestration and Medicaid Disproportionate Share Hospital (DSH) payments have been delayed. The CARES Act provides $100 billion to hospitals and other entities and of that amount the federal government has announced plans for how the first $30 billion will be distributed, with $360.9 million going to Colorado hospitals.

Key Considerations: This is very similar to a provider rate reduction, but targeted to hospitals. The Department has significant flexibility in designing the allocation of the supplemental payments to potentially mitigate the impact on hospitals that are more dependent on the revenue to maintain operations, such as some of the rural and critical access hospitals. Increased federal funds may offset some of the lost revenue to hospitals.

➔ NURSING PROVIDER RATES - SUSPEND

JBC ACTION AS OF 3/16/20: The JBC approved approximately $19.0 million total funds, including $9.5 million General Fund, for a 3.0 percent increase in nursing home provider rates consistent with the statutory formula that requires nursing home rates to adjust annually by the lesser of actual costs or 3.0 percent General Fund growth. The JBC rejected a request from the Department to sponsor legislation that would eliminate the annual statutory rate adjustment.

RECOMMENDATION: Staff recommends that the JBC sponsor legislation to skip the statutory adjustments in FY 2020-21 and FY 2021-22, resuming in FY 2022-23 with a maximum 3.0 percent increase on the current base. This is similar to what the General Assembly did in the previous economic downturn.

The JBC could consider permanently eliminating the statutory annual adjustment to nursing home rates, as requested by the Department, so that in the future nursing home rate adjustments are determined annually through the budget process. Since a permanent change is likely to require significant deliberation by the General Assembly, the JBC staff recommendation in a budget environment limited by the coronavirus is for a temporary suspension.

At the other end of the spectrum, the JBC could consider suspending the statutory nursing home rate adjustment for just FY 2020-21. However, the JBC staff suspects the FY 2021-22 budget will be similarly tight to the FY 2020-21 budget, and thus recommends a 2-year suspension to avoid needing

another bill next year. If the JBC staff assumption about the FY 2021-22 budget is wrong and the General Assembly wants to add more money for nursing homes, it could do so through the annual budget process.

Although the staff recommendation is for flat funding in FY 2020-21 and FY 2021-22, the Department is investigating and may implement temporary emergency rate increases for providers with significant increased costs related to the coronavirus response, such as hazard pay, increased staffing to account for employees who are sick or otherwise unable to work, and higher costs for cleaning supplies and personal protective equipment. Those temporary emergency increases may benefit this class of providers for the duration of the emergency, but as of the drafting of this document the Department was still determining which providers were most impacted and in need of emergency temporary funding.

➔ COMPREHENSIVE WAIVER LIST - REMOVE APPROVED BILL

JBC ACTION AS OF 3/16/20: The JBC approved the drafting of a bill requiring the Department of Health Care Policy and Financing to annually enroll a designated percentage of the identified waiting list (as of November 1 of each year) for the Adult Comprehensive Home and Community Based Services Waiver. Specified enrollments are to occur over a five year period, with all eligible individuals enrolling in year six and beyond.

RECOMMENDATION: Staff recommends that the Committee remove this bill from the list of potential legislation for the 2020 Legislative Session.

KEY CONSIDERATIONS: The Department includes funding in its annual budget request to increase the number of new enrollments onto the Adult Comprehensive Waiver. JBC action as of March 16, 2020 includes approval of funding for 399 new enrollments totaling $18.4 million total funds, including $9.2 million General Fund. Enrollments include: emergency placements, individuals transitioning from the Children's Habilitation Residential Program or Children's Extensive Services waivers, or for Colorado Choice Transition (CCT) clients transitioning from an institutional setting.

In order to meet the timeline identified in the bill draft, the number of new enrollments required to be funded in FY 2020-21 above those already funded in the Long Bill, is 180. As a result, the FY 2020-21 fiscal impact of this legislation is approximately $11.1 million total funds, including $5.5 million General Fund. Assuming that the Department requests funding for 399 new enrollments each year into the future, the FY 2021-22 fiscal impact of the legislation will be approximately $20 million total funds, including $10 million General Fund, above the Department's annual budget request.

➔ SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved continuation funding of $1.5 million for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training Grant Program. Pursuant to Section 25.5-5-208, C.R.S., the Department is required to grant $1.5 million annually to organizations that provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The source of cash funds is the Marijuana Tax Cash Fund.

RECOMMENDATION: Staff recommends legislation to eliminate the grant program and repurpose the Marijuana Tax Cash Fund in a manner that provides General Fund relief. This is a grant program and the money goes for training rather than direct services.

KEY CONSIDERATIONS: This is a grant program and the money goes for training rather than direct services.

➔ COMMUNITY FIRST CHOICE – REMOVE APPROVED BILL

JBC ACTION AS OF 3/16/20: The JBC approved a bill to implement Community First Choice with an estimated cost of $1.6 million total funds, including $270,126 General Fund and 3.6 FTE.

RECOMMENDATION: Staff recommends removing the bill from the JBC's list of potential legislation. When fully implemented, the bill is expected to increase costs due to higher utilization by $27.4 million General Fund, but also allow Colorado to earn an enhanced 6.0 percent on select services saving $44.8 million General Fund. The net savings do not begin until FY 2022-23 and full ramp up and implementation would not be complete until FY 2024-25. It is unlikely the Department could accelerate the savings because the Department must implement conflict-free case management and the single assessment tool before proceeding with Community First Choice. The Department could delay upfront costs for planning and systems development and still meet a similar implementation date. Because the costs are so far in the future, staff recommends delaying the legislation for at least a year.

KEY CONSIDERATIONS: The recommended reduction is to a new initiative that has not yet been implemented. Eliminating the increase would have no immediate negative health, life, or safety impact.

SUMMARY OF OTHER RECOMMENDATIONS AND OPTIONS IF DEEPER CUTS ARE REQUIRED

10.0-20.0 PERCENT REDUCTION SCENARIOS

Staff recommends that the Committee consider the following options based on a scenario in which General Fund appropriations and transfers must be reduced by 10.0-20.0 percent (or revenue increased by an equivalent amount) in FY 2020-21.

BUDGET BALANCING OPTIONS FOR DEEPER CUT					
FY 2020-21 EXPENSE	BILL? Y/N	NET GF IMPACT	OTHER FUNDS	TOTAL FUNDS	FTE
Primary Care Fund-reduce	Y	($24,600,000)	$0	($24,600,000)	0.0
Provider rates-each 1% reduction	Y	(17,721,473)	(30,463,939)	(48,185,412)	0.0
Higher federal match-assume one more quarter	N	(91,919,567)	85,864,732	(6,054,835)	0.0
Child and youth behavioral health-eliminate	Y	(677,492)	0	(677,492)	(3.9)
IDD State-only services-25% reduction	N	(4,484,147)	(598,517)	(5,082,664)	0.0
Comprehensive waiver-freeze new enrollment	N	(3,540,000)	(3,540,000)	(7,080,000)	0.0
Medicaid adult dental benefit-eliminate	Y	(35,365,816)	(94,858,843)	(130,224,659)	0.0
CHP+-eliminate	Y	(62,712,068)	(129,883,221)	(192,595,289)	0.0
TOTAL		**($241,020,563)**	**($173,479,788)**	**($414,500,351)**	**(3.9)**

➔ PRIMARY CARE FUND - REDUCE

JBC ACTION AS OF 3/16/20: The JBC approved $24.6 million cash funds based on the forecast of tobacco tax revenues.

Through the Primary Care Fund tobacco tax funds are distributed to providers who:

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

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

OPTION: By declaring a fiscal emergency and passing legislation the General Assembly could temporarily reduce the tobacco tax funds flowing to the Primary Care Fund and redirect the money to offset General Fund for Medical Services Premiums.

This is a grant program with no federal match. As such, the JBC staff views it as a lower priority than preserving core Medicaid and CHP+ eligibility and benefits that leverage federal funds.

The General Assembly reduced the Primary Care Fund in FY 2009-10 and FY 2010-11, but was able reinvest a portion of the money in a program that drew a federal match and benefited the same providers. By leveraging matching federal funds the General Assembly was able to mitigate the impact on providers while still achieving General Fund savings. The refinancing in the last economic downturn involved a special State Plan Amendment. The JBC staff is still researching whether something equivalent could be done within the current structure of the Medicaid program. If that is possible, this would move from an option to staff recommended legislation, but with General Fund savings of half to two-thirds of the total so that some of the money could be reinvested to match federal funds and partially or wholly offset the negative impact on providers.

Most of the Primary Care Fund goes to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The FQHCs and RHCs are receiving significant federal support, including to date for Colorado providers $24.1 million in CARES Act Supplemental Funding Awards and another $1.7 million in Coronavirus Preparedness and Response Supplemental Funding. The FQHCs and RHCs may receive future distributions that have not yet been announced from the $100 billion nationwide in the CARES Act for the Public Health and Social Services Emergency Fund, depending on how the federal government decides to allocate the money. In addition, FQHCs and RHCs are eligible for increased flexibility to bill for telehealth services, telehealth grants, grants for rural community health, funds for detection, treatment, prevention and diagnosis of COVID-19, and loans. Approximately $2.6 million of the Primary Care Fund goes to providers that are not FQHCs or RHCs.

KEY CONSIDERATIONS: Reducing the Primary Care Fund may impact access to care and health, life, and safety for vulnerable populations, to the extent the providers decrease services offered to indigent clients. Additional federal funds available to FQHCs and RHCs may offset some lost Primary Care Fund revenue.

➔ PROVIDER RATES – EACH 1% REDUCTION

JBC ACTION AS OF 3/16/20: The JBC approved $91.3 million total funds, including $33.6 million General Fund, for a 1.9 percent common policy increase in community provider rates.

OPTION: Each 1.0 percent across-the-board reduction in provider rates is expected to generate savings of $48.2 million total funds, including $17.7 million General Fund, in the Department of Health Care Policy and Financing. Before reducing a Medicaid provider rate federal regulation requires the Department to present the federal Centers for Medicare and Medicaid Services (CMS) with an analysis of the affect, if any, on client access to care. This creates a risk that the General Assembly might balance the budget counting on provider rate reductions in Medicaid that could be delayed in receiving federal approval, or even denied.

As an alternative to an across-the-board approach, the Department may be able to recommend targeted reductions that would have a larger impact on some providers and reduce the need for reductions to other providers.

Key Considerations: There are no maintenance of effort requirements prohibiting provider rate reductions from starting before the emergency declaration ends, but there are federal requirements

that the Department analyze the impact on access to care. The impact of provider rate reductions on health, life, and safety are indirect and relative to how much the provider rates affect access to care.

➔ HIGHER FEDERAL MATCH – ASSUME ONE MORE QUARTER

JBC ACTION AS OF 3/16/20: The JBC assumed a 50.0 percent standard federal match rate for Medicaid for state FY 2020-21.

OPTION: The JBC could assume Colorado will receive a 56.2 percent standard federal match rate for Medicaid for one or more quarters during FY 2020-21. This would reduce the estimated General Fund by approximately $91.9 million per quarter.

At the time this document was prepared, the JBC staff felt uncomfortable assuming Colorado would receive the higher match rate for any quarter in FY 2020-21. Pursuant to the federal Families First Coronavirus Relief Act the temporary increase in the standard federal match continues through the last quarter when a disaster is declared by the federal Secretary of Health and Human Services. Making the wrong assumption about the duration of a federal emergency declaration could be costly. However, if new information emerges about the actual or likely duration of a federal disaster declaration, the JBC may want to assume one or more additional quarters with a higher federal match.

To receive the higher federal match a state may not reduce Medicaid eligibility or increase Medicaid premiums, and may not charge copays for any testing or treatment related to COVID-19. States must also provide continuous eligibility and may not reduce benefits for people enrolled in Medicaid on or after March 18, 2020, through the last month a federal emergency is declared. So, assumptions about how long an emergency declaration persists play into assumptions about when other strategies to contain costs could be implemented.

The estimated savings is based on the February 2020 forecast. If the Medicaid and CHP+ forecasts change the amount of savings attributable to the change in the federal match rate will change in proportion to the forecast changes.

Key Considerations: This is a change that will happen with or without General Assembly approval for the duration of the federal emergency declaration, if Colorado meets the criteria to qualify for the higher federal match.

➔ S.B. 19-195 CHILD AND YOUTH BEHAVIORAL HEALTH SYSTEM - ELIMINATE

JBC ACTION AS OF 3/16/20: For FY 2019-20, the appropriation includes $1.4 million total funds, including $619,484 General Fund, and 3.9 FTE for c*hild and youth behavioral health system* e*nhancements* (created in S.B. 19-195). For FY 2020-21, the appropriation increases by $98,676 total funds, including $58,008 General Fund and 1.1 FTE.

OPTION: Eliminating this program would reduce General Fund appropriations to the Department by $677,492 General Fund between FYs 2019-20 and 2020-21. Reducing the appropriation would eliminate 5.0 FTE, including 3.9 FTE who have already been hired in FY 2019-20.

Key Considerations: Program added since FY 2013-14/ Affects a vulnerable population

Additional Background:
This bill requires the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) to work collaboratively to provide Medicaid-covered wraparound services for children and youth at risk of out-of-home placement or who are currently in out-of-home placement. Out-of-home placement is defined to mean a child or youth who has been diagnosed as having a mental health or behavioral health disorder that may require a level of care that is provided in a residential child care facility, inpatient psychiatric hospital, or other intensive care setting outside the home. It also includes children and youth who have entered the Division of Youth Services or are at risk of child welfare involvement. The DHS is also required to create three new tools to assess, screen, and provide a single referral and entry point for children with mental or behavioral health issues. The Department of Public Health and Environment (CDPHE) must provide free training for providers on these tools.

➔ IDD STATE ONLY SERVICES - 25% REDUCTION

JBC ACTION AS OF 3/16/20: The JBC approved a total appropriation of $20.3 million total funds, including $17.9 General Fund and $2.4 million cash funds from the Intellectual and Developmental Disabilities Services (IDD Services) Cash Fund, for programs that serve individuals with intellectual and developmental disabilities and are funded with state-only fund types. JBC action is reflected in the following table:

JBC ACTION AS OF MARCH 16, 2020					
LINE ITEM	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Family Support Services Program	$7,718,316	$7,329,111	$389,205	$0	$0
State Supported Living Services	10,064,078	8,342,912	1,721,166	0	0
State Supported Living Services Case Management	2,481,614	2,197,917	283,697	0	0
Preventive Dental Hygiene	66,648	66,648	0	0	0
TOTAL JBC ACTION AS OF MARCH 16, 2020	**$20,330,656**	**$17,936,588**	**$2,394,068**	**$0**	**$0**

OPTION: A 25.0 percent reduction in the appropriation for state-only funded services for individuals with intellectual and developmental disabilities will result in a savings of $5.1 million total funds, including $4.5 million General Fund and $0.6 million cash funds from the IDD Services Cash Fund. Although this is an option for General Fund savings, JBC Staff is concerned that implementation of this option will result in decreased services for individuals currently enrolled in these programs and increased waiting lists for non-Medicaid eligible individuals.

OPTION 1: 25.0 PERCENT REDUCTION IN FY 2020-21					
LINE ITEM	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Family Support Services Program	$1,929,579	$1,832,278	$97,301	$0	$0
State Supported Living Services	2,516,020	2,085,728	430,292	0	0
State Supported Living Services Case Management	620,404	549,479	70,924	0	0
Preventive Dental Hygiene	16,662	16,662	0	0	0
SAVINGS AFTER 25.0 PERCENT REDUCTION	**$5,082,664**	**$4,484,147**	**$598,517**	**$0**	**$0**

KEY CONSIDERATIONS: The Department's FY 2020-21 budget request includes funding to provide services to individuals who do not qualify for Medicaid waivers. The cost of services is covered

entirely by state funds, including the General Fund and cash funds from the IDD Services Cash Fund. A reduction in services provided to individuals enrolled in these programs will not negatively impact the anticipated change in the State's FMAP rate.

➔ COMPREHENSIVE WAIVER - FREEZE NEW ENROLLMENT

JBC ACTION AS OF 3/16/20: The JBC approved an appropriation to the Adult Comprehensive Services line item of $547.9 million total funds, including $273.1 million General Fund and $0.8 million cash funds from the Intellectual and Developmental Services (IDD Services) Cash Fund.

OPTION: Freezing new enrollment opportunities that become available in FY 2020-21 as a result of attrition will reduce the number of individuals receiving services. Initiating the new enrollment freeze on October 1, 2020 will reduce expenditures by approximately $7.1 million total funds, including $3.5 million General Fund.

KEY CONSIDERATIONS: The Department's annual caseload forecasts for Adult Comprehensive Services includes factors related to the churn rate of clients receiving services through the waiver. When one client stops receiving services through the waiver, it provides an opportunity for another individual to enroll. The Department estimates that churn makes up approximately 240 enrollments each year. Freezing new enrollments that become available as a result of the client churn rate beginning October 1, 2020 is estimated to reduce waiver expenditures by approximately $7.1 million total funds, including $3.5 million General Fund. Please note, however, that freezing these enrollments will likely result in individuals remaining on the Adult Comprehensive Services Waiver waiting list for longer periods of time, and may result in an increase in the enrollment waiting list.

➔ MEDICAID ADULT DENTAL BENEFIT - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved $133.2 million total funds, including $36.9 from state sources, for the Medicaid adult dental benefit, based on the February 2020 forecast.

OPTION: If the General Assembly were to reduce an optional benefit, one of the better choices for achieving savings in FY 2020-21 would be the adult dental benefit. Eliminating the benefit completely would save roughly $35.4 million from state sources, after accounting for increases in utilization of the dental benefit for people receiving waiver services with an intellectual and developmental disability. The state sources could be repurposed to provide General Fund relief. The JBC staff considers this optional benefit one of the better choices for reduction for several reasons, including:

- Dental services for children to age 21 and emergency dental services for adults would still be covered, because these are required benefits. The Department does not anticipate an increase in utilization of emergency dental services in FY 2020-21 if the adult dental benefit is eliminated, but over time the utilization of emergency dental services may increase due to the lack of a preventive benefit.
- This is a relatively recent benefit that was implemented in 2014.
- The potential savings are sufficiently large to justify the effort required to reduce a benefit.

The JBC could pursue variations on this option that reduce, but do not eliminate, the benefit. For example, the JBC could reinstate the $1,000 annual cap that existed for the benefit prior to the FY 2019-20. This change would save an estimated $10.5 million total funds, including $2.9 million from state sources that could be reallocated to General Fund relief. Or, the JBC could eliminate the denture benefit added by H.B. 14-1336 to save $13.8 million total funds, including $6.9 million from state sources.

The Department provided several studies showing relationships between oral health and general health outcomes, particularly in the areas of cardiovascular disease, diabetes, respiratory disease, and preterm and low birth weight babies. The Department also emphasized that there are significant disparities in oral health across populations with evidence of dramatically lower health status among the poor, people in rural areas, the elderly, and people with disabilities. Citing findings of the national Health Interview Survey and the American Dental Association the Department argued that oral health impacts employability. Finally, the Department found this study suggesting a significant increase in emergency department visits after California eliminated an adult dental benefit in 2009: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1358

For these reasons, it may be better for the JBC to consider a partial reduction to the benefit, rather than elimination of the benefit. Reinstating the $1,000 annual cap and eliminating the denture benefit combined would save $9.8 million from state sources that could be repurposed to provide General Fund relief.

Key Considerations: This option affects a vulnerable population, but of the optional benefits that could be reduced or eliminated the negative impacts of choosing this benefit are partially mitigated by the continued coverage of emergency dental services, and this is a relatively recently added benefit.

➔ CHILDREN'S BASIC HEALTH PLAN (CHP+) - ELIMINATE

JBC ACTION AS OF 3/16/20: The JBC approved $192.6 million total funds, including $62.7 million from state sources, for the Children's Basic Health Plan (marketed as the Children's Health Plan Plus, or CHP+), based on the February 2020 forecast.

OPTION: If the General Assembly were to reduce an optional eligibility category, one of the better choices for achieving savings in FY 2020-21 would be the Children's Basic Health Plan. This option could save very roughly $62.7 million from state sources that could be repurposed to provide General Fund relief. The JBC staff considers this optional eligibility category one of the better choices for reduction for several reasons, including:

- The population has relatively higher income than most of the Medicaid population, serving children with effective income from 147 percent to 265 percent of the federal poverty guidelines and pregnant adults with effective income from 200 percent to 265 percent of the federal poverty guidelines.
- The population is relatively healthier with lower medical needs than the typical Medicaid population, due to age and income.
- There are no maintenance of effort requirements related to CHP+ to qualify for the higher federal match provided in the federal Families First Coronavirus Relief Act. As a result, there are fewer uncertainties about when the savings can start or how much can be achieved.

- Federal tax credits are available to help people in this income range purchase private insurance through the individual market.
- The potential savings are sufficiently large to justify the effort required to reduce eligibility.

In the February 2020 forecast the Department projected CHP+ would serve 77,079 people, including 76,181 children and 898 pregnant adults.

The JBC could pursue a variation on this option that reduces eligibility or benefits, but does not eliminate the program. For example, if the General Assembly wanted to eliminate the most recent expansion of CHP+ to children and pregnant adults with effective income from 206 percent of the federal poverty guidelines to 265 percent of the federal poverty guidelines it would save roughly $69.2 million total funds, including $22.2 million from state sources that could be repurposed to provide General Fund relief. Or, the JBC could identify a target dollar savings and ask the Department to structure a decrease in eligibility and/or benefits to achieve the target dollar savings.

The very rough savings estimates above based on the total projected expenditures for FY 2020-21. They do not include associated reductions that would occur in administrative costs, nor do they adjust for costs that would remain for dates of service in FY 2019-20 that are not billed and paid until FY 2020-21. Also, the timing of when the General Assembly makes decisions on the budget may impact the potential savings in FY 2020-21, because the Department must provide notice to clients before eliminating eligibility. If the JBC wants to pursue this option, additional work will be required to refine the savings estimate.

Key Considerations: This option affects a vulnerable population, but of the optional eligibility categories that could be reduced or eliminated this is a population that has relatively higher income and is relatively healthier and there are no federal maintenance of effort requirements to navigate.