JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2023-24

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Behavioral Health Community Programs, Indigent Care Program, and Other Medical Services)

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

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ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2021 and 2022 legislative sessions that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy22-23apprept.pdf

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

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

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24 *
General Fund	$2,814,718,278	$3,058,051,411	$4,084,846,478	$4,430,841,585
Cash Funds	1,652,320,542	1,678,436,542	1,838,980,393	1,733,776,198
Reappropriated Funds	45,994,354	87,047,288	95,058,195	105,359,098
Federal Funds	7,563,106,406	8,637,872,527	8,202,179,331	8,624,193,931
TOTAL FUNDS	**$12,076,139,580**	**$13,461,407,768**	**$14,221,064,397**	**$14,894,170,812**
Full Time Equiv. Staff	557.2	654.9	741.8	752.9

*Requested appropriation.

Funding for the Department of Health Care Policy and Financing in FY 2022-23 consists of 28.7 percent General Fund, 12.9 percent cash funds, 0.7 percent reappropriated funds, and 57.7 percent federal funds.

DIVISION BUDGET

The divisions covered in this briefing include Behavioral Health Community Programs, Indigent Care, and Other Medical Services. The funding for these divisions only is summarized in the table below.

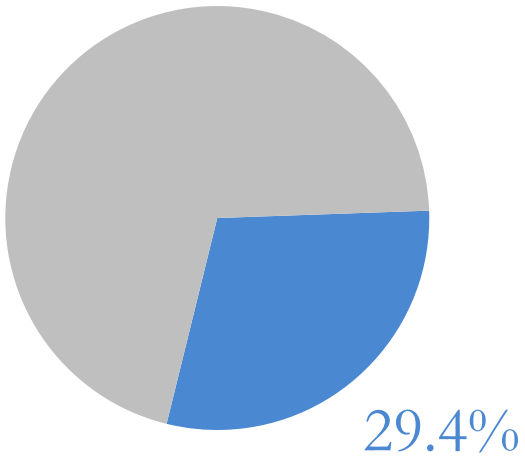
FUNDING SOURCE	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24 *
General Fund	$368,699,467	$437,222,564	$550,794,995	$560,904,215
Cash Funds	283,672,680	300,237,242	446,014,046	404,582,902
Reappropriated Funds	197,100	197,100	225,000	225,000
Federal Funds	962,624,838	1,203,605,643	1,129,334,820	1,142,567,209
TOTAL FUNDS	**$1,615,194,085**	**$1,941,262,549**	**$2,126,368,861**	**$2,108,279,326**
Full Time Equiv. Staff	0.0	4.0	6.3	4.0

*Requested appropriation.

Funding in FY 2022-23 for the divisions covered in this briefing packet consists of 25.9 percent General Fund, 21.0 percent cash funds, less than 0.1 percent reappropriated funds, and 53.1 percent federal funds in FY 2020-21.

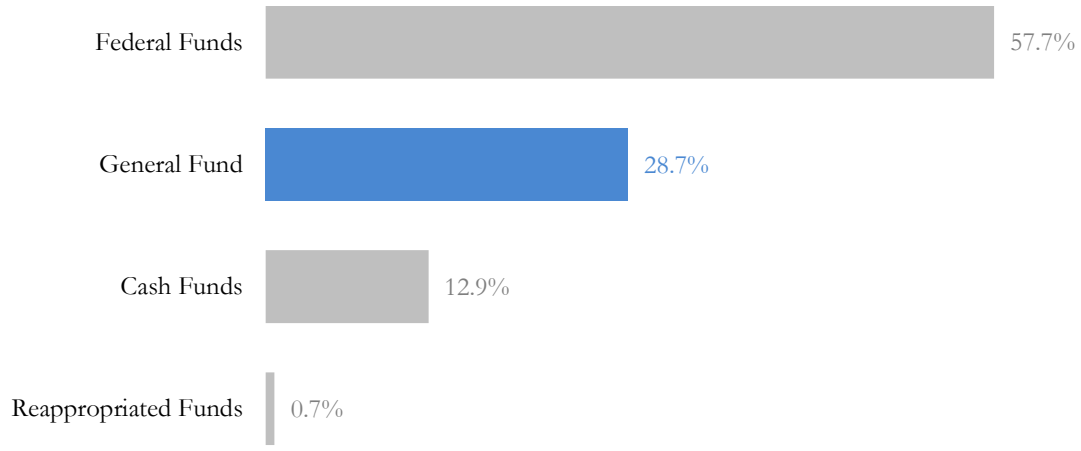
DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund



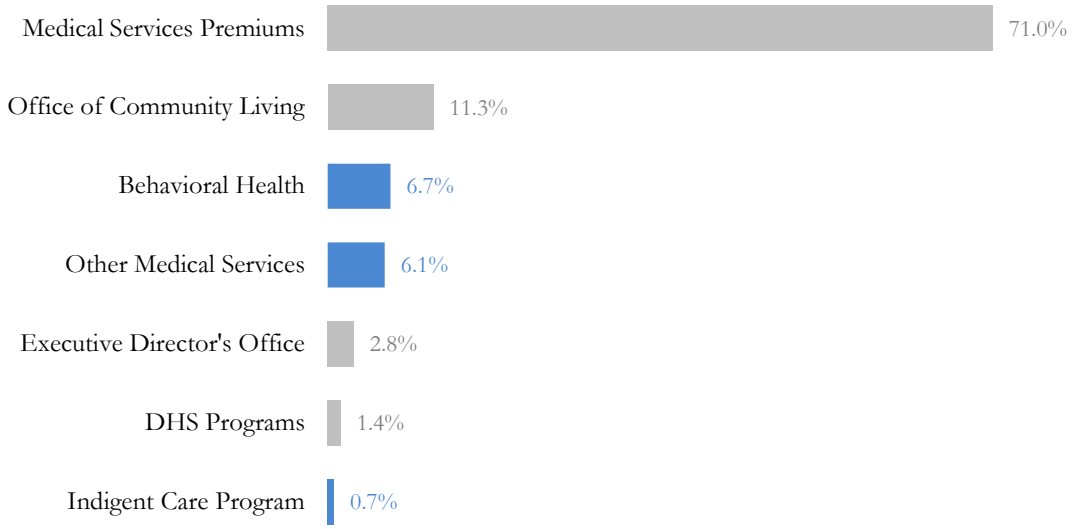
Based on the FY 2022-23 appropriation.

Department Funding Sources



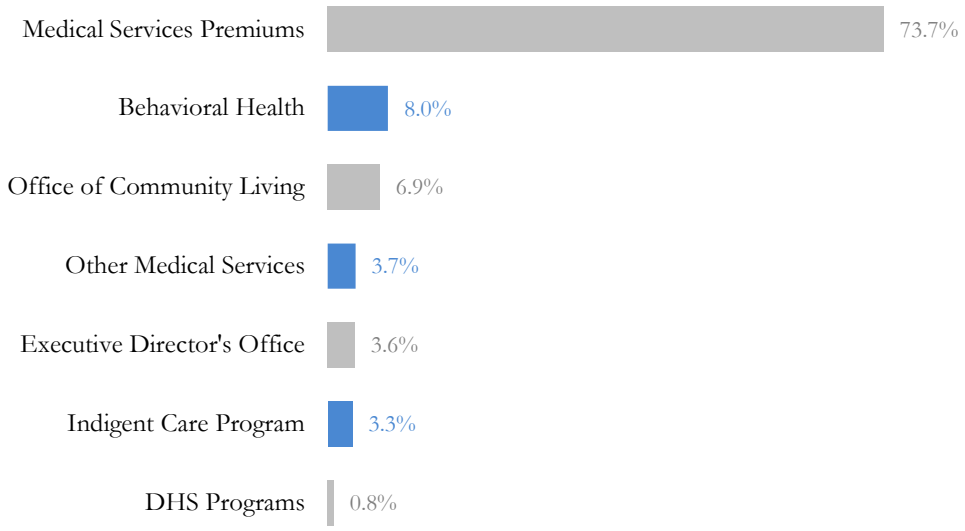
Based on the FY 2022-23 appropriation.

Distribution of General Fund by Division



Based on the FY 2022-23 appropriation.

Distribution of Total Funds by Division



Based on the FY 2022-23 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 28.7 percent General Fund, 12.9 percent cash funds, 0.7 percent reappropriated funds, and 57.7 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

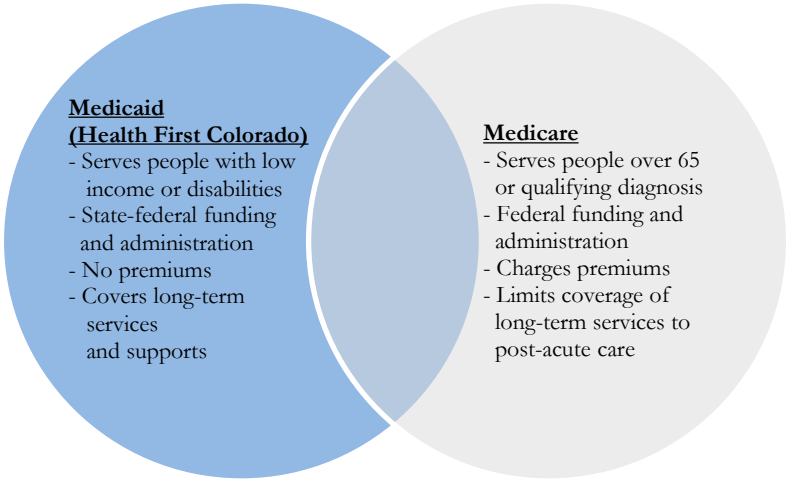
MEDICAID

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

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

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

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



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

For state fiscal year 2022-23 the average FMAP for the majority of Colorado Medicaid expenditures is 54.65 percent as a result of a temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act of 2020. The higher federal match is available for services from January 1, 2020 through the last quarter during which a disaster is declared by the federal Secretary of Health and Human Services. Based on the current disaster declaration, the higher federal match would expire at the end of March 2023, but the disaster declaration could be extended.

Standard Medicaid Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	50.00	50.00	50.00	50.00	50.00
FY 19-20	53.10	50.00	50.00	56.20	56.20
FY 20-21	56.20	56.20	56.20	56.20	56.20
FY 21-22	56.20	56.20	56.20	56.20	56.20
FY 22-23	*54.65*	56.20	56.20	56.20	*50.00*
FY 23-24	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*

Italicized figures are projections.

For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado receives an enhanced federal match of 90.0 percent. In Colorado the "newly eligible" population includes adults without dependent children with income to 138 percent of the federal poverty guidelines and parents with income from 69 percent to 138 percent of the federal poverty guidelines.[2] The state share of costs for the "newly eligible" comes from the Healthcare Affordability and Sustainability (HAS) Fee on hospitals, so there is no General Fund.

ACA "Newly Eligible" Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
FY 18-19	93.50	94.00	94.00	93.00	93.00
FY 19-20	91.50	93.00	93.00	90.00	90.00
FY 20-21	90.00	90.00	90.00	90.00	90.00
FY 21-22	90.00	90.00	90.00	90.00	90.00
FY 22-23	90.00	90.00	90.00	90.00	90.00
FY 23-24	90.00	90.00	90.00	90.00	90.00

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

After accounting for standard income disregards, Medicaid effectively covers people to 138 percent of the federal poverty guidelines, or $18,754 annual income for an individual and $31,781 annual income for a family of three. The Medicaid eligibility limits are slightly higher for children and pregnant women and if these populations earn income above the Medicaid limits they can still qualify for the Children's Basic Health Plan up to effectively 265 percent of the federal poverty guidelines, or $61,030 annual income for a family of three. In addition, there are special rules for the elderly, people with disabilities, and some smaller populations that are summarized in the table below.

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

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

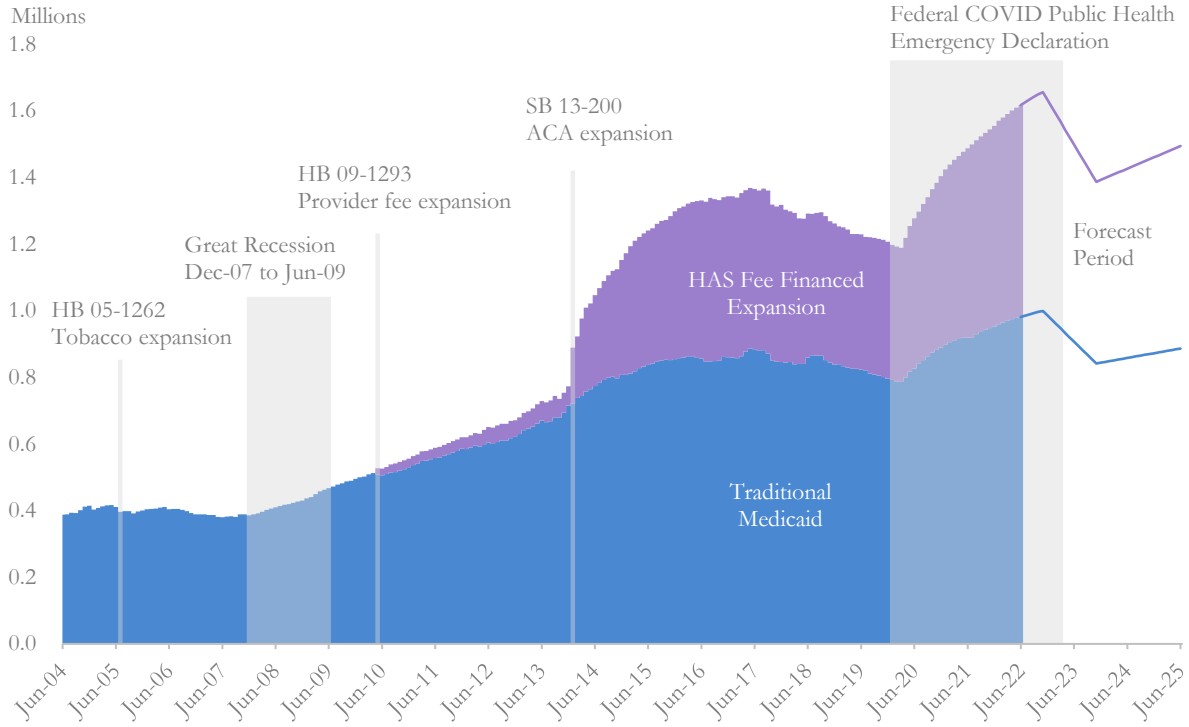
Special Medicaid Eligibility Categories	
Category	Eligibility Standard
Adults 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities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

Family Size	Federal Poverty Guideline – 2020	SSI Annual Income Limit
1	$13,590	$10,092
2	$18,310	$15,132
3	$23,030	
4	$27,750	
More	add $4,720 each	

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

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

Medicaid Enrollment of 1,618,038 as of June 2022
636,458 Healthcare Affordability and Sustainability (HAS) Fee Expansion
981,580 Traditional Medicaid (General Fund and non-HAS Fee sources)



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

This briefing includes discussion of Behavioral Health Community Programs, the Indigent Care Program, and the Medicare Modernization Act.

(1) Medical Services Premiums

See the December 2, 2022, briefing for Medical Services Premiums.

(2) Behavioral Health Community Programs

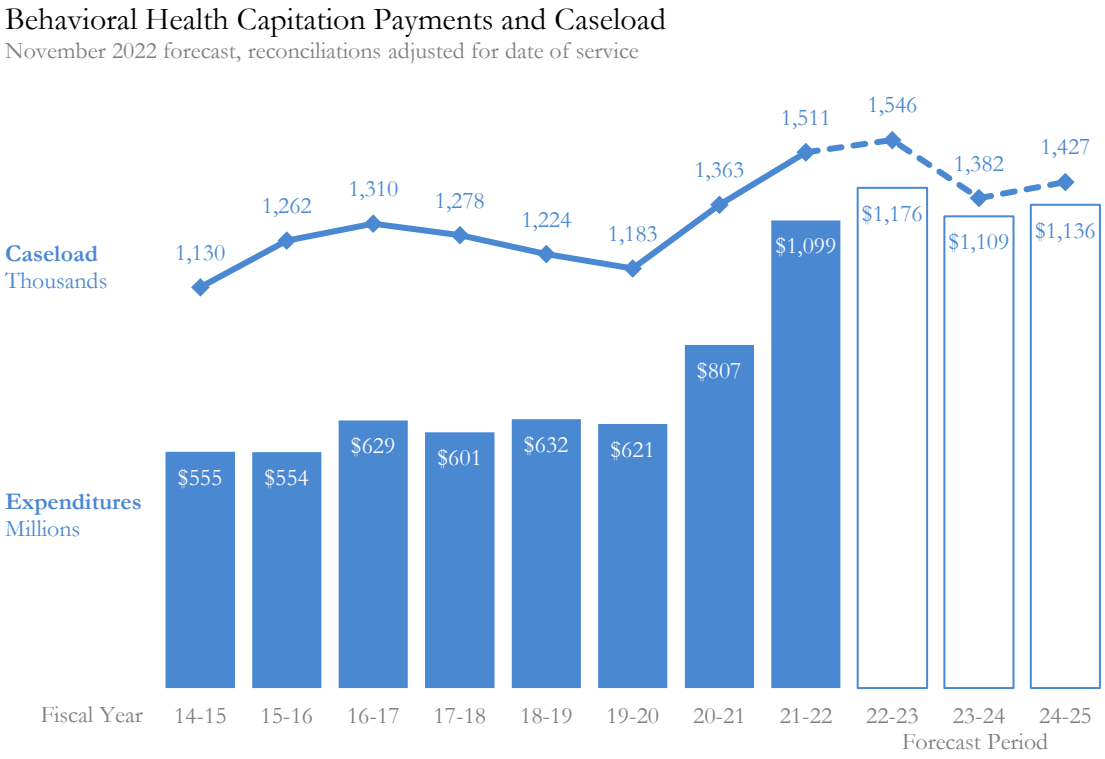
Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Managed Care Entities (MCEs) to provide or arrange for behavioral health services for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

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

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver programs that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. Changes in the federal match rate for various eligibility categories also affect the State's share of expenditures.

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

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



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

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

(3) Office of Community Living

See the December 12, 2022, briefing for the Office of Community Living.

(4) Indigent Care Program

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

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

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

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

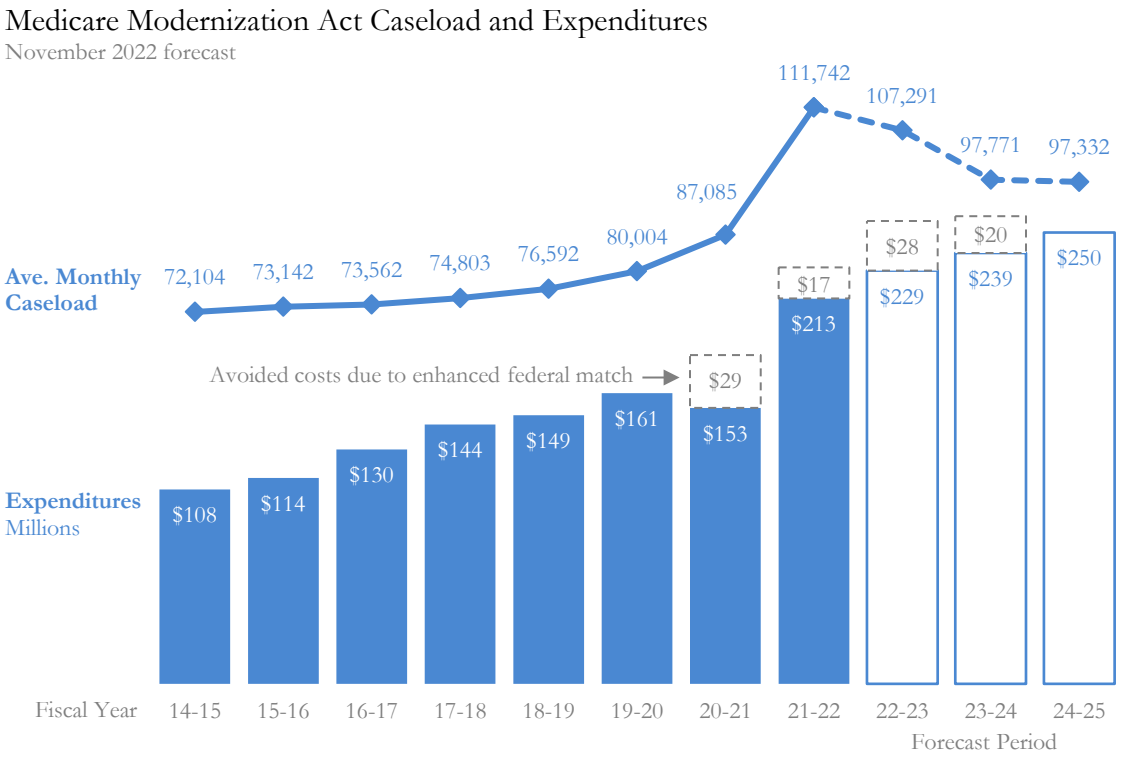
Indigent Care Program				
	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request
Hospital Payments				
Safety Net Provider Payments	$135,548,026	$254,743,329	$226,610,308	$226,610,308
Pediatric Specialty Hospital	10,764,010	10,764,010	10,764,010	10,764,010
Total Funds	$146,312,036	$265,507,339	$237,374,318	$237,374,318
General Fund	4,714,636	4,714,636	5,382,005	5,382,005
Cash Funds (HAS Fee)	67,774,013	110,819,422	113,305,154	113,305,154
Federal Funds	73,823,387	149,973,281	118,687,159	118,687,159
Clinic Payments				
Clinic Based Indigent Care	$6,039,386	$0	$0	$0
Primary Care Fund	24,666,536	51,647,974	48,087,990	48,087,990
Total Funds	$30,705,922	$51,647,974	$48,087,990	$48,087,990
General Fund	2,645,251	0	0	0
Cash Funds (tobacco tax)	24,666,536	22,755,512	24,176,000	24,176,000
Federal Funds	3,394,135	28,892,462	23,911,990	23,911,990
TOTAL Indigent Care	**$177,017,958**	**$317,155,313**	**$285,462,308**	**$285,462,308**
General Fund	7,359,887	4,714,636	5,382,005	5,382,005
Cash Funds	92,440,549	133,574,934	137,481,154	137,481,154
Federal Funds	77,217,522	178,865,743	142,599,149	142,599,149

(5) Medicare Modernization Act State Contribution

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

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

This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes. The end of the temporary 6.2 percent increase in the federal match rate authorized by the federal Families First Coronavirus Response Act explains a significant portion of the projected increase in the MMA obligation in FY 2022-23. The MMA payment is typically made from the General Fund with rare exceptions when Colorado used alternate fund sources.



(6) Programs Administered by Other Departments
See the December 2, 2022, briefing for the Executive Director's Office.

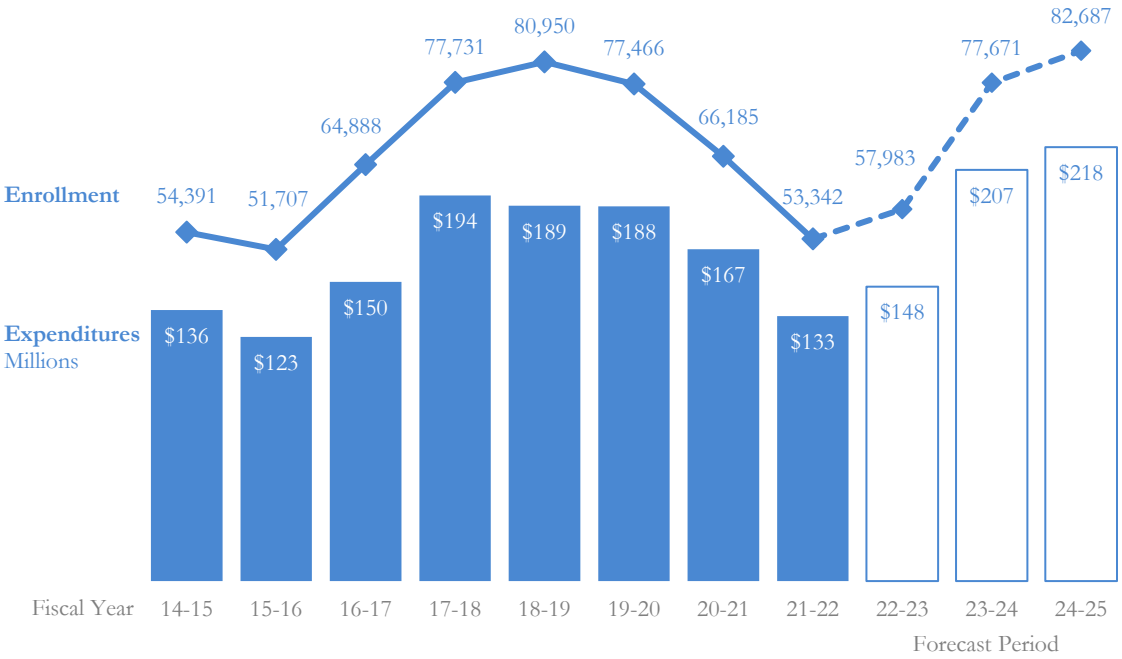
CHILD HEALTH PLAN PLUS

The Children's Basic Health Plan (marketed by the Department as the Child Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with more income than the Medicaid eligibility criteria allow, effectively to 265 percent[4] of the federal poverty guidelines or $61,030 annually for a family of three. Annual membership premiums vary based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines. Coinsurance costs are nominal.

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

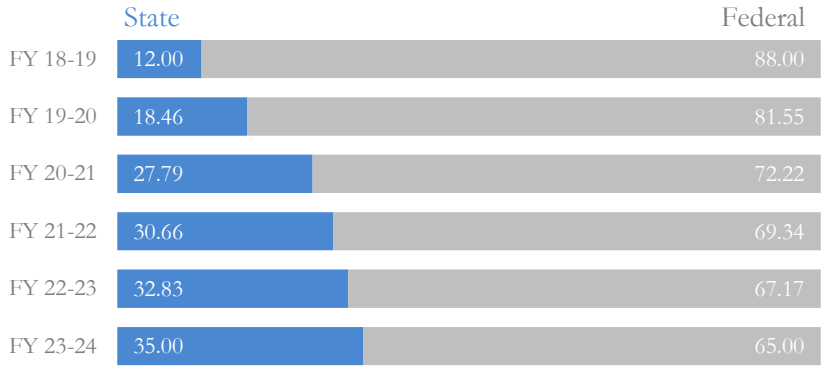
Historically, enrollment in CHP+ has been highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. Sometimes when Medicaid enrollment decreases CHP+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

Children's Basic Health Plan (CHP+) Enrollment and Expenditures
November 2022 forecast, without reconciliations



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

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



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

SUMMARY: FY 2022-23 APPROPRIATION & FY 2023-24 REQUEST

The table below summarizes all the requests submitted by the Department for context. The requests discussed in this briefing are highlighted in yellow.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION:						
H.B. 22-1329 (Long Bill)	14,175,863,675	4,079,738,465	1,805,089,552	94,985,445	8,196,050,213	711.7
Other Legislation	45,200,722	5,108,013	33,890,841	72,750	6,129,118	30.1
TOTAL	**$14,221,064,397**	**$4,084,846,478**	**$1,838,980,393**	**$95,058,195**	**$8,202,179,331**	**741.8**
FY 2023-24 REQUESTED APPROPRIATION:						
FY 2022-23 Appropriation	$14,221,064,397	4,084,846,478	$1,838,980,393	$95,058,195	$8,202,179,331	741.8
R1 Medical Services Premiums	407,679,567	155,659,118	2,072,047	(895,544)	250,843,946	0.0
R2 Behavioral Health	(10,567,103)	(3,443,854)	(1,075,502)	0	(6,047,747)	0.0
R3 Child Health Plan Plus	28,740,043	8,051,152	2,163,953	0	18,524,938	0.0
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
R5 Office of Community Living	29,857,884	14,353,416	(37,375)	0	15,541,843	0.0
R6 Value-based payments	8,679,810	2,853,173	317,098	0	5,509,539	0.0
R7 Provider rates	192,249,156	69,830,979	15,324,718	0	107,093,459	0.0
R8 Cost and quality indicators	7,305,880	976,856	701,458	0	5,627,566	0.0
R9 Birthing equity	(702,853)	(357,242)	0	0	(345,611)	0.0
R10 Children with complex needs	3,938,944	200,043	1,769,429	0	1,969,472	3.7
R11 Compliance	(10,748,066)	(3,417,450)	(1,531,371)	0	(5,799,245)	7.4
R12 Non-Medicaid BH eligibility & claims	2,889,302	2,889,302	0	0	0	8.4
R13 Case management redesign	3,602,309	168,000	1,533,155	0	1,901,154	0.0
R14 Convert contracts to FTE	(55,923)	(28,400)	440	0	(27,963)	3.7
R15 Administrative technical request	0	0	0	0	0	0.0
Centrally appropriated items	4,664,699	2,246,314	90,003	(79,760)	2,408,142	0.0
Annualize prior year budget actions	3,167,177	93,374,893	(126,457,433)	11,156,916	25,092,801	(12.1)
Human Services programs	3,057,977	1,456,094	0	0	1,601,883	0.0
Indirect cost recoveries	264,914	0	(76,093)	118,832	222,175	0.0
Transfers to other state agencies	12,782	4,853	1,278	459	6,192	0.0
NP Housing vouchers	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
TOTAL	**$14,894,170,812**	**$4,430,841,585**	**$1,733,776,198**	**$105,359,098**	**$8,624,193,931**	**752.9**
INCREASE/(DECREASE)	$673,106,415	$345,995,107	($105,204,195)	$10,300,903	$422,014,600	11.1
Percentage Change	4.7%	8.5%	(5.7%)	10.8%	5.1%	1.5%
Items Discussed in this Briefing	27,584,137	10,625,205	2,857,880	0	14,101,052	12.1
Percentage Change	0.2%	0.2%	0.2%	0.0%	0.2%	1.6%

R2 BEHAVIORAL HEALTH: The Department requests a net decrease of $10.6 million total funds, including a reduction of $3.4 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services.

R3 CHILD HEALTH PLAN PLUS: The Department requests an increase of $28.7 million total funds, including $8.1 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan, which is marketed as the Child Health Plan Plus.

R4 MEDICARE MODERNIZATION ACT: The Department requests an increase of $3.3 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

R9 BIRTHING EQUITY: The Department requests $1.2 million total funds, including $594,304 General Fund, for the combined cost of a new doula benefit and new donor milk benefit. The cost increases to $1.8 million total funds, including $901,802 General Fund, in the second year. As part of the request, the Department included an unrelated change to the High Risk Pregnant Women line item and showed this as an offset to the cost of the request. The Department identified this request as evidence-informed.

R10 CHILDREN WITH COMPLEX NEEDS: The Department requests $3.9 million total funds, including $200,043 General Fund, and four new positions (3.7 FTE in the first year) to: (1) create a department team for children with complex and co-occurring needs; (2) move certain payments for Autism Spectrum Disorder from fee-for-service to the managed care behavioral health program; and (3) expand skilled and therapeutic respite care for children with high physical and behavioral health needs. The expanded respite care drives most of the cost. The Department proposes using federal funds made available through the American Rescue Plan Act to expand Home- and Community-Based Services to offset the need for General Fund through December 2024. When the federal funds expire the General Fund cost increases to $884,715 in FY 2024-25 and $1,769,429 in FY 2025-26. The Department identified this request as theory-informed.

R12 NON-MEDICAID BH ELIGIBILITY & CLAIMS: The Department requests $2.9 million General Fund and 8.4 FTE, increasing to $3.0 million and 10.0 FTE in FY 2024-25, for ongoing operation of information technology systems that support eligibility determinations, claims processing, and data reporting for non-Medicaid behavioral health services. As part of the Behavioral Health Administration initiative, the Department previously received funding for development of the systems. The goal was to leverage the Department's experience and standardize procedures across programs, eventually resulting in financial efficiencies that would offset the cost of maintenance and ongoing operations. The Behavioral Health Administration has not yet estimated or captured the expected financial efficiencies, but the Department anticipates needing money for ongoing operations beginning in FY 2023-24. The Department identified this request as theory-informed.

FORECAST SUMMARY (R2, R3, AND R4)

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. These requests explain what drives the budget, but they are non-discretionary, as they represent the expected obligations under current law and policy. It would take a change to current law or policy to change the trends. This issue brief summarizes the forecasts for R1 Behavioral Health, R2 Child Health Plan Plus, and R3 Medicare Modernization Act.

SUMMARY

- For the three forecasts discussed in this briefing, the Department requests an increase of $18.1 million total funds, including $7.1 million General Fund, including:
    - In FY 2022-23 a net increase of $7.4 million total funds, including a decrease of $34.5 million General Fund
    - In FY 2023-24 a net increase of$10.6 million total funds, including an increase of $41.6 million General Fund
- The biggest factor impacting all three forecasts is the end of the federal public health emergency.
    - As a condition of accepting the 6.2 percent enhanced federal match that is available during the federal public health emergency, the Department cannot disenroll anyone from Medicaid or decrease their benefits due to a change in income.
        - This drives an increase in Medicaid enrollment and a decrease in CHP+ enrollment for the duration of the federal public health emergency.
    - The FY 2022-23 appropriation assumed the enhanced federal match would be available through June 2022. The request reflects two additional quarters with the enhanced federal match through December 2022.
    - Since the request was submitted, the federal public health emergency was extended again so that the enhanced federal match is available through at least March 2023. The Department's February forecast will reflect this new information.
    - Each quarter the federal public health emergency is extended saves the state approximately $100 million General Fund across all Medicaid programs after accounting for the increase in enrollment and the decrease in the state match.

DISCUSSION

For all of the forecast requests the total requested change is the sum of the forecasted changes in FY 2022-23 and in FY 2023-24. The Department will officially submit a supplemental request for FY 2022-23 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2023.

R2 BEHAVIORAL HEALTH

The behavioral health benefit includes traditional outpatient and inpatient services and a group of wraparound intensive support services. The wraparound intensive support services are authorized by a waiver under Section 1915(b)(3) of the Social Security Act, which allows the federal Centers for Medicare and Medicaid Services (CMS) to waive federal statutory provisions and allow states to offer alternate or additional services that are demonstrated to be more cost effective than traditional services

covered by Medicaid, with federal financing from the savings generated by the alternate or additional services. Any qualified provider could offer the so-called "B3" wraparound intensive support services but historically the services have been delivered almost universally by Community Mental Health Centers (CMHCs).

OUTPATIENT SERVICES	INPATIENT AND RESIDENTIAL SERVICES	WRAPAROUND INTENSIVE SUPPORT "B3" SERVICES
• Individual, group, and family therapy • Medication management • Psychiatrist services • Outpatient hospital psychiatric services	• Emergency and crisis services • Inpatient hospital psychiatric care • Residential and inpatient substance use disorder (SUD) treatment • Residential and inpatient withdrawal management	• Prevention/early intervention • Clubhouses/drop-in centers • Vocational services • Intensive case management • Assertive Community Treatment • Residential mental health treatment • Respite care • Recovery services/peer support

In FY 2020-21, 18.2 percent (242,924) of Medicaid members used behavioral health services. Some members received more than one type of service and appear in multiple categories, so the sum of the bulleted categories will not equal the total. Of the members who received behavioral health services:

- 71.2 percent (172,903) used mental health services
- 16.4 percent (39,946) used Substance Use Disorder (SUD) services
- 46.7 percent (113,405) used wraparound intensive support B3 services

There were 172,903 distinct utilizers of mental health services. Some members received more than one type of service and appear in multiple categories, so the sum of the bulleted categories will not equal the total. Of the members who received mental health services:

- 99.0 percent (172,657) received outpatient mental health services
- 6.2 percent (10,667) used inpatient services
- 2.2 percent (3,817) received residential mental health services

There were 39,946 distinct utilizers of SUD services. Some members received more than one type of service and appear in multiple categories, so the sum of the bulleted categories will not equal the total. Of the members who received SUD services:

- 92.8 percent (172,657) used outpatient services
- 13.9 percent (5,559) received residential treatment
- 3.7 percent (1,491) had an inpatient SUD stay

FY 2022-23 FORECAST

The table below shows the major contributors to the change from the FY 2022-23 appropriation to the Department's November 2022 forecast for FY 2022-23. It does not show differences from FY 2021-22 expenditures.

FY 2022-23 Behavioral Health Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2022-23 Appropriation	$1,131,039,135	$272,281,483	$84,161,905	$774,595,747
Enrollment	82,638,492	14,159,853	5,431,879	63,046,760
Per capita	(29,677,763)	(7,227,198)	1,487,899	(23,938,464)
Risk corridor reconciliation	(7,739,681)	(1,961,327)	(488,631)	(5,289,723)
Federal match for public health emergency	0	(16,541,511)	(1,179,045)	17,720,556
TOTAL	**$1,176,260,183**	**$260,711,300**	**$89,414,007**	**$826,134,876**
Increase/(Decrease)	45,221,048	(11,570,183)	5,252,102	51,539,129
Percentage Change	4.0%	-4.2%	6.2%	6.7%

ENROLLMENT: Actual Medicaid enrollment is running slightly higher than the Department had forecast in February, but most of this increase is to account for the extension of the federal public health emergency. As a condition of accepting the 6.2 percent enhanced federal match that is available during the federal public health emergency, the Department cannot disenroll anyone from Medicaid or decrease their benefits due to a change in income.

PER CAPITA: The final capitated payments developed through the rate setting process were slightly lower than the Department had forecasted in February and the Department made some adjustments for groups enrolled in Medicaid that do not receive a capitation payment.

RISK CORRIDOR RECONCILIATION: The forecast includes an adjustment for money the Department expects to recoup from the Regional Accountable Entities for services rendered in FY 2001-22 that fell below a risk corridor negotiated in the contract. When the Department implements new policies with unpredictable outcomes, in this case a new residential Substance Use Disorder (SUD) benefit, the Department often establishes a risk corridor. If actual utilization falls outside the risk corridor, the Department either increases payments or recoups payments through a reconciliation process.

FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The appropriation assumed the enhanced federal match would be available through June 2022 and the forecast reflects two additional quarters with the enhanced federal match through December 2022. Since the request was submitted, the federal public health emergency was extended again so that the enhanced federal match is available through at least March 2023. The Department's February forecast will reflect this new information. Each quarter the federal public health emergency is extended saves the state approximately $100 million General Fund across all Medicaid programs after accounting for the increase in enrollment and the decrease in the state match.

FY 2023-24 FORECAST

The table below shows the major contributors to the change from the FY 2022-23 forecast to the FY 2023-24 forecast.

FY 2023-24 Behavioral Health Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2022-23 Projection	$1,176,260,183	$260,711,300	$89,414,007	$826,134,876
Enrollment	(100,580,163)	(21,584,921)	(13,237,729)	(65,757,513)
Per capita	42,589,429	12,711,736	5,605,353	24,272,340
Federal match for public health emergency	0	16,541,511	1,179,045	(17,720,556)
TOTAL	**$1,118,269,449**	**$268,379,626**	**$82,960,676**	**$766,929,147**
Increase/(Decrease)	(57,990,734)	7,668,326	(6,453,331)	(59,205,729)
Percentage Change	-4.9%	2.9%	-7.2%	-7.2%

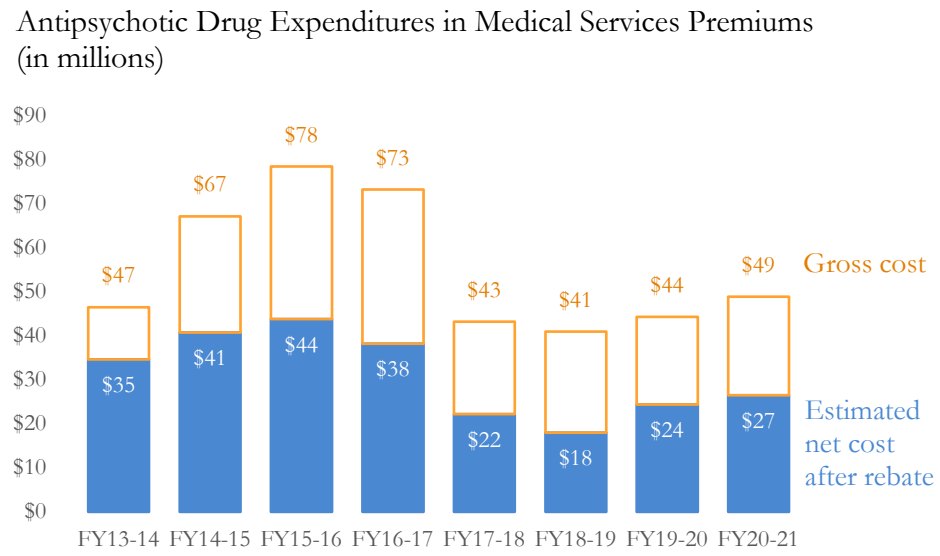
ENROLLMENT: The Department expects Medicaid enrollment to decrease dramatically for the first part of the year due to the end of the federal public health emergency and the federal prohibition on disenrolling people from Medicaid. After the level adjustment, the Department expects enrollment to start to grow again from the lower base. The projected average enrollment for the fiscal year is significantly lower than the prior year.

PER CAPITA: The Department expects that the majority of people losing Medicaid coverage at the end of the federal public health emergency will be low utilizers of behavioral health, so the per capita rates will increase.

FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The forecast includes an increase in General Fund and cash funds and a corresponding decrease in federal funds due to the expected end of the extra 6.2 percent federal match that is tied to the duration of the federal public health emergency.

PHARMACEUTICALS

Expenditures for antipsychotic drugs are funded in the Medical Services Premiums line item, along with all other pharmaceutical costs, rather than in the Behavioral Health Community Programs division. The most recent actual data on antipsychotic drugs reported by the Department is through FY 2020-21. The Department does not forecast antipsychotic drug costs separate from total pharmacy expenditures. Federal rules prohibit the Department from reporting actual rebates by drug, but the Department looked at average rebates and provided an estimate of net costs for antipsychotic drugs after the rebates.



R3 Child Health Plan Plus

FY 2022-23 Forecast

The table below shows the major contributors to the change from the FY 2022-23 appropriation to the Department's November 2022 forecast for FY 2022-23. It does not show differences from the FY 2021-22 expenditures.

FY 2022-23 Children's Basic Health Plan Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Appropriation	$182,938,101	$24,514,105	$39,470,009	$118,953,987
Enrollment	(23,107,342)	(4,118,380)	(1,849,166)	(17,139,796)
Per capita	(7,415,743)	(1,285,308)	(568,628)	(5,561,807)
CHP+ Trust balance	0	(5,222,715)	5,222,715	0
Federal match for public health emergency	(654,158)	(5,685,384)	(584,818)	5,616,044
TOTAL	**$151,760,858**	**$8,202,318**	**$41,690,112**	**$101,868,428**
Increase/(Decrease)	(31,177,243)	(16,311,787)	2,220,103	(17,085,559)
Percentage Change	-17.0%	-66.5%	5.6%	-14.4%

Enrollment: Actual CHP+ enrollment is running lower than the Department had forecast in February and the Department further decreased the forecast to account for the extension of the federal public health emergency. During the federal public health emergency there are clients churning from CHP+ to Medicaid but no clients churning from Medicaid to CHP+.

Per capita: The forecast makes a small true-up to the capitated payments per member per month.

CHP+ Trust balance: There is an available balance in the CHP+ Trust that the Department's forecast assumes will be used to offset the need for General Fund in FY 2022-23. The primary source of revenue to the CHP+ Trust is tobacco master settlement, but the Trust also receives money from

member premiums, interest, recoveries, and reversions. The General Fund makes up the difference between revenues to the CHP+ Trust and expenditures.

FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The appropriation assumed the enhanced federal match would be available through June 2022 and the forecast reflects two additional quarters with the enhanced federal match through December 2022. Since the request was submitted, the federal public health emergency was extended again so that the enhanced federal match is available through at least March 2023. The Department's February forecast will reflect this new information. Each quarter the federal public health emergency is extended saves the state approximately $100 million General Fund across all Medicaid programs after accounting for the increase in enrollment and the decrease in the state match. The CHP+ match rate is derived from the Medicaid match rate.

FY 2023-24 FORECAST

The table below shows the major contributors to the change from the FY 2022-23 forecast to the FY 2023-24 forecast.

FY 2023-24 Children's Basic Health Plan Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2022-23 Projection	$151,760,858	$8,202,318	$41,690,112	$101,868,428
Enrollment	50,831,273	11,701,627	4,074,600	35,055,046
Per capita	7,229,086	1,411,283	381,239	5,436,564
CHP+ Trust balance	0	5,222,715	(5,222,715)	0
Federal match for public health emergency	654,158	5,685,384	584,818	(5,616,044)
TOTAL	**$210,475,375**	**$32,223,327**	**$41,508,054**	**$136,743,994**
Increase/(Decrease)	58,714,517	24,021,009	(182,058)	34,875,566
Percentage Change	38.7%	292.9%	-0.4%	34.2%

ENROLLMENT: The Department projects a very large increase in enrollment at the end of the federal public health emergency when members can transition from Medicaid to CHP+.

PER CAPITA: The Department projects a small year over year growth in capitation rates.

CHP+ TRUST BALANCE: The Department's forecast assumes an accumulated balance in the CHP+ Trust is used to offset the need for General Fund in FY 2022-23 and then the money is no longer available to offset the need for General Fund in FY 2023-24.

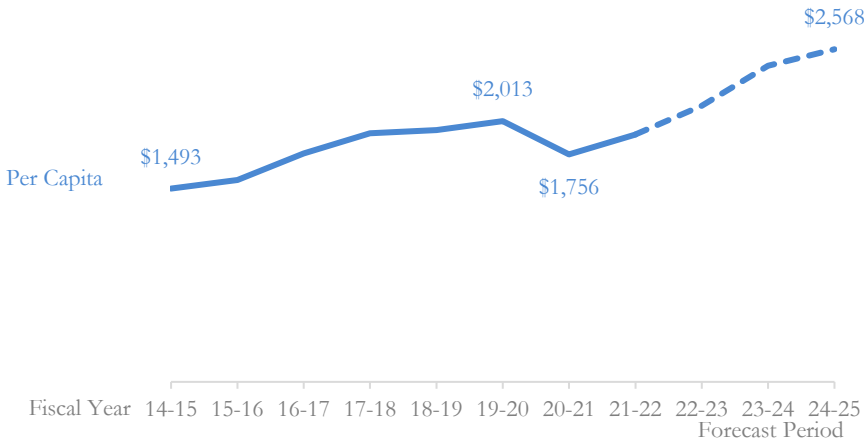
FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The forecast includes an increase in General Fund and cash funds and a corresponding decrease in federal funds due to the expected end of the enhanced federal match that is tied to the duration of the federal public health emergency.

R4 MEDICARE MODERNIZATION ACT

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

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

Medicare Modernization Act per capita costs are rising based on the federal formula calculation of prescription drug costs



FY 2022-23 FORECAST

The table below shows the major contributors to the change from the FY 2022-23 appropriation to the Department's November 2022 forecast for FY 2022-23. It does not show differences from the FY 2021-22 expenditures.

FY 2022-23 Medicare Modernization Act	
	GENERAL FUND
FY 2022-23 Appropriation	$235,472,292
Enrollment	9,067,693
Per capita	(484,340)
Federal match for public health emergency	(15,197,007)
TOTAL	**$228,858,638**
Increase/(Decrease)	(6,613,654)
Percentage Change	-2.8%

ENROLLMENT: The change in the forecast is almost entirely attributable to the extension of the federal public health emergency and the prohibition on disenrolling people from Medicaid.

PER CAPITA: The federal formula for determining the rate per member came in slightly lower than expected.

FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The appropriation assumed the enhanced federal match would be available through June 2022 and the forecast reflects two additional quarters with the enhanced federal match through December 2022. Since the request was submitted, the federal public

health emergency was extended again so that the enhanced federal match is available through at least March 2023. The Department's February forecast will reflect this new information. Each quarter the federal public health emergency is extended saves the state approximately $100 million General Fund across all Medicaid programs after accounting for the increase in enrollment and the decrease in the state match.

FY 2023-24 FORECAST

The table below shows the major contributors to the change from the FY 2022-23 forecast to the FY 2023-24 forecast.

FY 2023-24 Medicare Modernization Act	
	GENERAL FUND
FY 2023-24 Projection	$228,858,638
Enrollment	(8,516,129)
Per capita	3,218,580
Federal match for public health emergency	15,197,007
TOTAL	**$238,758,096**
Increase/(Decrease)	9,899,458
Percentage Change	4.3%

ENROLLMENT: The Department expects Medicaid enrollment to decrease dramatically for the first part of the year due to the end of the federal public health emergency and the federal prohibition on disenrolling people from Medicaid. After the level adjustment, the Department expects enrollment to start to grow again from the lower base. The projected average enrollment for the fiscal year is significantly lower than the prior year.

PER CAPITA: The federal formula for determining the state obligation is expected to result in a higher cost per member per month due to continued increases in drug prices.

FEDERAL MATCH FOR PUBLIC HEALTH EMERGENCY: The forecast includes an increase in General Fund due to the expected end of the enhanced federal match that is tied to the duration of the federal public health emergency.

BIRTHING EQUITY (R9)

The issue brief explores the Department's request in R9 Birthing Equity for $1.2 million total funds, including $594,304 General Fund, for the combined cost of a new doula benefit and new donor milk benefit. The cost for these new benefits increases to $1.8 million total funds, including $901,802 General Fund, in the second year.

SUMMARY

- The Department proposes covering doula services from non-medical professionals to provide physical, emotional, and information support and advocacy for birthing people.
    - A qualified doula would meet only minimal initial training requirements, but an experienced doula would accumulate significant knowledge based on assisting with an average of 48 births per year.
    - The request assumes the cost of the doula benefit would be partially offset by savings from reduced cesarean deliveries and preterm births.
    - Other state Medicaid programs that cover doula services have had trouble attracting providers.
- The Department proposes covering donor human milk for high-risk infants.
    - Consumption of human milk is associated with better health outcomes than formula.
    - The Department speculates that the new benefit will increase utilization of human milk over formula, that families accessing donor milk would be better informed of the benefits of breastfeeding, and that they would be more likely to form feeding routines centered on breastfeeding instead of formula.
    - The request assumes Medicaid clients would consume 42 percent of the available supply of donor human milk, based on the proportion of Colorado births covered by Medicaid.

DISCUSSION

The Department requests $1.2 million total funds, including $594,304 General Fund, for the combined cost of a new doula benefit and new donor milk benefit. The cost increases to $1.8 million total funds, including $901,802 General Fund, in the second year.

As part of the request, the Department included an unrelated change to the High Risk Pregnant Women line item and showed this as an offset to the cost of the request.

R9 Birthing Equity			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
FY 2023-24			
Doula benefit	$996,561	$492,465	$504,096
Services	*837,202*	*411,807*	*425,395*
Stakeholder engagement	*150,000*	*75,000*	*75,000*
Training	*100,000*	*50,000*	*50,000*
Outreach	*30,000*	*15,000*	*15,000*
Reduction in cesarean births	*(120,641)*	*(59,342)*	*(61,299)*
Donor milk benefit	$203,677	$101,839	$101,838
Subtotal - New Benefits	**$1,200,238**	**$594,304**	**$605,934**
High Risk Pregnant Women	($1,903,091)	($951,546)	($951,545)
Total Request	**($702,853)**	**($357,242)**	**($345,611)**
FY 2024-25			
Doula benefit	$1,624,177	$799,963	$824,214
Services	*1,758,123*	*864,794*	*893,329*
Stakeholder engagement	*0*	*0*	*0*
Training	*100,000*	*50,000*	*50,000*
Outreach	*30,000*	*15,000*	*15,000*
Reduction in cesarean births	*(263,946)*	*(129,831)*	*(134,115)*
Donor milk benefit	$203,677	$101,839	$101,838
Subtotal - New Benefits	**$1,827,854**	**$901,802**	**$926,052**
High Risk Pregnant Women	($1,903,091)	($951,546)	($951,545)
Total Request	**($75,237)**	**($49,744)**	**($25,493)**

In Colorado Medicaid covers just under 25 percent of the population but 42 percent of births. Both new benefits are intended to address documented disparities in health outcomes by race and socioeconomic status.

DOULA BENEFIT

The Department proposes a new benefit to cover doula services. The request describes a doula as a trained, non-medical professional who provides continuous physical, emotional, and information support to a birthing person before, during, and after childbirth to advocate on the person's behalf. The request includes funding for stakeholder engagement to help design the new benefit, including determining the appropriate credentials for a doula to participate in Medicaid. The Department indicates that the largest doula certifying organization is DONA International and it offers certification workshops that can be completed in 24 cumulative hours. The Department does not currently cover birthing support services such as doulas or birthing classes.

The Department identifies a variety of studies suggesting correlations between doula support and lower cesarean births, lower pre-term births, healthier birth weights, increased breastfeeding, lower post-partum depression, increased adherence to infant safety protocols, and more positive perceptions of the birthing experience. The request assumes that for people receiving the doula benefit cesarean births would decrease 6.0 percent and preterm births would drop 1.5 percent. Most of the savings is driven by the decrease in cesarean births. While the Department found several studies suggesting a decrease in cesarean births associated with doula support, the most recent randomized controlled trial

cited by the Department worked with people in low-income areas in Indiana and found that the doula group had no significant reduction in cesarean births.

The stakeholder engagement would inform payment procedures but the request assumes the Department will pay doulas $1,500 for 6-12 visits spread over pre- and post-partum plus the delivery. In addition to a rate that is at the high end compared to other state Medicaid programs, the Department proposes on-going funding for training to help doulas navigate Medicaid reimbursement and to invest in community-based training programs. The Department hopes to incentivize training Medicaid members to become doulas.

With these investments, the Department expects to involve doulas in 1,172 Medicaid births per year by year two of the implementation, which is significantly higher than the experience of other states. The Department notes that Oregon and Minnesota have struggled to attract providers. Minnesota's Medicaid program pays doulas $770 and covered doula services for only 804 births total in six years. Oregon paid $350 and covered doula services for only 204 births in four years before recently raising rates to $1,500 in hope of attracting more providers. There are six state Medicaid programs that cover doula services and six others that are preparing to implement coverage. Data on the number of births covered is not yet available from the other states. The Department indicates there are currently 94 doulas operating in Colorado and estimates each doula can assist with 48 births per year.

DONOR MILK BENEFIT

The Department proposes a new benefit to cover the cost of donor human milk for high-risk infants. Human milk consumption is associated with beneficial health outcomes, including lower rates of sepsis, feeding intolerance, necrotizing enterocolitis, and hospital stays, as well as improved developmental outcomes. The Department speculates that the new benefit would increase utilization of human milk over formula, that families accessing donor milk would be better informed of the benefits of breastfeeding, and that they would be more likely to form feeding routines centered on breastfeeding instead of formula. According to the Department, studies indicate that the use of donor milk is perceived as a short term solution for preterm and other babies that are challenged to start breastfeeding while formula is viewed as a long term feeding strategy.

The Department cites data from the Department of Public Health and Environment indicating that overall 95 percent of Coloradans breastfeed their children for some portion of time, but 17.4 percent of children birthed to low-income families in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) never breastfeed.

A stakeholder engagement process would inform the conditions of medical necessity for the benefit. The request assumes the Department would pay similar to the current out-of-pocket cost of $4.64 per ounce to provide donor milk at no cost to qualifying Medicaid clients.

The supply of human milk is limited by the volume of donations. The Department identified one current supplier in Colorado that meets national quality standards, the Mother's Milk Bank in Arvada. The request assumes Medicaid clients could access the limited supply in proportion to the number of births covered by Medicaid. In other words, the Department assumes that Medicaid clients will take 42 percent of the supply.

HIGH RISK PREGNANT WOMEN

As part of the request, the Department included an unrelated change to the High Risk Pregnant Women line item and showed this as an offset to the cost of the request. Prior to the Medicaid residential Substance Use Disorder (SUD) benefit, the Department sent money to the Department of Human Services to administer a program for high-risk pregnant people that covered residential and outpatient treatment. With the expansion of the SUD benefit, pregnant people have access to these services through the standard Medicaid benefit, rather than needing the specialized High Risk Pregnant Women program. Funding for the High Risk Pregnant Women program should go away due to the implementation of the residential SUD benefit regardless of whether the General Assembly approves funding for the proposed new doula and donor milk benefits.

In FY 2020-21 the Department spent $548,821 from the High Risk Pregnant Women line item during the ramp up of the residential SUD benefit and in FY 2021-22 the Department did not spend any money from the line item. The Department indicates that it did not request a reduction in funding in FY 2021-22 in part because it was concerned about the potential for straggler claims. The lack of a JBC staff recommendation to reduce the funding in FY 2021-22 was an error attributable to the way budget responsibilities are divided across departments and a lack of understanding about the connections between the new residential SUD benefit and the High Risk Pregnant Women program.

The Department sees a nexus between the High Risk Pregnant Women program and the proposed new benefits in that they all try to improve health outcomes at birth.

APPENDIX A
NUMBERS PAGES
(DIGITAL ONLY)

Appendix A details actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. This information is listed by line item and fund source. ***Appendix A is only available in the online version of this document.***

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS Healthcare Affordability and Sustainability Cash Fund.					
Behavioral Health Capitation Payments	811,992,425	852,041,516	1,118,068,471	1,113,835,257 *	
General Fund	173,123,597	0	269,399,988	269,039,402	
Cash Funds	52,718,658	63,158,906	83,315,662	82,325,517	
Reappropriated Funds	0	0	0	0	
Federal Funds	586,150,170	788,882,610	765,352,821	762,470,338	
Behavioral Health Fee-for-service Payments	14,851,894	12,592,071	12,970,664	10,572,909 *	
General Fund	2,692,858	2,280,953	2,881,495	2,390,732	
Cash Funds	989,215	871,824	846,243	639,585	
Reappropriated Funds	0	0	0	0	
Federal Funds	11,169,821	9,439,294	9,242,926	7,542,592	
TOTAL - (3) Behavioral Health Community Programs	826,844,319	864,633,587	1,131,039,135	1,124,408,166	(0.6%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	175,816,455	2,280,953	272,281,483	271,430,134	(0.3%)
Cash Funds	53,707,873	64,030,730	84,161,905	82,965,102	(1.4%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	597,319,991	798,321,904	774,595,747	770,012,930	(0.6%)

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	135,548,026	254,743,330	226,610,308	226,610,308	
General Fund	0	0	0	0	
Cash Funds	67,774,013	110,819,422	113,305,154	113,305,154	
Reappropriated Funds	0	0	0	0	
Federal Funds	67,774,013	143,923,908	113,305,154	113,305,154	
Pediatric Specialty Hospital	10,764,010	10,764,010	10,764,010	10,764,010	
General Fund	4,714,636	4,714,636	5,382,005	5,382,005	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,049,374	6,049,374	5,382,005	5,382,005	
Appropriation from Tobacco Tax Fund to the General Fund	390,989	364,131	381,798	381,798	
General Fund	0	0	0	0	
Cash Funds	390,989	364,131	381,798	381,798	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Primary Care Fund	24,666,536	51,647,973	48,087,990	48,087,990	
General Fund	0	0	0	0	
Cash Funds	24,666,536	22,755,511	24,176,000	24,176,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	28,892,462	23,911,990	23,911,990	

Appendix A: Numbers Pages

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
Children's Basic Health Plan Administration	1,204,364	2,336,020	3,864,405	3,864,405 *	
General Fund	0	0	0	0	
Cash Funds	370,894	716,224	1,243,319	1,352,542	
Reappropriated Funds	0	0	0	0	
Federal Funds	833,470	1,619,796	2,621,086	2,511,863	
Children's Basic Health Plan Medical and Dental Costs	166,658,064	133,119,234	179,073,696	206,649,737 *	
General Fund	2,761,239	11,045,841	24,132,307	31,855,097	
General Fund Exempt	390,989	0	381,798	381,798	
Cash Funds	44,010,133	30,065,351	38,226,690	40,155,512	
Reappropriated Funds	0	0	0	0	
Federal Funds	119,495,703	92,008,042	116,332,901	134,257,330	
Clinic Based Indigent Care	6,039,386	0	0	0	
General Fund	2,645,251	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,394,135	0	0	0	
TOTAL - (4) Indigent Care Program	345,271,375	452,974,698	468,782,207	496,358,248	5.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	10,121,126	15,760,477	29,514,312	37,237,102	26.2%
General Fund Exempt	390,989	0	381,798	381,798	0.0%
Cash Funds	137,212,565	164,720,639	177,332,961	179,371,006	1.1%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	197,546,695	272,493,582	261,553,136	279,368,342	6.8%

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	23,557	10,000,000	10,000,000		
General Fund	0	0	0		
Cash Funds	23,557	10,000,000	10,000,000		
Reappropriated Funds	0	0	0		
Federal Funds	0	0	0		
Senior Dental Program	2,987,821	3,990,358	3,990,358		
General Fund	2,962,510	3,962,510	3,962,510		
Cash Funds	25,311	27,848	27,848		
Reappropriated Funds	0	0	0		
Federal Funds	0	0	0		
Commission on Family Medicine Residency Training Programs	7,130,420	9,490,170	9,490,170		
General Fund	3,123,124	4,520,085	4,520,085		
Cash Funds	0	0	0		
Reappropriated Funds	0	225,000	225,000		
Federal Funds	4,007,296	4,745,085	4,745,085		
Medicare Modernization Act State Contribution Payment	151,204,900	235,472,292	238,758,096	*	
General Fund	151,204,900	235,472,292	238,758,096		
Public School Health Services Contract Administration	1,035,786	2,000,000	2,000,000		
General Fund	517,893	1,000,000	1,000,000		
Cash Funds	0	0	0		
Reappropriated Funds	0	0	0		
Federal Funds	517,893	1,000,000	1,000,000		

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
Public School Health Services	127,813,978	172,092,626	172,092,626		
General Fund	0	0	0		
Cash Funds	57,869,729	84,651,774	84,651,774		
Reappropriated Funds	0	0	0		
Federal Funds	69,944,249	87,440,852	87,440,852		
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	500,000	1,500,000	1,500,000		
General Fund	0	0	0		
Cash Funds	500,000	1,500,000	1,500,000		
Reappropriated Funds	0	0	0		
Federal Funds	0	0	0		
Reproductive Health Care for Individuals Not Eligible for Medicaid	0	3,614,490	3,614,490		
General Fund	0	3,614,490	3,614,490		
Urban Indian Health Organizations State Only Payments	0	48,025	0		
General Fund	0	48,025	0		
ARPA HCBS State-only Funds	0	56,589,558 4.0	46,067,172 4.0		
General Fund	0	0	0		
Cash Funds	0	56,589,558	46,067,172		
Primary Care and Behavioral Health Statewide Integration Grant Program	0	31,750,000 2.3	0 0.0		
Cash Funds	0	31,750,000	0		

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	Request vs. Appropriation
State University Teaching Hospitals Denver Health and Hospital Authority	0	0	0		
General Fund	0	0	0		
Cash Funds	0	0	0		
Reappropriated Funds	0	0	0		
Federal Funds	0	0	0		
State University Teaching Hospitals University of Colorado Hospital	1,204,207	0	0		
General Fund	330,343	0	0		
Cash Funds	0	0	0		
Reappropriated Funds	197,100	0	0		
Federal Funds	676,764	0	0		
TOTAL - (5) Other Medical Services	291,900,669	526,547,519	487,512,912	(7.4%)	
FTE	0.0	6.3	4.0	(36.5%)	
General Fund	158,138,770	248,617,402	251,855,181	1.3%	
Cash Funds	58,418,597	184,519,180	142,246,794	(22.9%)	
Reappropriated Funds	197,100	225,000	225,000	0.0%	
Federal Funds	75,146,202	93,185,937	93,185,937	0.0%	
TOTAL - Department of Health Care Policy and Financing	1,464,016,363	1,317,608,285	2,126,368,861	2,108,279,326	(0.9%)
FTE	0.0	0.0	6.3	4.0	(36.5%)
General Fund	344,076,351	18,041,430	550,413,197	560,522,417	1.8%
General Fund Exempt	390,989	0	381,798	381,798	0.0%
Cash Funds	249,339,035	228,751,369	446,014,046	404,582,902	(9.3%)
Reappropriated Funds	197,100	0	225,000	225,000	0.0%
Federal Funds	870,012,888	1,070,815,486	1,129,334,820	1,142,567,209	1.2%

NOTE: An asterisk (*) indicates that the FY 2022-23 request for a line item is affected by one or more decision items.

APPENDIX B
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

The General Assembly includes footnotes in the annual Long Bill to: (a) set forth purposes, conditions, or limitations on an item of appropriation; (b) explain assumptions used in determining a specific amount of an appropriation; or (c) express legislative intent relating to any appropriation. Footnotes to the 2022 Long Bill (H.B. 22-1329) can be found at the end of each departmental section of the bill at https://leg.colorado.gov/bills/hb22-1329. The Long Bill footnotes relevant to this document are listed below.

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

Comment: This footnote expresses the General Assembly's intent regarding how the appropriation should be used. The Department is in compliance with the footnote and using the money for the grant program authorized in Section 25.5-5-208, C.R.S.

31 Department of Health Care Policy and Financing, Other Medical Services, State-only Payments for Home- and Community-Based Services -- This appropriation remains available for expenditure until the close of the 2023-24 state fiscal year.

Comment: This footnote provides roll-forward authority for the funds through FY 2023-24.

UPDATE ON LONG BILL REQUESTS FOR INFORMATION

The Joint Budget Committee annually submits requests for information to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2022-23 Report):

https://leg.colorado.gov/sites/default/files/fy22-23apprept.pdf

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

2 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by November 1, 2022, discussing member utilization of capitated behavioral health services in FY 2020-21 and the Regional Accountable

Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year 2021, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

Comment: The Department submitted the report as requested. A full copy of the report can be found here:

https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20BH%20LRFI%20%232%202022.pdf

The Joint Budget Committee continues to hear concerns about the inadequacy of the Medicaid behavioral health provider network and the impact of provider rates and administrative procedures on the provider network. Many of the concerns relate to perceived differential treatment of Community Mental Health Centers and the independent provider network. This request was submitted as part of the JBC's efforts to get a better handle on the issue.

The Department reports that 18.2 percent of Medicaid clients (242,924 members) accessed behavioral health services in FY 2020-21. However, the Department believes this rate is not representative of the number of members needing care, citing a national survey finding that 21 percent of adults and 17 percent of children report a mental illness and a Colorado survey finding 24.3 percent of Coloradans report eight or more days of poor mental health in the 30 days prior. The detail requested regarding services utilized by members was covered above in the Forecast Summary issue brief. The JBC staff infers from the report that the Department believes network inadequacy is a contributing factor to the lower than expected penetration rate.

Measuring network adequacy is complex and fraught with issues around data standardization to ensure apples to apples comparisons and challenges with incomplete data. Also, the Department is trying to look not just at practitioner to member ratios but also distance and travel time, appointment wait times, cultural/linguistic competency, and disability services. The report showed a positive trend in the number of enrolled providers, but this not necessarily a helpful indicator of network adequacy, since a provider can be anything from an individual in private practice to a group of many practitioners.

Fiscal Year and Quarter	Number of Enrolled Behavioral Health Providers
FY 2019-20 Q4	6,391
FY 2020-21 Q1	7,451
FY 2020-21 Q2	7,984
FY 2020-21 Q3	8,307
FY 2020-21 Q4	8,627

The report also provided information on the number of practitioners by region, which is arguably a better measure of capacity, but the report focused on the number of practitioners added by quarter without important contextual information on total practitioners, member to practitioner ratios, or a longer time horizon than one year. In researching questions from the JBC staff, the Department identified some errors in the data reported and requested additional time to develop a more complete and accurate picture of changes in network adequacy by region over time.

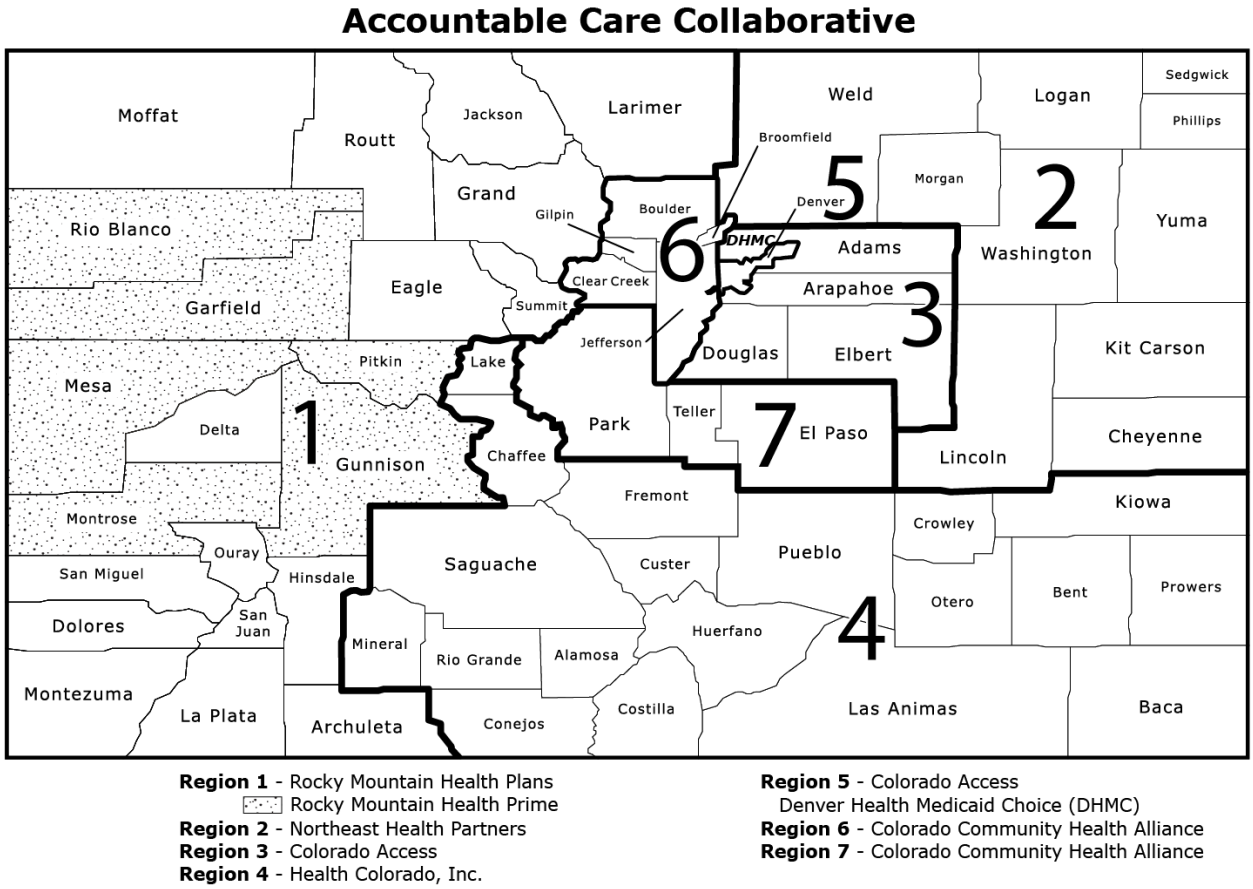
The report indicates that at the end of 2021 there were issues with RAEs not processing applications from new providers in a timely manner. The Department cautions that in some cases the number of new provider applications was small, so a few delays caused big percentage differences on this metric. In January 2022, the Department implemented new stricter policies requiring timely processing of provider applications by RAEs and since then there has been a dramatic increase in the percentage of providers credentialed and contracted within 90 days.

	RAE 1 Rocky Mtn Health Plans	RAE 2 Northeast Health Partners	RAE 3 & 5 CO Access	RAE 4 Health Colorado, Inc.	RAE 6 & 7 CO Community Health Alliance	Denver Health
CY 21 Q1	100%	100%	89%	79%	*	89%
CY 21 Q2	100%	98%	90%	86%	*	90%
CY 21 Q3	100%	45%	92%	45%	92%	92%
CY 21 Q4	100%	63%	87%	63%	75%	87%
CY 22 Q1	96%	97%	99%	97%	100%	100%
CY 22 Q2	100%	100%	100%	100%	100%	100%

The report suggests no systemic issues with timely claims processing. All of the RAEs processed clean claims within thirty days more than 99 percent of the time. A "clean claim" can be processed without additional information from the provider and includes claims with errors but not a claim under review for medical necessity or where a provider is under investigation for fraud or abuse. While it could be a major concern for a provider with a claim that is part of the 0.6 percent of delayed claims, it is not common for the processing of claims to take longer than thirty days. The RAEs are required to respond to provider questions within two days and all the RAEs met this obligation 100 percent of the time.

To get at the requested information on the performance of the RAEs, the Department provided background on the performance incentives for the RAEs. Each year, they are eligible to earn up to 5% of their annual behavioral health capitation payment for reaching performance metrics.

Before discussing each of the metrics, a map of the Accountable Care Collaborative will be useful for interpreting what region of the state is being measured.



The measures used by the Department are described in the bullets below.

a. **Engagement in Outpatient SUD Treatment:** Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
b. **Follow-up within 7 Days after an Inpatient Hospital Discharge for a Mental Health Condition:** Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.
c. **Follow-up within 7 Days after an Emergency Department Visit for SUD:** Percent of member discharges from an emergency department episode for treatment of a covered

SUD diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.

d. **Follow-up after a Positive Depression Screen:** Percent of members engaged in mental health service within 30 days of screening positive for depression.

e. **Behavioral Health Screening or Assessment for Foster Care Children:** Percentage of foster care children who received a behavioral screening or assessment within 30 days of MCE enrollment.

	Out-patient SUD	Follow-up w/n 7 Days of Discharge for Mental Health Condition	Follow-up w/n 7 Days of ED Visit for SUD	Follow-up w/n 30 Days of Positive Depression Screen	Behavioral Health Assessment for Children in Foster Care
1 Western counties	47.90%	44.80%	32.46%	57.49%	16.39%
2 NE counties	50.80%	50.07%	29.64%	87.09%	18.60%
3 Adams/Arapahoe/Douglas/Elbert	45.09%	56.76%	30.50%	43.47%	15.41%
4 SE counties	48.51%	70.43%	36.49%	50.19%	33.11%
5 Denver	36.65%	56.03%	35.25%	39.21%	28.57%
6 Jefferson/Boulder/Gilpin/Clear Creak	41.61%	64.51%	35.30%	47.48%	17.82%
7 El Paso/Park/Teller	54.10%	41.42%	32.75%	73.39%	23.29%
Denver Health	*	*	*	*	*

3 Department of Health Care Policy and Financing, Indigent Care Programs -- The Department is requested to submit a report by February 15, 2023, detailing the progress on all outstanding issues with administration of the Children's Basic Health Plan. The report should include a progress report on completing backlogged issues since the authorized additional FTE and a projection of when each backlogged issue will be completed and program authorities will become current and compliant. Finally, the report should include a recommendation on whether the administrative staffing level for the Children's Basic Health Plan is sufficient to maintain effective operation and performance into the future.

Comment: This report is not due until February 15, 2023. The date was selected to ensure that the Department had time to hire and train the additional FTE and make sufficient progress on the backlogged issues for the report to be relevant.

4 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include

information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted the report as requested. When schools provide medically necessary services to public school children with disabilities, or provide certain health screening or nursing services, and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. The majority of qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, specialized non-emergency transportation services, and psychology, counseling, and social work. In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement. In FY 2021-22, $59,990,967 was distributed through the program to 57 providers who served 20,026 unique members. A copy of the full report is available here:

https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20SHS%20LRFI%204%202021-22_0.pdf

APPENDIX C
DEPARTMENT ANNUAL PERFORMANCE REPORT

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

For consideration by the Joint Budget Committee in prioritizing the department's FY 2023-24 budget request, the FY 2021-22 Annual Performance Report and the FY 2022-23 Performance Plan can be found at the following link:

https://operations.colorado.gov/performance-management/department-performance-plans