JOINT
BUDGET
COMMITTEE

STAFF BUDGET BRIEFING
FY 2020-21

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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DECEMBER 9, 2019

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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.

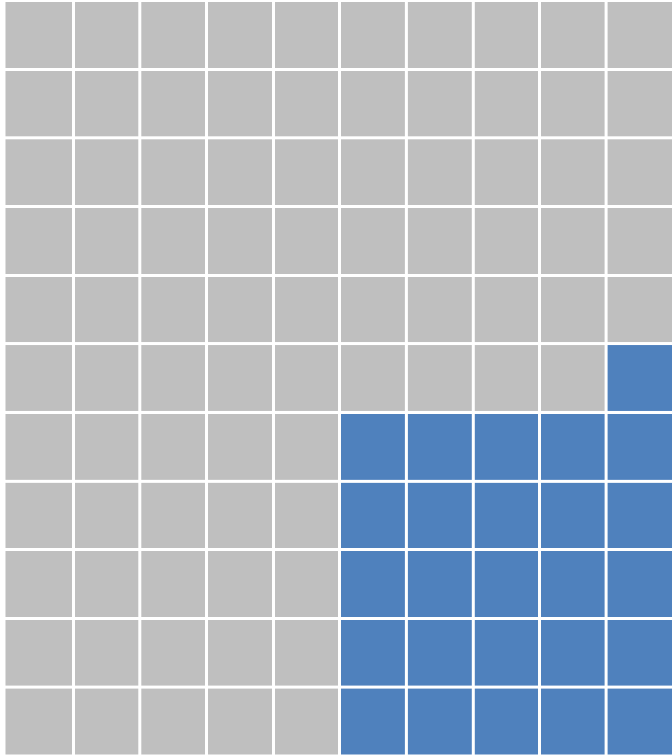
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

Funding Source	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21 *
General Fund	$2,832,866,579	$2,957,484,523	$3,151,370,264	$3,377,544,826
Cash Funds	1,215,445,935	1,389,264,217	1,386,291,098	1,519,856,266
Reappropriated Funds	77,491,711	83,491,228	93,615,672	93,500,756
Federal Funds	5,802,250,189	5,944,110,291	6,057,784,830	6,226,469,238
TOTAL FUNDS	**$9,928,054,414**	**$10,374,350,259**	**$10,689,061,864**	**$11,217,371,086**
Full Time Equiv. Staff	459.3	506.3	544.6	578.8

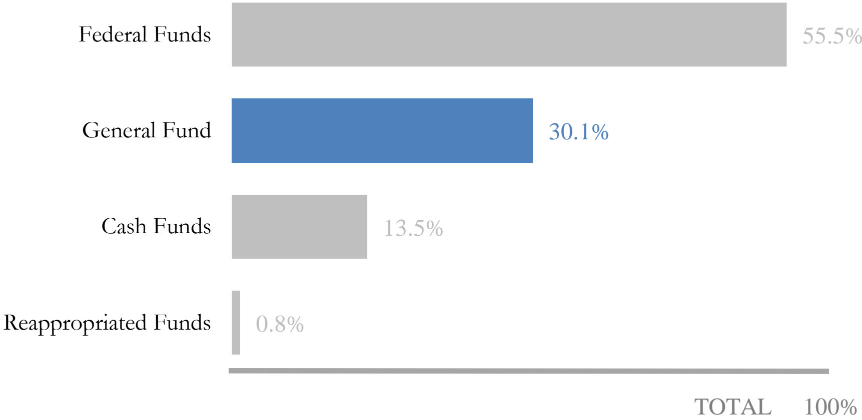
*Requested appropriation.

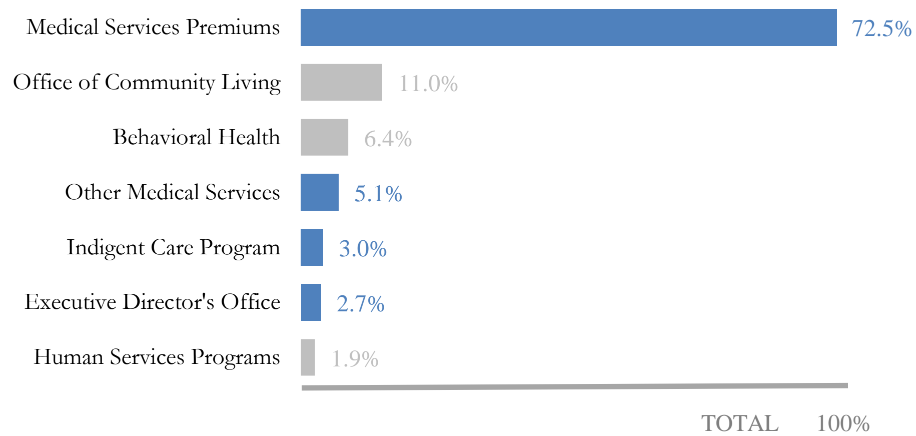
DEPARTMENT BUDGET: GRAPHIC OVERVIEW

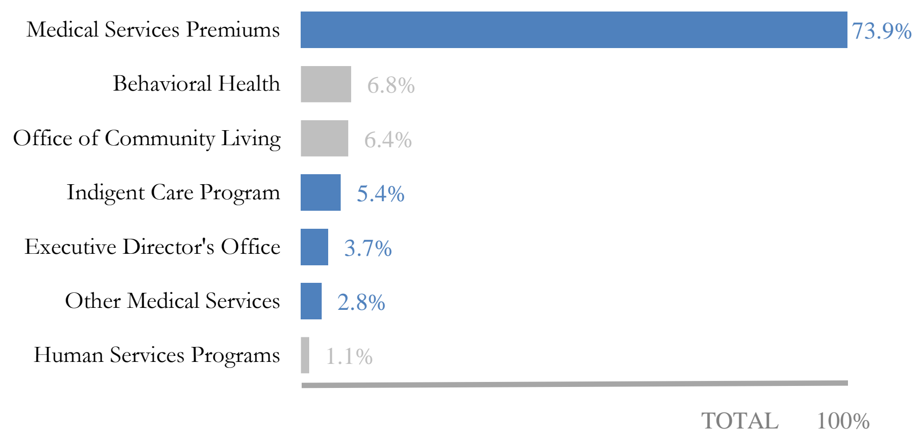
Department Share of Statewide General Fund
FY 2019-20
Health Care Policy and Financing 25.8 %



Department Funding Sources
FY 2019-20




Distribution of General Fund by Division
FY 2019-20
Medical Services Premiums 72.5%
Office of Community Living 11.0%
Behavioral Health 6.4%
Other Medical Services 5.1%
Indigent Care Program 3.0%
Executive Director's Office 2.7%
Human Services Programs 1.9%
TOTAL 100%


Distribution of Total Funds by Division
FY 2019-20
Medical Services Premiums 73.9%
Behavioral Health 6.8%
Office of Community Living 6.4%
Indigent Care Program 5.4%
Executive Director's Office 3.7%
Other Medical Services 2.8%
Human Services Programs 1.1%
TOTAL 100%

GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 30.1 percent General Fund, 13.5 percent cash funds, 0.8 percent reappropriated funds, and 55.5 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.

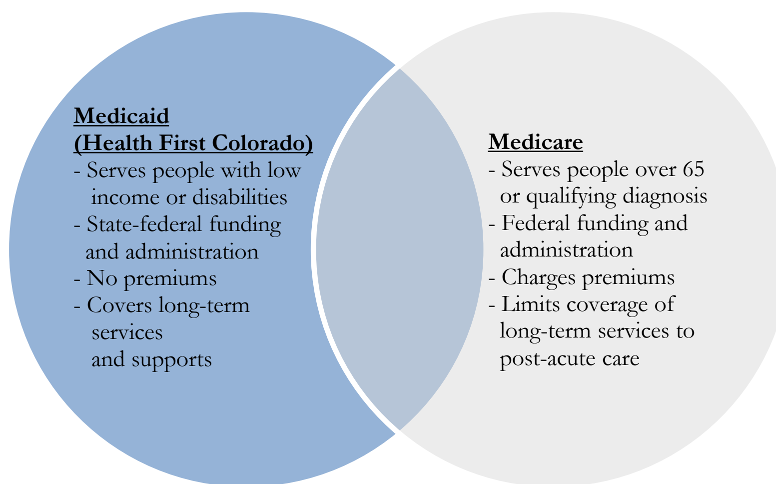
MEDICAID

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 "dual 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 citizens on Medicaid age 65 and older are enrolled in Medicare and a portion of people with disabilities.

[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 2019-20 the average FMAP for the majority of Colorado Medicaid expenditures is 50.0 percent and that is not expected to change in FY 2020-21. For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado will receive an enhanced federal match of 93.0 percent in 2019 and 90 percent in 2020 and beyond.

Standard Medicaid Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 15-16	50.79	51.01	50.72	50.72	50.72
FY 16-17	50.20	50.72	50.02	50.02	50.02
FY 17-18	50.00	50.02	50.00	50.00	50.00
FY 18-19	50.00	50.00	50.00	50.00	50.00
FY 19-20	50.00	50.00	50.00	50.00	50.00
FY 20-21	*50.00*	50.00	*50.00*	*50.00*	*50.00*

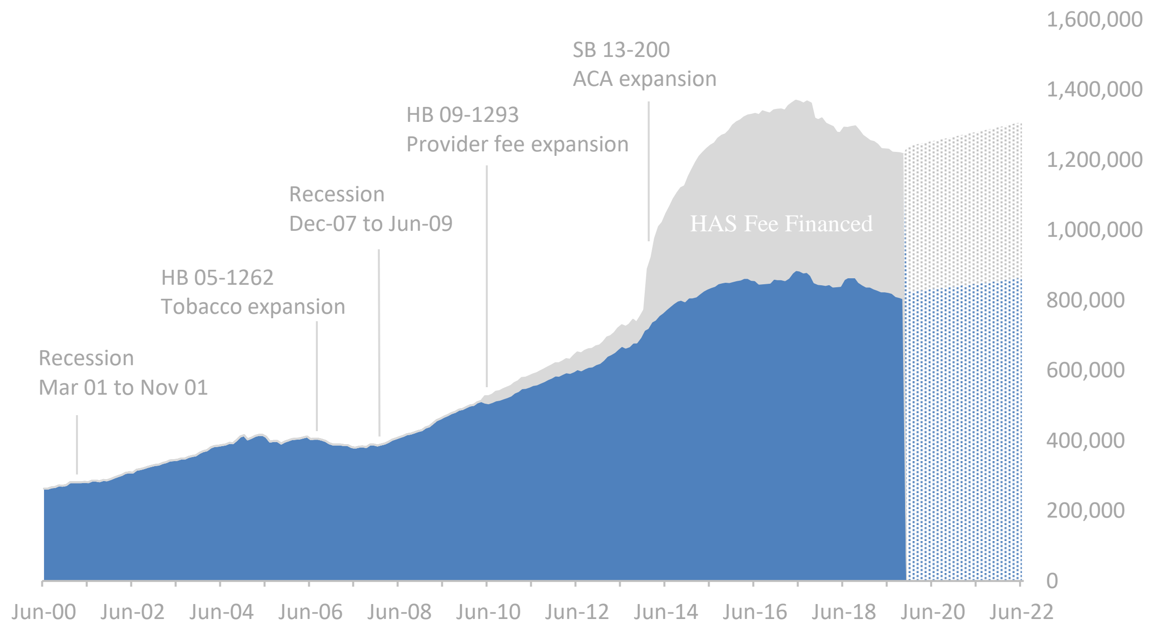
Italicized figures are projections.

ACA "Newly Eligible" Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 15-16	100.00	100.00	100.00	100.00	100.00
FY 16-17	97.50	100.00	100.00	95.00	95.00
FY 17-18	94.50	95.00	95.00	94.00	94.00
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

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.[2]

The most significant factor affecting 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. During the time frame covered by the graphic below there were three major eligibility expansions and a number of smaller expansions. The first expansion, authorized by H.B. 05-1262, used revenue from a tobacco tax approved by voters to remove asset tests, moderately increase income limits for parents, and expand eligibility for children needing long-term services and supports. Increases in enrollment due to the expanded eligibility were offset by an improving economy. Over time, increases in the population and costs of services exceeded tobacco tax revenues and the General Fund filled in the difference for this expansion. In the second and third expansions, authorized by H.B. 09-1293 and S.B. 13-200, a provider fee on hospitals combined with a 90 percent federal match rate, provided through the federal Affordable Care Act (ACA), allowed Colorado to nearly double income eligibility limits for parents and begin covering low-income adults without dependent children, along with some smaller changes to eligibility determination procedures for children and the creation of a buy-in program for people with disabilities. The implementation of some of the increases in eligibility authorized by H.B. 09-1293 was delayed to take advantage of favorable federal match rates authorized by the federal Affordable Care Act based on the date of a coverage expansion, such that the full impact of both bills on eligibility was not realized until January 2014.

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



After accounting for standard income disregards, Medicaid effectively covers people to 138 percent of the federal poverty guidelines, or $17,236 annual income for an individual and $29,435 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 $56,525 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.

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

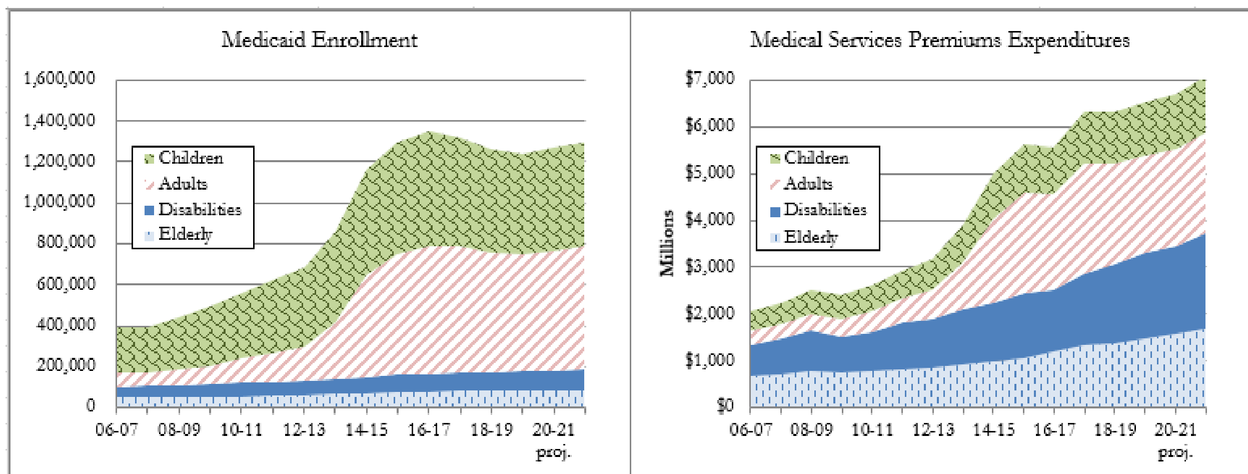
Family Size	Federal Poverty Guideline - 2018	SSI Annual Income Limit
1	$12,490	$9,252
2	$16,910	$13,884
3	$21,330	
4	$25,750	
More	add $4,420 each	

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

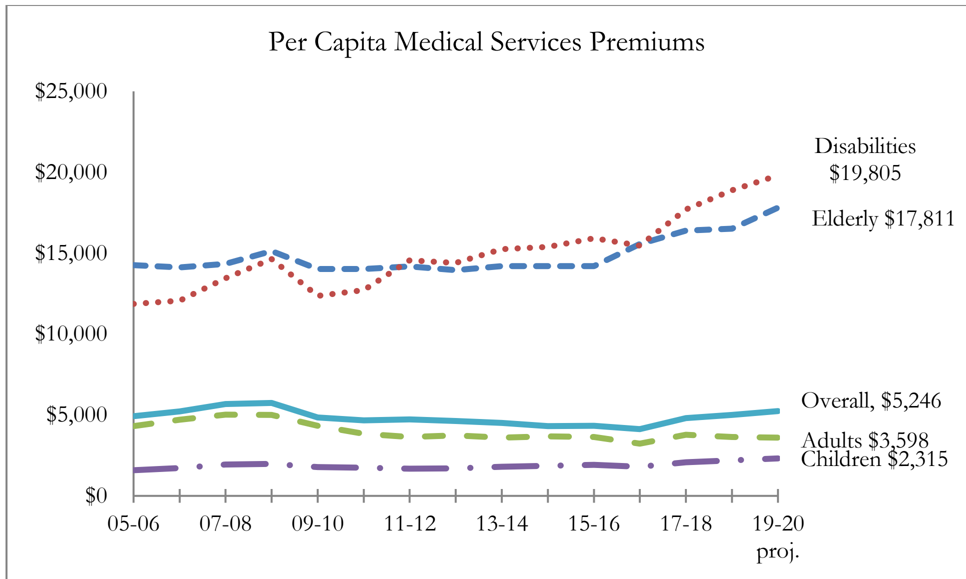
(1) MEDICAL SERVICES PREMIUMS

Medical Services Premiums is a subset of Medicaid expenditures that pays for physical health care and long-term services and supports. The number of Medicaid clients, the costs of providing health care services, and the utilization of health care services drives expenditures for Medical Service Premiums.

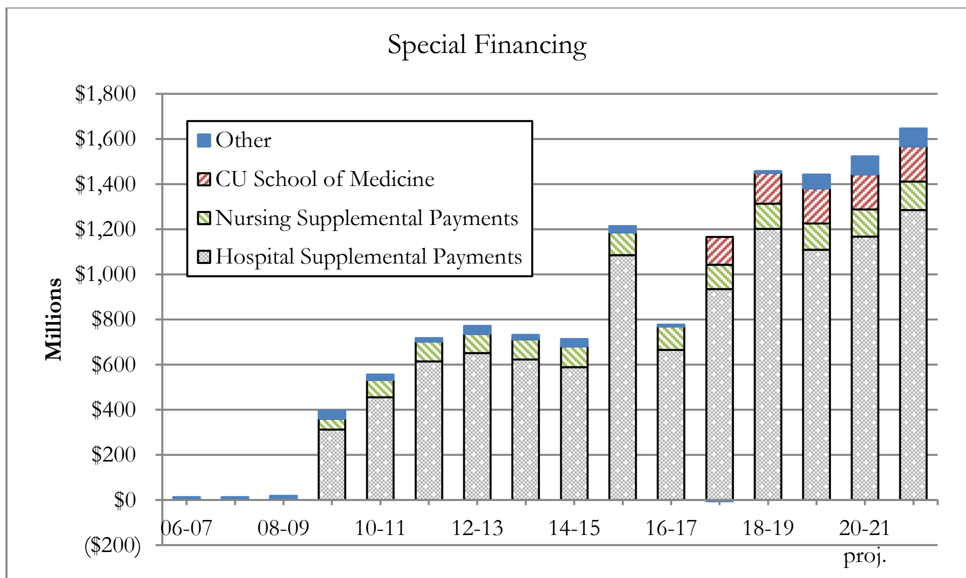
The two charts below illustrate recent changes in Medicaid enrollment and expenditures by broad eligibility category. The expenditures in these charts do not include special financing from provider fees, certified public expenditures, and interagency transfers for providers such as hospitals, nursing homes, and the physicians of the University of Colorado's School of Medicine. This special financing does not necessarily follow trends in enrollment, utilization, and the cost of care. Therefore, a separate chart that appears later illustrates the trends in special financing.



As illustrated in the following chart, per capita costs for the elderly and people with disabilities are much higher than for children and adults. For the population that is dually eligible for Medicare and Medicaid, Medicare absorbs a portion of the expenditures, which dampens the trends in Medicaid per capita costs for the elderly. Changes in the caseload mix influence per capita costs as well as changes in utilization and the cost of care. For example, recent eligibility expansions have added higher income adults and children, who tend to have lower medical costs, resulting in lower per capita trends.



The charts above track direct payments for physical health services and for long-term services and supports, but the Medical Services Premiums section also includes indirect special financing through provider fees, certified public expenditures, and interagency transfers for providers like hospitals, nursing homes, and the physicians of the University of Colorado's School of Medicine. A portion of the Healthcare Affordability and Sustainability (HAS) Fee, which replaced the Hospital Provider Fee, pays for enrollment expansion, but the majority of the fee matches federal funds in order to make supplemental payments back to hospitals based on the amount of services they provide to low-income clients. The Nursing Facility Fee works in a similar way to boost payments for nursing homes. Beginning in FY 2017-18, the General Assembly authorized interagency transfers between the Department of Higher Education and the Department of Healthcare Policy and Financing to increase payments for physicians of the University of Colorado's School of Medicine. Federal and state policies setting parameters on these types of special financing influence expenditures more than Medicaid enrollment, utilization, and cost of care patterns. The table below shows actual and projected expenditures on special financing.



(2) Behavioral Health Community Programs

Behavioral health services include both mental health and substance use-related services. With a few exceptions (e.g., non-citizens), Medicaid clients are eligible for behavioral health services. Behavioral health services are provided to Medicaid clients through a statewide managed care or "capitated" program. Under capitation, the Department contracts with regional entities to provide or arrange for behavioral health services for clients within their geographic region enrolled in the Medicaid program. Each regional entity receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its region. The "per-member-per-month" rates 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.

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.

See the 12/10/19 briefing on Behavioral Health Community Programs for more information.

(3) Office of Community Living

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. As part of the waiver, Colorado may limit the number of waiver program participants, which has resulted in a large number of individuals being unable to immediately access the services they need. Colorado has three Medicaid waivers for individuals who qualify for intellectual and developmental disability services:

- Adult Comprehensive waiver (also called the Comprehensive or Comp waiver) is for individuals over the age of eighteen who require residential and daily support services to live in the community.
- Supported Living Services waiver (SLS waiver) is for individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.
- Children's Extensive Services waiver (also called the CES waiver or children's waiver) is for youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

New enrollments are funded for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and to service all individuals eligible for the Supported Living Services (SLS) and Children's Extensive Services (CES) waivers.

See the 12/12/19 briefing on the Office of Community Living for more information.

(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

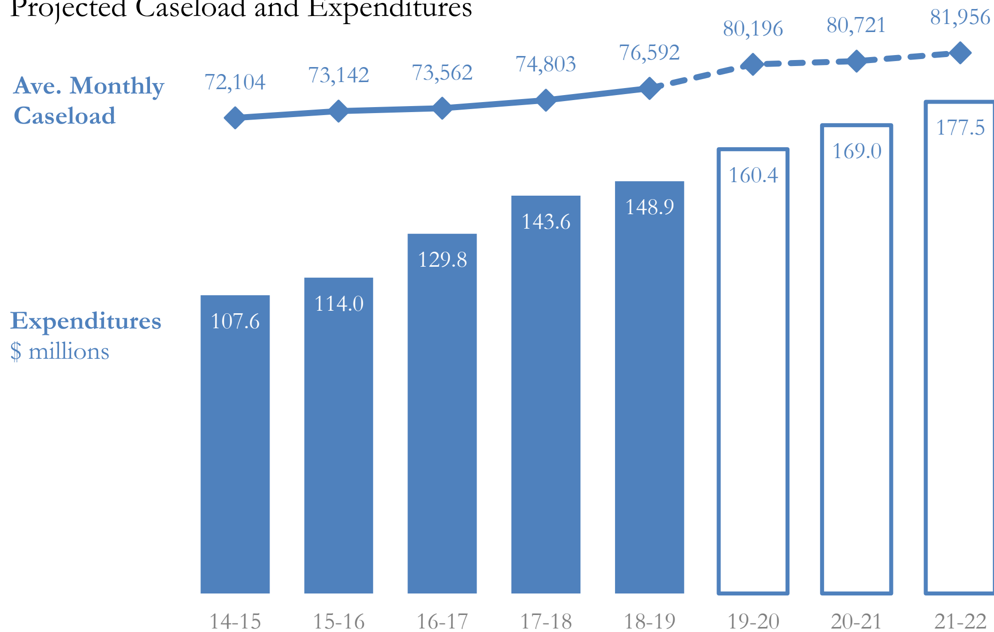
Medicaid, this is not an insurance program or an entitlement. Federal and state policies influence funding more than the number of individuals served, utilization, or the cost of services. The majority of the funding is from federal sources. State funds for the program come from the Healthcare Affordability and Sustainability (HAS) Fee, certifying public expenditures at hospitals, and the General Fund.

COLORADO INDIGENT CARE PROGRAM						
	FY 2014-15 ACTUAL	FY 2015-16 ACTUAL	FY 2016-17 ACTUAL	FY 2017-18 ACTUAL	FY 2018-19 ACTUAL	FY 2019-20 APPROPRIATION
Safety Net Provider Payments	$309,470,584	$310,125,957	$311,296,186	$298,355,771	$311,296,186	$311,296,186
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760	6,079,573
Pediatric Specialty Hospital	13,455,012	13,455,012	13,455,012	13,455,012	13,455,012	13,455,012
TOTAL	**$329,045,356**	**$329,700,729**	**$330,870,958**	**$317,930,543**	**$330,870,958**	**$330,830,771**
General Fund	9,639,107	9,632,746	9,748,236	9,786,412	9,758,522	9,747,199
Cash Funds	153,201,150	152,556,889	155,073,238	149,107,296	155,648,093	155,648,093
Federal Funds	166,205,099	167,511,094	166,049,484	159,036,835	165,464,343	165,435,479
Total Funds Change		$655,373	$1,170,229	($12,940,415)	$12,940,415	($40,187)
Percent Change		0.2%	0.4%	(3.9%)	4.1%	0.0%

For people who are uninsured, or underinsured, who earn less than 250 percent of the FPL, the Colorado Indigent Care Program (CICP) can reduce costs. The CICP is not an insurance program, but 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. Of the supplemental funding, 75 percent is distributed based on write-off costs and 25 percent on performance metrics. 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. A small amount of the money goes to clinics where Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds. The state match for the clinic payments comes from the General Fund. In addition, there is a special pediatric hospital supplemental payment with a state match from the General Fund.

(5) MEDICARE MODERNIZATION ACT

The federal Medicare Modernization Act 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 table below summarizes Colorado's payments to the federal government.



(6) Programs Administered By Other Departments

The Department of Health Care Policy and Financing (HCPF) transfers Medicaid money to several other departments. The General Assembly appropriates money to HCPF and then transfers it to the administering departments to comply with federal regulations that one state agency receives all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments. The Department of Human Services is the largest recipient of transfers from HCPF.

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than Medicaid eligibility criteria allow. 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.

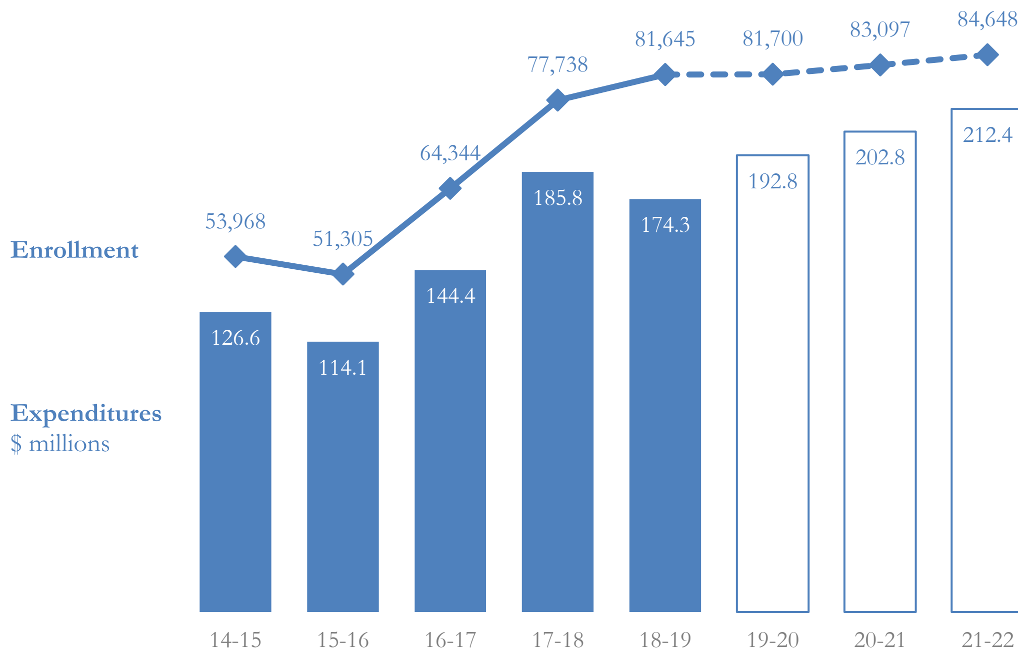
Federal funds match state funds for program costs not covered by member contributions. The federal match rate for CHP+ is derived from the standard FMAP for Medicaid and can vary based on how personal income in Colorado compares to other states. Federal policies provided a temporary boost to the match rates for federal fiscal years 2015-16 through 2018-19. In federal fiscal year 2019-20 the match rate phased down to 76.5 and in federal fiscal year 2020-21 it will step down again to 65.0 percent, where it is scheduled to remain through the federal authorization (to October 2027) for the program.

CHP+ Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	88.00	88.01	88.00	88.00	88.00
FY 18-19	88.00	88.00	88.00	88.00	88.00
FY 19-20	79.38	88.00	76.50	76.50	76.50
FY 20-21	*67.88*	76.50	*65.00*	*65.00*	*65.00*

Italicized figures are projections.

CHP+ typically receives roughly $15 million in revenue from the tobacco master settlement agreement distribution formula and any remaining state match comes from the General Fund.

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+. In addition, the program has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations.



SUMMARY: FY 2019-20 APPROPRIATION & FY 2020-21 REQUEST

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	31,206,417	14,528,084	1,262,406	0	15,415,927	11.8
TOTAL	**$10,689,061,864**	**$3,151,370,264**	**$1,386,291,098**	**$93,615,672**	**$6,057,784,830**	**544.6**
FY 2020-21 Requested Appropriation:						
FY 2019-20 Appropriation	$10,689,061,864	3,151,370,264	$1,386,291,098	$93,615,672	$6,057,784,830	544.6
R1 Medical Services Premiums	307,654,186	118,712,084	111,034,880	0	77,907,222	0.0
R2 Behavioral Health	41,588,549	13,337,312	7,561,171	0	20,690,066	0.0
R3 Child Health Plan Plus	8,856,952	25,551,305	1,690,167	0	(18,384,520)	0.0
R4 Medicare Modernization Act	17,929,806	17,929,806	0	0	0	0.0
R5 Office of Community Living	35,370,073	17,697,932	(489,128)	0	18,161,269	0.0
R6 Customer service	3,428,079	1,046,792	552,719	8	1,828,560	4.3
R7 Pharmacy pricing and technology	4,561,775	1,152,570	654,693	0	2,754,512	5.0
R8 Accountability and compliance resources	3,085,585	658,086	194,286	0	2,233,213	11.5
R9 Bundled payments	743,065	63,224	68,307	0	611,534	1.9
R10 Provider rates	2,090,599	538,753	266,277	0	1,285,569	0.0
R11 Substance use disorder patient placement and benefit implementation	(85,566,035)	(16,622,834)	(5,519,687)	0	(63,423,514)	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	1,746,531	431,632	5,002	0	1,309,897	0.0
R14 Enhanced care and condition management	433,636	143,099	73,715	0	216,822	1.0
R15 Medicaid recovery and third party liability	(12,301,943)	(3,468,482)	2,074,120	0	(10,907,581)	5.8
R16 Case management and state-only programs	402,372	(69,366)	0	0	471,738	3.8
R17 Program capacity for older adults	558,020	184,146	94,864	0	279,010	0.9
R18 Public school health services expansion	75,000	0	0	0	75,000	0.0
R19 Leased space	111,119	46,070	9,490	0	55,559	0.0
R20 Safety net provider payments	0	0	0	0	0	0.0
Annualize HB 18-1136 Residential and inpatient SUD treatment	173,762,995	34,119,290	11,481,214	0	128,162,491	0.0
Annualize prior year budget actions	28,953,507	15,670,229	(798,578)	117,389	13,964,467	0.0
Public school health services forecast	11,599,440	(1)	5,799,719	0	5,799,722	0.0
Centrally appropriated items	2,523,227	1,277,178	229,341	(233,072)	1,249,780	0.0
Human Services programs	2,042,194	1,021,082	0	0	1,021,112	0.0
Transfers to other state agencies	572,194	243,792	0	0	328,402	0.0
NP Paid family leave	505,041	246,802	2,518	757	254,964	0.0
NP OIT Budget request package	116,209	53,696	5,774	0	56,739	0.0
Other	44,779	1,617	10,356	2	32,804	0.0
TOTAL	**$11,217,371,086**	**$3,377,544,826**	**$1,519,856,266**	**$93,500,756**	**$6,226,469,238**	**578.8**
INCREASE/(DECREASE)	$528,309,222	$226,174,562	$133,565,168	($114,916)	$168,684,408	34.2
Percentage Change	4.9%	7.2%	9.6%	(0.1%)	2.8%	6.3%

DESCRIPTION OF INCREMENTAL CHANGES

R1 MEDICAL SERVICES PREMIUMS: The Department requests a net increase of $307.7 million total funds, including $118.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. *See the issue brief "Forecast Trends" for more information.*

R2 BEHAVIORAL HEALTH PROGRAMS: The Department requests a net increase of $41.6 million total funds, including an increase of $13.3 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services. *See the 12/10/19 briefing on Behavioral Health Community Programs for more information.*

R3 CHILD HEALTH PLAN PLUS: The Department requests a net increase of $8.9 million total funds, including $25.6 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. *See the issue brief "Forecast Trends" for more information.*

R4 MEDICARE MODERNIZATION ACT: The Department requests an increase of $17.9 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. *See the issue brief "Forecast Trends" for more information.*

R5 OFFICE OF COMMUNITY LIVING: The Department requests a net increase of $35.4 million total funds, including $17.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the 12/12/19 briefing on the Office of Community Living for more information.*

R6 CUSTOMER SERVICE: The Department requests $3.4 million total funds, including $1.0 million General Fund, and 4.3 FTE for additional technology, staff, and consulting services for the Member Contact Center that handles customer service calls and chats.

- Technology - $3.0 million total funds, including $906,003 General Fund, to increase the range of questions that artificial intelligence can answer in chat, reduce staff time spent querying external systems by integrating key member data (such as claims and prior authorization requests) with the Customer Relations Management software, enhance survey tools for collecting member feedback, and purchase workload management software that helps schedule staff based on demand.
- Staff - $351,633 total funds, including $116,039 General Fund, for 4.5 additional call center positions in FY 20-21 and FY 21-22, at which point the Department would reevaluate the progress of technology solutions and the need for ongoing staff.
- Consulting services - $75,000 total funds, including $24,750 General Fund, to study consolidating member contact points with the goal of a single phone number for all needs that would route calls to the appropriate party. The request is related to HCPF services, but with an eye toward potentially including other state public assistance programs in the future.

R7 PHARMACY PRICING AND TECHNOLOGY: The Department requests $4.6 million total funds, including $1.2 General Fund, and 5.0 FTE for initiatives to ensure appropriate utilization of drugs and to control pharmacy and physician administered drug expenditures.

- Prescription drug rate setting – $124,813 total funds, including $41,191 General Fund, and 1.0 FTE, for a different methodology for pricing new drugs when the Average Acquisition Cost is not known. Beginning in FY 2021-22 the Department would need an additional $250,000 total funds, including $82,500 General Fund, for contractor costs for the initiative.
- Physician administered drug rate setting – $138,000 total funds, including $20,752 General Fund, for a different methodology for pricing physician administered drugs. The amount required increases to $300,000 total funds and $99,000 General Fund in FY 2021-22,
- Prescription Drug Monitoring Program – $907,142 total funds, including $89,866 General Fund, to integrate data from the Prescription Drug Monitoring Program into the Department's pharmacy claims processing system. ***This requires a statutory change to allow the Department access to the statutorily restricted Prescription Drug Monitoring Program.***
- Prescriber tool true-up – $2.9 million total funds, including $833,910 General Fund, primarily for higher than expected costs for a prescriber tool required by S.B. 18-266 (Controlling Medicaid Costs, sponsored by the JBC) that will help providers identify the most cost effective medications based on diagnosis information, but including $406,800 total funds and $24,258 General Fund to expand the scope of the prescriber tool to integrate enrollment and eligibility information for other public benefits that may improve health outcomes for the patient. An associated supplemental will be submitted in January for $7.1 million total funds, including $1.4 million General Fund, in FY 2019-20. The supplemental includes $1.8 million federal funds for additional development costs and $5.3 million total funds and $1.4 million General Fund for delays in achieving the projected savings from implementing the prescriber tool.
- Administration – $506,150 total funds, including $167,031 General Fund, and 4.0 FTE to address pharmacy appeals claims and expand the capacity of the Department to study and pursue pharmacy cost containment initiatives.

R8 ACCOUNTABILITY AND COMPLIANCE RESOURCES: The Department requests $3.1 total funds, including $658,086 General Fund, and 11.5 FTE to address operational compliance and oversight deficiencies, ensure quality, and improve benefit management. The request crosses multiple programs.

R8 Accountability and Compliance Resources					
	FTE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Operational Compliance					
Long-Term Services and Supports					
Single Entry Point financial monitoring	1.0	$97,177	$48,587	$0	$48,590
Case Management Agency program monitoring	1.0	82,506	41,250	0	41,256
Provider enrollment processing and claims research	1.0	90,927	45,462	0	45,465
Wage pass-through monitoring	1.0	116,081	58,039	0	58,042
Cost Allocation and Reporting					
Cost allocation by match rate and funding source	1.0	102,436	34,829	16,389	51,218
Documenting ACC/similar costs per fed requirements	1.0	102,435	34,828	16,389	51,218
State plan amendments, rule drafting, regulatory research	1.0	109,831	37,342	17,573	54,916
Subtotal - Operational Compliance	*7.0*	*701,393*	*300,337*	*50,351*	*350,705*
Quality Assurance					
County scorecard and performance	1.0	166,081	56,467	26,573	83,041
MPRRAC					
Rate review support	1.0	97,177	33,040	15,548	48,589
Contract surveys and analysis	0.0	250,000	125,000	0	125,000
Negotiating and forecasting prices for contract services	1.0	85,670	29,128	13,707	42,835
Configuring (defining and coordinating) MMIS changes	0.0	1,785,264	114,114	88,107	1,583,043
Subtotal - Quality Assurance	*3.0*	*2,384,192*	*357,749*	*143,935*	*1,882,508*

R8 Accountability and Compliance Resources					
	FTE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Benefit Management					
Children's Basic Health Plan (CHP+)					
Benefit redesign	1.0	90,930	0	29,206	61,724
Improving health outcomes and performance measures	1.0	90,929		29,206	61,723
Offset to CHP+ Administration	0.0	(181,859)	0	(58,412)	(123,447)
Subtotal - Benefit Management	*2.0*	*0*	*0*	*0*	*0*
TOTAL	**12.0**	**$3,085,585**	**$658,086**	**$194,286**	**$2,233,213**

R9 BUNDLED PAYMENTS: The Department requests $743,065 total funds, including $63,224 General Fund, and 1.9 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.

R10 PROVIDER RATES: The Department requests $2.1 million total funds, including $538,753 General Fund, for changes to provider rates. ***The proposed modification to nursing home rates would require a statutory change.***

R10 Provider Rate Adjustments					
Rate	Proposed Change	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Personal Care and Homemaker	2.75% inflation	$4,534,519	$2,267,259	$0	$2,267,260
Alternative care facility	6.4%	3,693,258	1,846,629	0	1,846,629
Adult day programs	19.0%	3,444,422	1,722,211	0	1,722,211
Behavioral health fee-for-service (mostly impacts RCCFs)	Rebalance to within 80-100% benchmark	1,586,971	875,964	(20,264)	731,271
Habilitation in Residential Child Care Facilities	Differentiate rates based on support need	532,362	266,181	0	266,181
Family planning	Pay evaluation and management consistent with other family planning	97,092	9,709	0	87,383
Ambulatory surgical centers	Add services otherwise paid at hospital	0	0	0	0
Nursing home	Bill to remove statutory 3% increase and for FY 20-21 instead provide 0.29%	(18,967,828)	(9,483,914)	0	(9,483,914)
Anesthesia	Reduce to Medicare	(5,977,532)	(1,789,672)	(320,397)	(3,867,463)
In-home dialysis	Align reimbursable units with Medicare	(929,537)	(292,415)	(34,471)	(602,651)
Durable medical equipment	Rebalance to within 80-100% Medicare	(49,244)	(17,432)	(3,733)	(28,079)
Subtotal - Targeted Adjustments		**($12,035,517)**	**($4,595,480)**	**($378,865)**	**($7,061,172)**
Across-the-board adjustment	0.29%	14,126,117	5,134,233	645,142	8,346,742
TOTAL		**$2,090,600**	**$538,753**	**$266,277**	**$1,285,570**

R11 SUBSTANCE USE DISORDER PATIENT PLACEMENT AND BENEFIT IMPLEMENTATION: The Department requests a decrease of $85.6 million total funds, including a reduction of $16.6 million General Fund, to account for slower development of provider capacity to offer the benefit than originally projected. An associated supplemental will be submitted in January 2020 for $80,000 total funds, including $26,400 General Fund, to contract for a patient placement referral tool to ensure clients are able to access the benefit in an appropriate setting. See the *12/10/19 briefing for Behavioral Health* for more information.

R12 WORK NUMBER VERIFICATION: The Department requests a net reduction of $22.6 million total funds, including a decrease of $3.8 million General Fund, for implementing a system that allows for automated income verification at enrollment for a portion of applications where data is available. The Department projects this will reduce the number of people initially determined eligible for Medicaid and CHP+ who are later determined ineligible, as well as county administrative time to verify income. The request assumes system implementation January 1, 2021, and the projected net savings approximately doubles in FY 2021-22 to $46.2 million total funds, including $7.7 million General Fund.

R13 LONG-TERM CARE UTILIZATION AND MANAGEMENT: The Department requests $1.7 million total funds, including $431,632 General Fund, to expand a contract for utilization management to include reviews of in-home skilled care authorizations within the participant directed programs (In-Home Support Services and Consumer Directed Attendant Support Services).

R14 HIGH COST CONDITION MANAGEMENT: The Department requests $433,636 total funds, including $143,099 General Fund, and 1.0 FTE for coordinating care for people with a high cost diagnosis of chronic pain, anxiety, or depression and to deploy interactive web and mobile software designed to help people manage these conditions.

R15 MEDICAID RECOVERY AND THIRD PARTY LIABILITY: The Department requests a net decrease of $12.3 million total funds, including $3.5 million General Fund, and an increase of 5.8 FTE for initiatives to increase tort and casualty recoveries, avoid claims when a third party is liable, and use artificial intelligence to identify and recover improper payments.

R16 CASE MANAGEMENT AND STATE-ONLY PROGRAMS: The Department requests a net increase of $402,372 total funds, including a reduction of $69,366 General Fund, and 3.8 FTE for case management and state-only programs for people with intellectual and developmental disabilities. *See the 12/12/19 briefing on the Office of Community Living for more information.*

R17 PROGRAM CAPACITY FOR OLDER ADULTS: The Department requests $558,020 total funds, including $184,146 General Fund, and 0.9 FTE for oversight of both the Program of All-Inclusive Care for the Elderly (PACE) and nursing homes. Of the total, $294,820 total funds and $97,291 General Fund and the 0.9 FTE are to compensate for a decrease in federal oversight audits of PACE facilities, to contract for a satisfaction survey, and to create performance measures for PACE. The remaining $263,200 total funds and $86,856 General Fund is for contract resources to study potential performance-based reimbursement options for nursing homes to replace the current statutory cost-based reimbursement. Finally, ***the Department proposes legislation to make budget-neutral technical changes to the nursing home rate statutes.***

R18 PUBLIC SCHOOL HEALTH SERVICES EXPANSION: The Department requests $75,000 federal funds for administrative costs to expand the school health services that are allowed to claim a federal match through Medicaid beyond those included within an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) to include the Medicaid portion of services to the whole school population, such as health screenings.

R19 LEASED SPACE: The Department requests $111,119 total funds, including $46,070 General Fund, for leased space costs at 303 E. 17th Ave. An associated supplemental will be submitted in January for $72,035 total funds, including $29,865 General Fund for higher costs in FY 2019-20. The payment

includes a negotiated fixed rate plus a variable amount for the Department's share of operating costs. The request is for inflationary costs with no change in the square footage occupied by the Department.

R20 SAFETY NET PROVIDER PAYMENTS: The Department requests a net $0 change to move money between line items to better reflect money spent for the Colorado Indigent Care Program.

ANNUALIZE HB 18-1136 RESIDENTIAL AND INPATIENT SUD TREATMENT: The request includes $173.8 million total funds, including $34.1 million General Fund, to expand Medicaid benefits to include inpatient and residential substance use disorder treatment and medical detoxification services as required by H.B. 18-1136 (Pettersen/Priola & Jahn). See the *12/10/19 briefing for Behavioral Health* for more information.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes adjustments for out-year impacts of prior year legislation and budget actions, summarized in the table below. The titles of the annualizations begin with either a bill number or the relevant fiscal year. For budget decisions made in the Long Bill, the title includes a reference to the priority number the Department used in that year for the initiative, if relevant. If there is no reference to a bill number or priority number, then the change was initiated by an action other than a bill or request from the Department.

The largest increases are for previously approved provider rate increases that either started after the first of the fiscal year and/or had lagging costs due to delays between when services are billed and paid (includes FY 19-20 R13 Provider rates, SB 19-238 Wages and accountability home care, FY 19-20 Participant directed personal care and homemaker rates, and SB 19-209 PACE Program funding methodology). The next largest changes are for ongoing information technology projects involving systems related to eligibility, enrollment, benefits authorization, and claims processing (includes FY 19-20 R12 Medicaid enterprise operations, SB 16-192/FY 18-19 R17 Single assessment tool, and FY 19-20 NP OeHI operating).

Annualize Prior Year Budget Actions						
	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 R12 Medicaid enterprise operations	6,563,485	2,399,407	513,326	0	3,650,752	0.2
FY 19-20 Participant directed personal care and homemaker rates	6,454,701	3,227,351	0	0	3,227,350	0.0
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 19-209 PACE Program funding methodology	1,339,954	669,977	0	0	669,977	0.0
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	561,287	248,084	18,117	5,441	289,645	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

Annualize Prior Year Budget Actions						
	Total	GF	CF	RF	FF	FTE
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
FY 19-20 NP Salesforce	1,037	518	0	0	519	0.0
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 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
FY 19-20 CDPHE Technical correction to reconcile	(35,477)	(17,740)	0	0	(17,737)	0.0
HB 18-1328 Redesign residential child health care waiver	(29,500)	(14,750)	0	0	(14,750)	0.0
FY 19-20 Leap year	(2,754)	(1,377)	0	0	(1,377)	0.0
Prior year salary survey	(373)	(187)	0	0	(186)	0.0
TOTAL	**$28,953,507**	**$15,670,229**	**($798,578)**	**$117,389**	**$13,964,467**	**0.0**

PUBLIC SCHOOL HEALTH SERVICES FORECAST: The request includes $11,599,440 total funds for projected changes in certified public expenditures by local school districts and boards of cooperative education services (BOCES) for services to Medicaid children with an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) that are eligible for federal matching funds.

CENTRALLY APPROPRIATED ITEMS: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; short-term disability; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor's Office of Information Technology (OIT); and CORE operations.

HUMAN SERVICES PROGRAMS: The Department's request reflects adjustments for several programs that are financed with Medicaid funds, but operated by the Department of Human Services. *See the briefings for the Department of Human Services for more information.*

TRANSFERS TO OTHER STATE AGENCIES: The Department requests $572,194 total funds, including $243,792 General Fund, for transfers to programs administered by other departments, primarily for the Facility Survey and Certification program in the Department of Public Health and Environment.

NP PAID FAMILY LEAVE: The Department requests $505,041 total funds, including $246,802 General Fund, for the Department's share of the statewide paid family leave proposal. *See the 12/2/19 briefing for Compensation Common Policies for more information.*

NP OIT BUDGET REQUEST PACKAGE: The Department requests $116,209 total funds, including $53,696 for the Department's share of the statewide OIT budget request package. *See the 12/17/19 briefing for the Office of Information Technology for more information.*

OTHER: The Department requests $44,779 total funds, including $1,617 General Fund for a new forecast of tobacco tax revenues available to finance the Children's Basic Health Plan and changes to the cost allocation for the Colorado Benefits Management System.

SUPPLEMENTALS

SET ASIDE FOR SUPPLEMENTALS: The Governor's budget letter includes a set aside in FY 2019-20 of $43.8 million General Fund for potential supplementals for the Department of Health Care Policy and Financing, including $42.3 million for the most recent forecast of enrollment and expenditures and $1.5 million for the FY 2019-20 impact of discretionary requests. Although the Governor's official supplemental request is not due until January 2020, the budget request for the Department includes projected FY 2019-20 impacts associated with the following requests.

FY 2019-20 Set-Aside for Supplementals

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
R1 Medical Services Premiums	64,206,386	36,885,502	42,906,264	0	(15,585,380)
R2 Behavioral Health	(15,654,741)	(2,733,519)	(985,814)	0	(11,935,408)
R3 Children's Basic Health Plan	(3,536,486)	0	(737,600)	0	(2,798,886)
R4 Medicare Modernization Act	9,321,829	9,321,829	0	0	0
R5 Office of Community Living	(2,658,717)	(1,133,637)	(579,579)	0	(945,501)
R7 Pharmacy pricing and technology	7,135,879	1,408,842	325,528	0	5,401,509
R11 Substance use disorder patient placement and benefit implementation	80,000	26,400	13,600	0	40,000
R19 Leased space	72,035	29,865	6,152	0	36,018
Total	**$58,966,185**	**$43,805,282**	**$40,948,551**	**$0**	**($25,787,648)**

Due to timing issues there were some discrepancies between the set aside identified in the Governor's letter and the supplemental needs identified in the Department's request. This mostly impacted the total funds; the difference in General Fund was nominal. According to OSPB, the amounts identified in the Department's request and reflected in the table above are what the Governor intended to propose.

POTENTIAL LEGISLATION

- In *R7 Pharmacy pricing and technology* the Department proposes allowing the Department to access restricted data in the Prescription Drug Monitoring Program (PDMP) to help the Department better understand the full impact of pharmacy policies, coordinate care, and enforce compliance with federal requirements that providers check the PDMP before prescribing a controlled substance.

- In *R10 Provider rates* the Department proposes eliminating a statutory formula that annually increases nursing home rates by the lesser of actual costs or 3 percent above the prior year General Fund.
- In *R17 Program capacity for older adults* the Department proposes legislation to make budget-neutral technical changes to the nursing home rate statutes.

EVIDENCE BASED EVALUATION

The Office of State Planning and Budgeting identified the following requests as opportunities to use evidence to improve program outcomes.

- *R6 Improve customer service* – OSPB characterizes the request as "theory-informed" on the evidence based continuum, because it includes plans for post-implementation evaluations with no control or comparison group. The rating is not based on preexisting evidence to suggest the proposed interventions will be effective. The Department claims it "has experience" that increases in agents and self-service options improve call metrics, but notes that due to high variation in call volume from month to month and long training times for new staff, "the data does not always show a direct improvement in call statistics when staffing increases or when technology improves." Theory-informed evaluations produce moderate to low confidence in the program effectiveness. OSPB indicates the current average speed to answer calls is 25 minutes and the call abandonment rate is 7 percent and identifies the Department's goal as an average speed to answer of 9 minutes or less.
- *R7 Pharmacy pricing and technology* – OSPB characterizes one component of the request as "theory-informed" on the evidence based continuum, because there are existing evaluations with no control or comparison group. These existing evaluations show a decline in opioid use when other states expanded access to Prescription Drug Monitoring Program (PDMP) data. Also, the Department plans to measure opioid prescription use per capita as a measure of the effectiveness of expanding access to the PDMP. Theory-informed evaluations produce moderate to low confidence in the program effectiveness. It is important to note that the evaluations in other states took place prior to the federal SUPPORT Act that requires Medicaid providers to consult the PDMP before prescribing a controlled substance beginning in October 2021.

ISSUE: FORECAST TRENDS (R1, R3, R4, R12, R18)

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy and account for over 77 percent of the new total funds and over 85 percent of the new General Fund proposed. 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.

SUMMARY

- Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy and account for over 77 percent of the new funding proposed.
- They are non-discretionary, as they represent the expected obligations under current law and policy.
- Enrollment is a major driver of overall expenditures and the Department projects only 2.1 percent enrollment growth in FY 2020-21.
- The major driver of General Fund expenditures is enrollment of the elderly and people with disabilities and their utilization of long-term services and supports. The Department is projecting enrollment of the elderly and people with disabilities to increase 3.0 percent in FY 2020-21.
- The federal match rate for the Children's Basic Health Plan is scheduled to step down over federal fiscal years 2019-20 and 2020-21 by a total of 23 percentage points from the current 88 percent to 65 percent. The Department projects sufficient reserves and revenues in the Children's Basic Health Plan Trust to cover increased state costs in state FY 2019-20, but beginning in FY 2020-21 the Department is projecting a need for $25.6 million General Fund growing to $40.3 million General Fund in FY 2021-22.

DISCUSSION

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined, the forecast requests account for over 77 percent of the total funds and over 85 percent of the General Fund proposed by the Department, including $411.4 million total funds and $193.2 million General Fund. It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy. The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2019. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2019. The mid-February forecasts come after deadlines for the Governor to submit supplementals and budget amendments. Typically, governors do not submit official revised requests based on the mid-February forecasts, nor official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the

mid-February forecast for the budget, because it is the most recent available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2019-20 expenditures. The requests for changes in FY 2019-20 will be officially submitted in January and until then the Governor's budget includes a placeholder for the FY 2019-20 fiscal impact of the forecasts. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2019-20 is the change from the appropriation and not the change from FY 2018-19.

FY 19-20					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Appropriation					
Medical Services Premiums	$7,895,417,528	$2,285,686,174	$983,543,298	$88,876,290	$4,537,311,766
Behavioral Health	723,074,435	201,872,261	38,385,780	0	482,816,394
Children's Basic Health Plan	209,101,718	395,352	43,749,748	0	164,956,618
Medicare Modernization Act	151,073,595	151,073,595	0	0	0
Office of Community Living	679,286,143	344,518,627	7,451,769	0	327,315,747
TOTAL	**$9,657,953,419**	**$2,983,546,009**	**$1,073,130,595**	**$88,876,290**	**$5,512,400,525**
FY 19-20 Projection (Nov)					
Medical Services Premiums	7,959,623,914	2,322,571,676	1,026,449,562	88,876,290	4,521,726,386
Behavioral Health	707,419,694	199,138,742	37,399,966	0	470,880,986
Children's Basic Health Plan	205,565,232	395,352	43,012,148	0	162,157,732
Medicare Modernization Act	160,395,424	160,395,424	0	0	0
Office of Community Living	676,627,426	343,384,990	6,872,190	0	326,370,246
TOTAL	**$9,709,631,690**	**$3,025,886,184**	**$1,113,733,866**	**$88,876,290**	**$5,481,135,350**
Difference Proj. to Approp.					
Medical Services Premiums	64,206,386	36,885,502	42,906,264	0	(15,585,380)
Behavioral Health	(15,654,741)	(2,733,519)	(985,814)	0	(11,935,408)
Children's Basic Health Plan	(3,536,486)	0	(737,600)	0	(2,798,886)
Medicare Modernization Act	9,321,829	9,321,829	0	0	0
Office of Community Living	(2,658,717)	(1,133,637)	(579,579)	0	(945,501)
TOTAL	**$51,678,271**	**$42,340,175**	**$40,603,271**	**$0**	**($31,265,175)**
Percent Change					
Medical Services Premiums	0.8%	1.6%	4.4%	0.0%	-0.3%
Behavioral Health	-2.2%	-1.4%	-2.6%	n/a	-2.5%
Children's Basic Health Plan	-1.7%	0.0%	-1.7%	n/a	-1.7%
Medicare Modernization Act	6.2%	6.2%	n/a	n/a	n/a
Office of Community Living	-0.4%	-0.3%	-7.8%	n/a	-0.3%
TOTAL	**0.5%**	**1.4%**	**3.8%**	**0.0%**	**-0.6%**

FY 20-21					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 19-20 Projection (Nov)					
Medical Services Premiums	$7,959,623,914	$2,322,571,676	$1,026,449,562	$88,876,290	$4,521,726,386
Behavioral Health	707,419,694	199,138,742	37,399,966	0	470,880,986
Children's Basic Health Plan	205,565,232	395,352	43,012,148	0	162,157,732
Medicare Modernization Act	160,395,424	160,395,424	0	0	0
Office of Community Living	676,627,426	343,384,990	6,872,190	0	326,370,246
TOTAL	**$9,709,631,690**	**$3,025,886,184**	**$1,113,733,866**	**$88,876,290**	**$5,481,135,350**
FY 20-21 Projection (Nov)					
Medical Services Premiums	8,223,017,776	2,413,078,995	1,095,643,661	88,876,290	4,625,418,830
Behavioral Health	938,539,570	249,360,085	57,451,889	0	631,727,596
Children's Basic Health Plan	218,031,616	26,003,891	44,846,455	0	147,181,270
Medicare Modernization Act	169,003,401	169,003,401	0	0	0
Office of Community Living	714,501,218	364,857,421	4,252,988	0	345,390,809
TOTAL	**$10,263,093,581**	**$3,222,303,793**	**$1,202,194,993**	**$88,876,290**	**$5,749,718,505**
Difference FY 19-20 Proj. to FY 20-21 Proj.					
Medical Services Premiums	263,393,862	90,507,319	69,194,099	0	103,692,444
Behavioral Health	231,119,876	50,221,343	20,051,923	0	160,846,610
Children's Basic Health Plan	12,466,384	25,608,539	1,834,307	0	(14,976,462)
Medicare Modernization Act	8,607,977	8,607,977	0	0	0
Office of Community Living	37,873,792	21,472,431	(2,619,202)	0	19,020,563
TOTAL	**$553,461,891**	**$196,417,609**	**$88,461,127**	**$0**	**$268,583,155**
Percent Change					
Medical Services Premiums	3.3%	3.9%	6.7%	0.0%	2.3%
Behavioral Health	32.7%	25.2%	53.6%	n/a	34.2%
Children's Basic Health Plan	6.1%	6477.4%	4.3%	n/a	-9.2%
Medicare Modernization Act	5.4%	5.4%	n/a	n/a	n/a
Office of Community Living	5.6%	6.3%	-38.1%	n/a	5.8%
TOTAL	**5.7%**	**6.5%**	**7.9%**	**0.0%**	**4.9%**

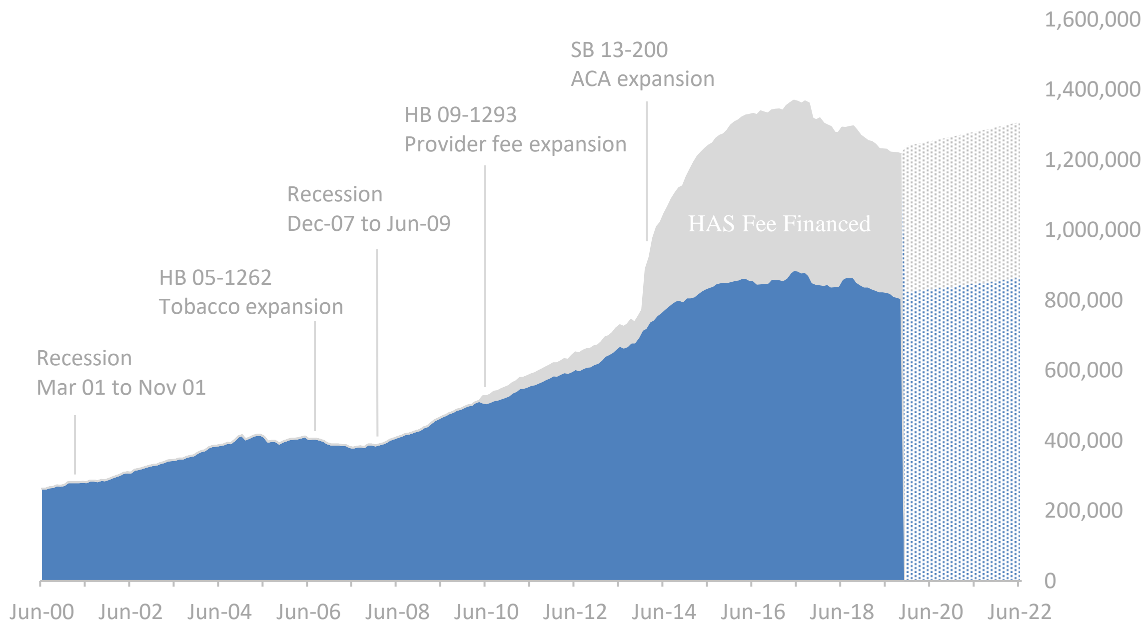
This issue brief focuses on the forecasts for *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan,* and *R4 Medicare Modernization Act*. The forecasts for *R2 Behavioral Health* and *R5 Office of Community Living* will be covered in the briefings for those programs.

R1 Medical Services Premiums

Enrollment Trends

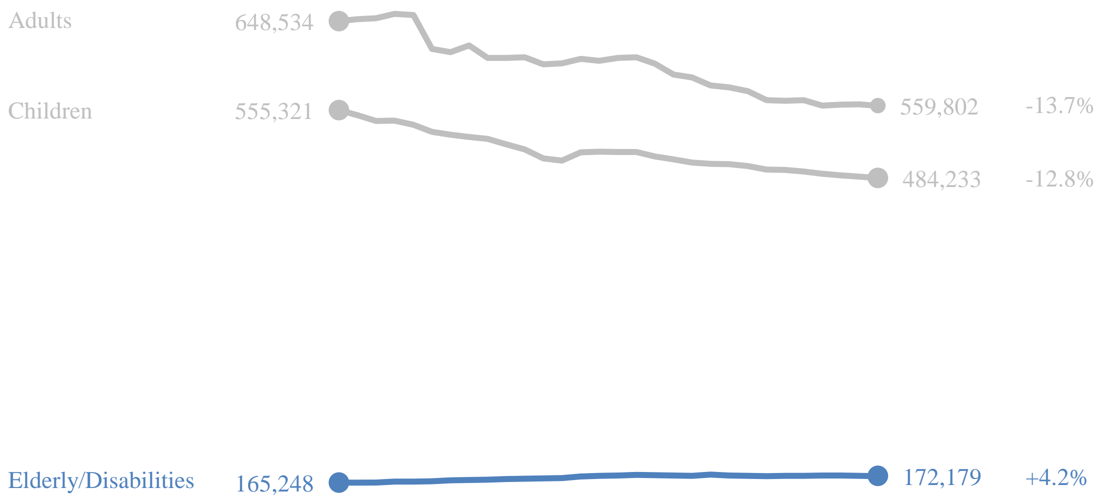
The biggest factor driving all of the forecast requests is enrollment. On top of economic and demographic drivers of enrollment growth, H.B. 09-1293 and S.B. 13-200 authorized a major eligibility expansion. A provider fee on hospitals and federal funds finances the expansion. In addition, the federal Affordable Care Act (ACA) changed the way Medicaid calculates income for determining eligibility in a manner that increased eligibility in Colorado. Finally, enrollment from among people previously eligible but not enrolled increased during the expansion and implementation of the ACA.

Medicaid Enrollment of 1,229,339 as of June 2019
405,963 Healthcare Affordability and Sustainability (HAS) Fee
823,376 General Fund and non-HAS Fee sources

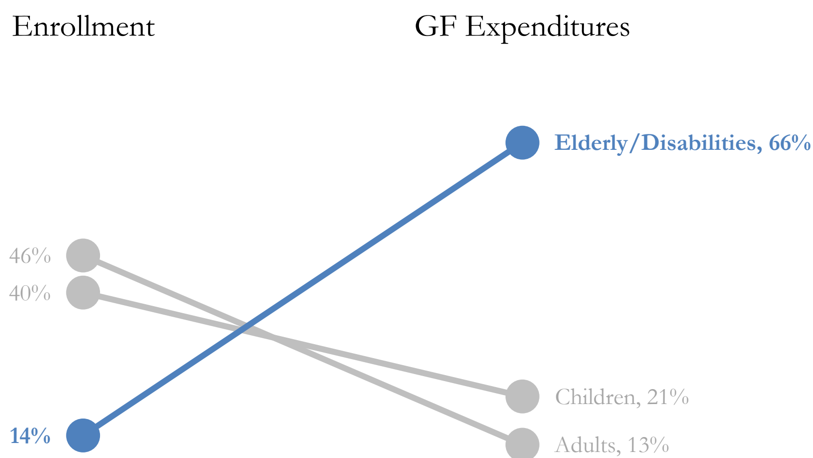


Enrollment has been trending downward since the peak enrollment in May 2017 of 1,369,103. However, the decreases have been in adults and children while enrollment of the elderly and people with disabilities continues to increase.

Medicaid Enrollment Changes May 2017 to October 2019

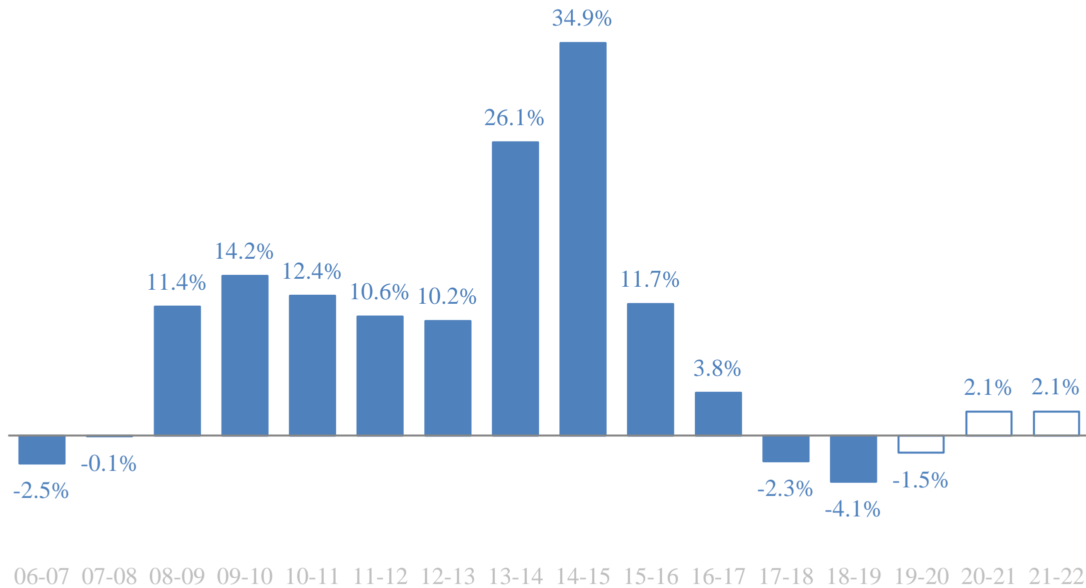


Where the enrollment declines are occurring is important because people 65 and over and people with disabilities utilize more medical services and higher cost medical services than the overall population. In addition, for qualifying clients Medicaid covers long-term services and supports, such as assistance with bathing, dressing, meals, and managing medications. Finally, services for the elderly and people with disabilities receive a 50 percent federal match with the state share primarily from the General Fund while large portions of adult and children populations receive an enhanced federal match with the state share coming from the provider fee on hospitals and other non-General Fund sources.



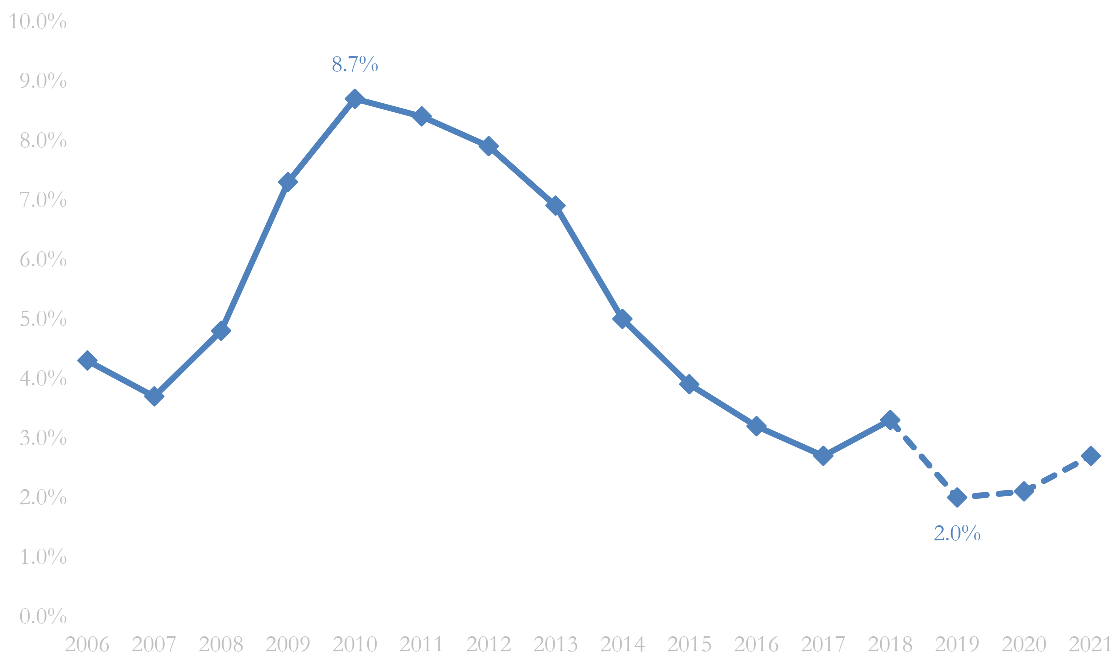
From FY 2008-09 through FY 2015-16 Medicaid enrollment grew more than 10 percent a year. Medicaid enrollment actually decreased in FY 2017-18 and FY 2018-19 and the Department expects a decrease in FY 2019-20. For FY 2020-21 and FY 2021-22 the Department projects moderate enrollment growth of 2.1 percent.

HCPF Projects Moderate Enrollment Growth
for FY 2020-21 and FY 2021-22



The Department assumes the recent reductions in enrollment will not continue in FY 2020-21 and FY 2021-22. Colorado's population continues to increase. Colorado is experiencing historically low unemployment that the Department assumes will not last indefinitely. Also, multi-year sustained reductions in Medicaid enrollment are very uncommon.

Colorado Unemployment Rate
State Demographer Projections



STATE AND FEDERAL POLICIES IMPACTING ENROLLMENT

Advocates have raised concerns that federal and state policies are causing people who meet the income eligibility criteria to not receive Medicaid coverage. In support of this position the advocates note that Colorado's decline in Medicaid and CHP+ enrollment from March 2017 to March 2019 was 8.0 percent compared to a national average of 2.3 percent. Also, the advocates argue improvements in the unemployment rate do not fully explain the recent decreases in enrollment. In addition to concerns about access to care, some provider groups have raised concerns to the JBC staff about impacts to reimbursement of a decrease in Medicaid clients and an increase in uninsured clients, including Children's Hospital, Federally Qualified Health Centers, and Community Health Centers.

Advocates have identified the following policies and practices that they believe inappropriately decrease Medicaid enrollment.

- Federal immigration regulations – Under a new rule green card applicants could be denied if the applicant is determined likely to use Medicaid or other public benefits and become a public charge. The rule is being litigated and has not taken effect. Also, advocates explain that it is worded in a way that it would not really impact anyone who would be eligible for Medicaid. However, advocates believe the "chilling effect" of the rule is causing people who would qualify for Medicaid to withdraw or not apply, such as citizen or otherwise legal family members of someone who might seek a green card. The rule was published September 2018, but it might have "chilled" enrollment earlier, as a version of the rule was leaked in February 2017 and it received press coverage. This is a federal rule that is beyond the scope of the Department's control, but advocates argue the Department could provide information about the applicability of the rule to help minimize impacts on enrollment.
- Returned mail – In April 2018 the Department changed a returned mail policy allowing counties to initiate a process for terminating benefits after one piece of returned mail, rather than three. Advocates assess the likelihood that this policy has resulted in eligible people losing access as "high."
- County processing backlog – Advocates say increasing backlogs in county administration are delaying the processing of enrollments, redeterminations, and income and resource verifications. Untimely processing can cause applications or renewals to be denied, requiring people to resubmit or appeal.
- Technical issues uploading documents to eligibility systems – There are a number of times when Medicaid clients and applicants are required to provide documentation to gain or retain eligibility, such as for income or resource verifications. Advocates say submitted documentation is, "chronically lost or misplaced." They specifically identified issues with the electronic portal for uploading information not registering timely submittals
- Seasonal work eligibility – The Department implemented policies for smoothing income to make it easier for people with seasonal or fluctuating work to retain eligibility, but advocates say that the administrative burden on clients of verifying income results in the policies not achieving the intended effect. Also, advocates raise concerns that the income smoothing calculation may not be working properly.

HOSPITAL LETTER

In a November 2019 letter to Governor Polis and Director Bimestefer several leaders of Colorado hospitals also raised concerns about state policies that may impinge access to care. The letter addresses multiple grievances, but the issues specifically identifying a problem with access to care include:

- New prior authorization and concurrent review requirements – The hospitals allege these delay urgent patient surgeries and admissions by a week or more.
- Denied claims for patients in observation over 48 hours – The hospitals assert that tens of thousands of claims have been erroneously denied, increasing challenges in placing patients in rehabilitation and long-term care facilities.
- Refused bills for behavioral health – The hospitals argue that the Department is directing them to behavioral health organizations and the behavioral health organizations are directing them to the Department and nobody is taking responsibility for needed post-hospital behavioral health care.

Regarding the new prior authorization and concurrent review requirements, the Department reports a one day turnaround and same day for expedited requests and does not agree with the concern raised by the hospitals that access to services is being delayed. Regarding denied claims for patients in observation over 48 hours, the Department says it is working on a system fix with an expected implementation in the first quarter of 2020. Regarding refused bills for behavioral health the Department clarified that as of July 2018 the Regional Accountable Entities (RAEs) rather than behavioral health organizations manage the behavioral health benefit. The Department reports that in March 2019 it initiated a Behavioral Health Hospital Engagement Forum in collaboration with the Colorado Hospital Association. In response to concerns raised through the forum the Department has modified contract language with the RAEs, issued guidance to hospitals that they should bill the RAEs, and streamlined the processing of specific behavioral health billing concerns.

The Department also noted that it began working with the Colorado Hospital Association (CHA) on these and other issues in October, creating work groups and setting up standing meetings with CHA staff. This collaboration began prior to receiving the November 21, 2019 letter from the hospital leaders.

R12 WORK NUMBER VERIFICATION

In *R12 Work number verification* the Department requests a net reduction of $22.6 million total funds, including a decrease of $3.8 million General Fund, for implementing a system that allows for automated income verification at enrollment for a portion of applications where data is available. The Department projects the policy will reduce the number of people initially determined eligible for Medicaid and CHP+ who are later determined ineligible, as well as county administrative time to verify income. The request assumes system implementation January 1, 2021, and the projected net savings approximately doubles in FY 2021-22 to $46.2 million total funds, including $7.7 million General Fund.

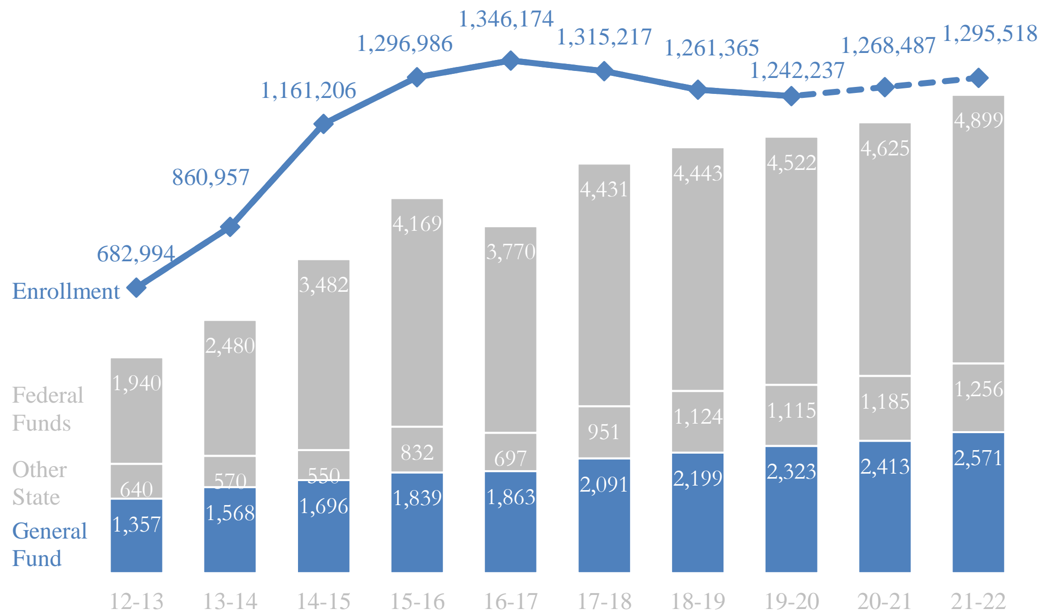
Currently, the Department uses self-reported income to determine eligibility and then attempts to verify the income through a process that takes a minimum of four months before anyone would lose benefits. The request would allow an automated income verification in some cases at the time of application by checking against a data set maintained by the vendor. The source for the data set is a partnership between the vendor and payroll providers that uploads payroll from both large and small employers. The Department reports the information is accurate as long as the social security numbers match and adds that the Supplemental Nutrition Assistance Program (SNAP) already uses a similar system. Based on the experience of SNAP, the Department expects data will be available to automatically verify income at enrollment for approximately 55 percent of applicants. If the data is not available for an instant verification, or an applicant disputes an instant verification, the Department will still use self-reported income and attempt to verify income later.

When the Department identifies a discrepancy of more than 10 percent between self-reported income and income verification checks the Medicaid client is given a "reasonable opportunity period" to explain the difference. Independent of this budget request, but potentially relevant to the policy debate, the Department is switching from a 90 day reasonable opportunity period to a 30 day reasonable opportunity period. The Department expects approval from the Medical Services Board in mid-2020.

This is another state policy that would increase verifications. The JBC staff is unsure if advocates have similar concerns about this proposal potentially inappropriately denying access and/or increasing the administrative burden on applicants and clients. The work number verification and decrease in the reasonable opportunity period could potentially increase the number of times applicants and existing clients need to provide an explanation of income and shorten deadlines for providing explanations. This might present an administrative burden to some applicants and clients, especially those with fluctuating income. Other clients and applicants will benefit from the automated verification of income eliminating the need to self-report and subsequently verify income. The Department expects the automated income verification to reduce the administrative burden for county eligibility workers, which might reduce the county administration backlogs that advocates identify as a potential barrier to access.

EXPENDITURE TRENDS

The overall expenditure trend largely mirrors the enrollment trend. As noted previously, enrollment is the primary driver of expenditures. A notable exception occurred in FY 2016-17 and FY 2017-18, when the transition to new payment systems moved money between state fiscal years. There are some less prominent deviations in the expenditure trend from the enrollment trend, mostly due to historic payment delays and variations in special financing.



When looking at expenditures by fund source, the variations in General Fund are less pronounced than the variations in other fund sources. This is because a provider fee on hospitals and federal funds finances most of the expansion populations responsible for a large portion of the variation in enrollment trends and finances the supplemental payments to hospitals. The General Fund expenditures are driven by the traditional Medicaid populations of children, pregnant women, the elderly, people with disabilities, and very low income parents. Of the traditional Medicaid populations, the elderly and people with disabilities cost the most per capita by a wide margin, and so these populations are typically the most responsible for the overall level of General Fund expenditures.

FY 2019-20

The table below shows key differences between the Department's November 2019 forecast for FY 2019-20 and the FY 2019-20 appropriation. The table does not show differences from FY 2018-19 expenditures. For example, the table shows that the Department lowered the forecast for private duty nursing by $6.7 million total funds from the assumptions used for the appropriation, but the Department still expects private duty nursing will increase significantly, by $9.7 million total funds or 10.0 percent, from the FY 2018-19 actual.

FY 2019-20 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2019-20 Appropriation	$7,895,417,528	$2,285,686,174	$1,072,419,588	$4,537,311,766
Acute Care				
Enrollment	(154,842,696)	(25,051,999)	(8,325,048)	(121,465,649)
Per capita	133,806,779	72,011,940	(7,718,733)	69,513,572
Subtotal - Acute Care	*(21,035,917)*	*46,959,941*	*(16,043,781)*	*(51,952,077)*
Long-term Services and Supports				
HCBS waivers	(9,839,084)	(4,898,864)	(20,678)	(4,919,542)
Long-Term Home Health	12,150,915	6,225,234	381,854	5,543,827
Private Duty Nursing	(6,696,009)	(2,529,771)	(783,081)	(3,383,157)
Nursing Homes	(8,910,075)	(4,421,572)	(27,527)	(4,460,976)
PACE	7,467,882	3,733,941	0	3,733,941
Hospice	(1,392,172)	(547,244)	67,383	(912,311)
Subtotal - LTSS	*(7,218,543)*	*(2,438,276)*	*(382,049)*	*(4,398,218)*
Medicare Insurance Premiums	(7,620,403)	(4,262,805)	0	(3,357,598)
Service Management	(10,279,275)	(2,354,067)	(826,386)	(7,098,822)
Hospital Supplemental Payments	*106,144,040*	*0*	*53,072,021*	*53,072,019*
Other	4,216,484	(1,019,292)	7,086,459	(1,850,683)
TOTAL	**$7,959,623,914**	**$2,322,571,675**	**$1,115,325,852**	**$4,521,726,387**
Increase/(Decrease)	64,206,386	36,885,501	42,906,264	(15,585,379)
Percentage Change	0.8%	1.6%	4.0%	-0.3%

ACUTE CARE

The acute care category includes expenditures for hospitals, primary care, specialty care, and pharmacy, among others.

- Enrollment - The Department overestimated enrollment nearly across the board. One of the largest corrections was for the ACA expansion enrollment, where the Department reduced the forecast by 7.1 percent. The ACA expansion includes adults without dependent children and higher income parents and the enrollment of these populations is sensitive to economic conditions, which remain better than the Department anticipated. These populations are financed with the provider fee on hospitals and federal funds, and so correcting the forecast does not change the General Fund, but it accounts for $99.9 million of the total funds decrease. The Department reduced enrollment projections for the elderly and people with disabilities by 2.2 percent and the forecast for parents, children, and pregnant women by 1.9 percent. These changes drive $23.3 million of the General Fund change.
- Per Capita - At the same time the Department decreased the enrollment forecast nearly across the board, it increase the projection of per capita expenditures nearly across the board, primarily because FY 2018-19 actual per capita expenditures were higher than expected. According to the Department, as the economy continues to improve the people leaving Medicaid tend to be healthier and have lower costs than those that remain, resulting in higher per capita expenditures. This only partially explains the change, though. The biggest increase in per capita assumptions was for the elderly and people with disabilities where the Department increased the forecast 8.7 percent, accounting for $38.7 million of the General Fund change. The second biggest increase was for parents, children, and pregnant women where the Department increased the forecast by 3.9 percent, accounting for $28.0 million of the General Fund change. The Department only

reduced the enrollment forecast for these populations by about 2.0 percent. If only healthy people with no claims left Medicaid it would not fully explain the increase in per capita expenditures for these populations.

In FY 2018-19 the General Assembly included assumptions about savings that would be generated from several cost containment initiatives. For example, the budget expected savings of $57.8 million total funds from integrating physical and behavioral health within the Accountable Care Collaborative, $37.0 million total funds from mandatory enrollment in the Accountable Care Collaborative, $10.0 million from S.B. 18-266 for cost and quality technology that guides referrals and prescriptions to the most cost effective providers and practices, and $5.6 million total funds from making end stage renal disease billable in lower cost settings. It is possible that some of the higher than expected per capita expenditures are attributable to not achieving the expected savings from cost containment initiatives.

OTHER

- Medicare Insurance Premiums and Service Management – The projected decreases are driven primarily by the reduced caseload forecast.
- Hospital Supplemental Payments – The increase is based on a revised forecast of the federal Upper Payment Limit (UPL) for hospitals.

LONG-TERM SERVICES AND SUPPORTS

In long-term services and supports there were both increases and decreases in the forecast that largely netted out.

- HCBS and Private Duty Nursing - For HCBS waivers and Private Duty Nursing the FY 2018-19 high growth in utilization was somewhat less high than the Department expected, causing the Department to lower the forecast for FY 2019-20, but FY 2018-19 utilization was higher than expected for long-term home health.
- Nursing Homes - For nursing facilities the Department lowered the estimated patient days 2.0 percent.
- PACE - For the Program for All-inclusive Care for the Elderly (PACE) the Department increased the estimated average cost per enrollee 3.8 percent and added $4.4 million total funds for retroactive payments.

FY 2020-21

The next table highlights key factors driving the projected growth in expenditures from FY 2019-20 to FY 2020-21.

FY 2020-21 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
FY 2019-20 Projection	$7,959,623,914	$2,322,571,675	$1,115,325,852	$4,521,726,387
Acute Care				
Enrollment	87,835,881	17,450,912	11,509,602	58,875,367
Per capita	(42,590,499)	(6,177,895)	(6,443,358)	(29,969,246)
Subtotal - Acute Care	*45,245,382*	*11,273,017*	*5,066,244*	*28,906,121*
Long-term Services and Supports				
HCBS waivers	55,368,876	27,420,748	263,690	27,684,438
Long-Term Home Health	13,807,283	6,660,714	162,819	6,983,750

FY 2020-21 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	OTHER STATE	FEDERAL FUNDS
Private Duty Nursing	832,704	415,935	106	416,663
Nursing Homes	24,219,828	12,032,278	37,533	12,150,017
PACE	19,973,954	9,986,977	0	9,986,977
Hospice	5,011,138	2,127,014	273,554	2,610,570
Subtotal - LTSS	*119,213,783*	*58,643,666*	*737,702*	*59,832,415*
Medicare Insurance Premiums	7,878,853	4,393,251	0	3,485,602
Provider Fees				
Hospitals	58,273,012	0	29,136,505	29,136,507
Nursing Homes	4,584,571	0	2,292,286	2,292,285
Subtotal - Provider Fees	*62,857,583*	*0*	*31,428,791*	*31,428,792*
Emergency Transportation Provider CPE	18,748,916	*(986,785)*	*9,867,851*	*9,867,851*
Service management	11,227,789	4,590,169	703,327	5,934,293
Federal match rate	0	13,395,073	20,525,112	(33,920,185)
Other	(1,778,443)	(801,072)	865,073	(1,842,444)
TOTAL	**$8,223,017,777**	**$2,413,078,994**	**$1,184,519,952**	**$4,625,418,832**
Increase/(Decrease)	263,393,863	90,507,319	69,194,100	103,692,445
Percentage Change	3.3%	3.9%	6.2%	2.3%

Some highlights of the FY 2020-21 forecast include:

ACUTE CARE

Overall the Department is projecting a 2.1 percent increase in enrollment with small variations by eligibility category.

- Enrollment - The General Fund is primarily attributable to $5.3 million for the elderly and people with disabilities and $11.5 million for parents, children, and pregnant women.
- Per capita - The projected reduction in per capita expenditures is primarily due to annualizing out the impact of an additional payment period that occurred in FY 2019-20 due to how the calendar fell. Eliminating the extra pay period reduced the projected General Fund by $17.2 million, which is partially offset by low positive per capita trends projected for nearly all populations.

LONG-TERM SERVICES AND SUPPORTS

- HCBS waivers and long-term home health - For HCBS waivers and long-term home health the Department assumes the trends of increasing costs per utilizer will continue and for long-term home health the Department is projecting growth in the number of utilizers.
- Nursing Homes - For nursing facilities the increase is primarily due to the statutory formula for calculating the rates as the Department is projecting only a 0.32 percent increase in patient days.
- PACE - For PACE the Department projects a 2.3 percent increase in the average cost per utilizer and continued strong growth in enrollment of 8.2 percent.

OTHER

- Medicare Insurance Premiums – The projected increase is attributable to a 4.1 percent increase in Medicare Part B Premiums and a 2.1 percent increase in enrollment.

- Hospital Supplemental Payments – The increase is based on a forecast of the federal Upper Payment Limit (UPL) for hospitals.
- Emergency Transportation Provider CPE – The increase is for annualizing a new policy that started mid FY 2019-20 allowing activities of local government emergency transportation providers to be certified as public expenditures to claim a federal match.
- Service Management – The increase is driven by the projected increase in the overall caseload.
- Federal match rate – The forecast annualizes two changes in the federal match rate. For the "newly eligible" pursuant to the federal Affordable Care Act (ACA) the federal match decreased from 93.0 percent in 2019 to 90.0 percent in 2020, resulting in a decrease in federal funds and necessitating an increase in cash funds from the provider fee on hospitals, called the Healthcare Affordability and Sustainability (HAS) fee. For the Children's Basic Health Plan the federal match decreases from 88.0 percent in federal fiscal year 18-19 to 76.5 percent in federal fiscal year 19-20 to 65.0 percent in federal fiscal year 20-21. The federal match for some Medicaid services for children and pregnant adults are indexed to the CHP+ match rate, resulting in a decrease in federal funds and necessitating an increase in General Fund.

R3 CHILDREN'S BASIC HEALTH PLAN (CHP+)

The Department requests a net increase of $8.9 million total funds, including $25.6 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. The total requested change is the sum of the forecasted changes in FY 2019-20 and FY 2020-21. The Department will officially submit a supplemental request for FY 2019-20 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2020.

The General Fund increase is attributable to changes in the federal match rate. The federal Affordable Care Act had temporarily increased the reimbursement rate for Colorado to 88.0 percent, but the federal reauthorization for CHP+ steps the federal match rate down over two years to the pre-ACA match rate. As a result, the Department projects the available federal funds for CHP+ will decrease and the state obligation will increase by $24.9 million in FY 2020-21. Some of the increase in the state share is absorbed by the Healthcare Affordability and Sustainability (HAS) Fee, but $16.3 million hits the General Fund. In addition, with the lower federal match rate the revenue to the CHP+ Trust, which primarily comes from tobacco settlement money, is projected to be insufficient to finance the projected 1.7 percent increase in caseload and 3.6 percent increase in per capita costs, driving the need for another $9.3 million General Fund.

The Department projects the General Fund obligation for CHP+ as a result of the decrease in the federal match rate will increase to $40.3 million in FY 2021-22 and largely follow enrollment and per capita trends thereafter.

CHP+ Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	88.00	88.01	88.00	88.00	88.00
FY 18-19	88.00	88.00	88.00	88.00	88.00

CHP+ Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 19-20	*79.38*	88.00	*76.50*	*76.50*	*76.50*
FY 20-21	*67.88*	76.50	*65.00*	*65.00*	*65.00*

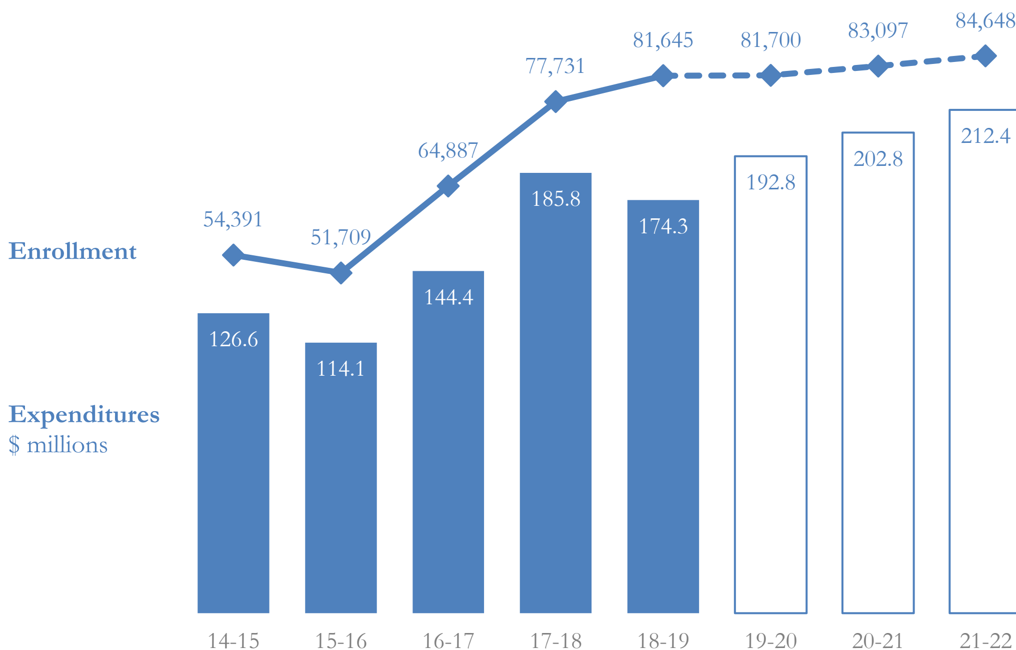
Italicized figures are projections.

The table below summarizes the projected cash flow for the CHP+ Trust.

Children's Basic Health Plan Trust				
	FY 18-19	FY 19-20	FY 20-21	FY 2021-22
Beginning Fund Balance	$17,853,283	$18,321,276	$5,558,788	$0
Revenue	$16,787,458	$16,761,736	$17,401,229	$15,174,904
Fees	1,264,903	1,184,893	1,205,938	1,228,020
Tobacco Settlement	15,156,991	15,210,000	15,829,751	13,626,494
Interest	365,564	366,843	365,540	320,390
Recoveries	0	0	0	0
Expenses	$16,319,465	$29,524,224	22,960,017	15,174,904
Net Cash Flow	$467,993	($12,762,488)	($5,558,788)	$0
Ending Fund Balance	$18,321,276	$5,558,788	$0	$0

The chart below summarizes the Department's forecast of enrollment and expenditures for CHP+. The Department's projection assumes enrollment and expenditures for CHP+ will increase in an improving economy as families move from Medicaid to CHP+, but the increase is partially offset by improving family incomes exceeding the CHP+ eligibility threshold.

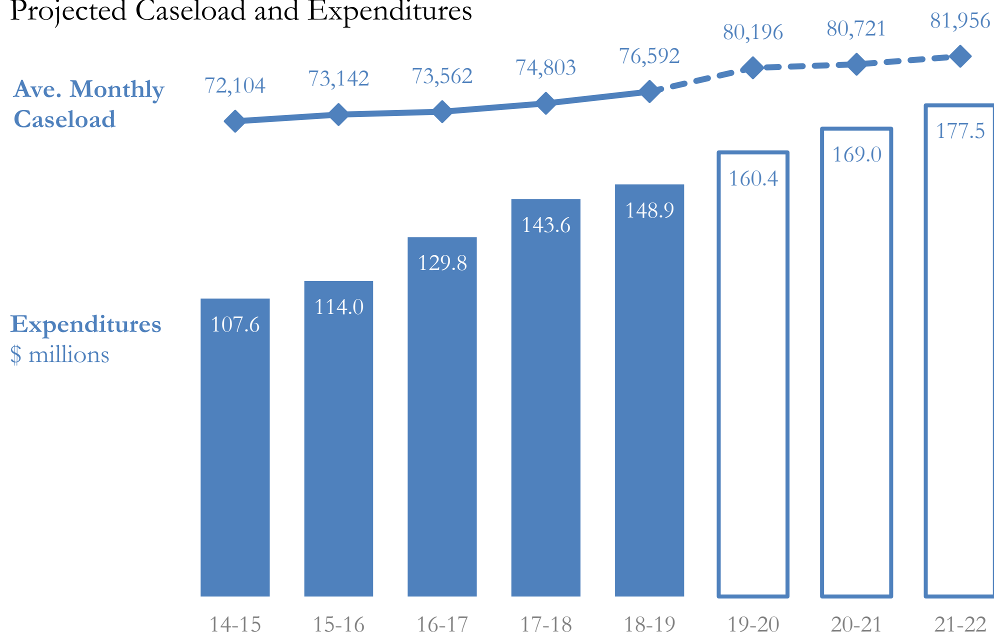
Children's Basic Health Plan (CHP+)
Projected Caseload and Expenditures



R4 MEDICARE MODERNIZATION ACT

The Department requests an increase of $17.9 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. The total requested change is the sum of the forecasted changes in FY 2019-20 and in FY 2020-21. The Department will officially submit a supplemental request for FY 2019-20 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2020.

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. Growth in the enrollment of people dually eligible for Medicare and Medicaid and changes in the cost of pharmaceuticals drive expenditures.



The Medicare Modernization Act is normally a 100 percent General Fund obligation, but from FY 2012-13 to FY 2014-15, in order to offset General Fund costs, Colorado applied bonus payments received from the federal government for meeting performance goals for enrolling children in Medicaid and CHP+ toward this obligation.

The federal Centers for Medicare and Medicaid Services (CMS) believes Colorado miscalculated the bonus payments earned and is seeking to recover $38.4 million. The Department is disputing the attempted recover in court. If Colorado loses it would need to come up with the $38.4 million. There are scenarios where Colorado might be able to allocate some of the costs to sources other than the General Fund and/or spread the repayment out over multiple years.

PUBLIC SCHOOL HEALTH SERVICES

The Department requests $11.6 million total funds to annualize a forecast adjustment last year for the Public School Health Services Program. There is no General Fund impact.

When schools provide health services to public school children with disabilities, as required by federal and state law[3], and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

Schools pay for the services and then complete documentation to get the costs certified as public expenditures by the Department of Health Care Policy and Financing in order to claim the matching federal funds. Under state law, schools must use the additional federal funds to expand or enhance health services for all students through a Local Services Plan developed with community input.

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

R18 PUBLIC SCHOOL HEALTH SERVICES EXPANSION

In addition to the standard forecast adjustment for the Public School Health Services Program, the Department submitted a request for $75,000 federal funds for administrative work to expand the program.

Currently, only school services to Medicaid clients with disabilities that are provided within an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) draw a federal match. Based on 2018 guidance from the federal Centers for Medicare and Medicaid Services (CMS) the Department projects Colorado could increase federal funds for schools by claiming a match for a broader array of services. The new policy would allow schools to receive federal funds for the Medicaid portion of Medicaid-allowable services to all children, regardless of whether the service is provided within an IEP or IFSP. This would allow schools to draw a federal match for things like the Medicaid-share of health screenings for the whole student population.

The Department believes it can make the change within the broad authority in Section 25.5-5-318, C.R.S. If approved by CMS, the Department projects the new policy would bring in an additional $13.6 million federal funds for schools in FY 2021-22. The state match for the federal funds would come from an administrative process that allows the Department to certify the money already being spent by school districts as public expenditures. There would be no General Fund impact.

[3] Individuals with Disabilities Education Act, Section 504 of the Rehabilitation act of 1973, and Title 22, C.R.S.

ISSUE: LONG-RANGE FINANCIAL PLAN

The Department submitted a long-range financial plan that identifies risk factors for the budget, potential changes in Colorado's healthcare landscape, and emerging trends that could impact expenditures and needed investments. The plan also projects that an economic shock similar to FY 2002-03 could increase expenditures $678.6 million total funds, including $174.9 million General Fund, in one year with elevated expenditures persisting for several years thereafter.

SUMMARY

- The Department identified economic conditions, demographics and particularly an aging population, rising health care costs, and potential federal policy changes as risk factors for the budget.
- In addition, the Department identified changes in the provider network and the legality of the Colorado Healthcare Affordability and Sustainability Enterprise as aspects of the healthcare landscape that could impact expenditures. In particular the Department highlighted the potential closure of a rural hospital or Regional Accountability Entity (RAE) that manages behavioral health as a change that would present access and expenditure challenges.
- Emerging trends emphasized by the Department include drug prices, minimum wage increases, waiting lists for people with intellectual and developmental disabilities, increasing utilization and costs for participant directed services, and enrollment in the Program for All-Inclusive Care for the Elderly (PACE).
- The Department projects an economic shock similar to FY 2002-03 could increase expenditures $678.6 million total funds, including $174.9 million General Fund, in one year with elevated expenditures persisting for several years thereafter.

DESCRIPTION

RISK FACTORS

The Department's long-range financial plan[4], submitted pursuant to Section 2-3-209, C.R.S., identifies four major risk factors for the budget:

1. Economic conditions
2. Demographics
3. Health care costs
4. Federal policy

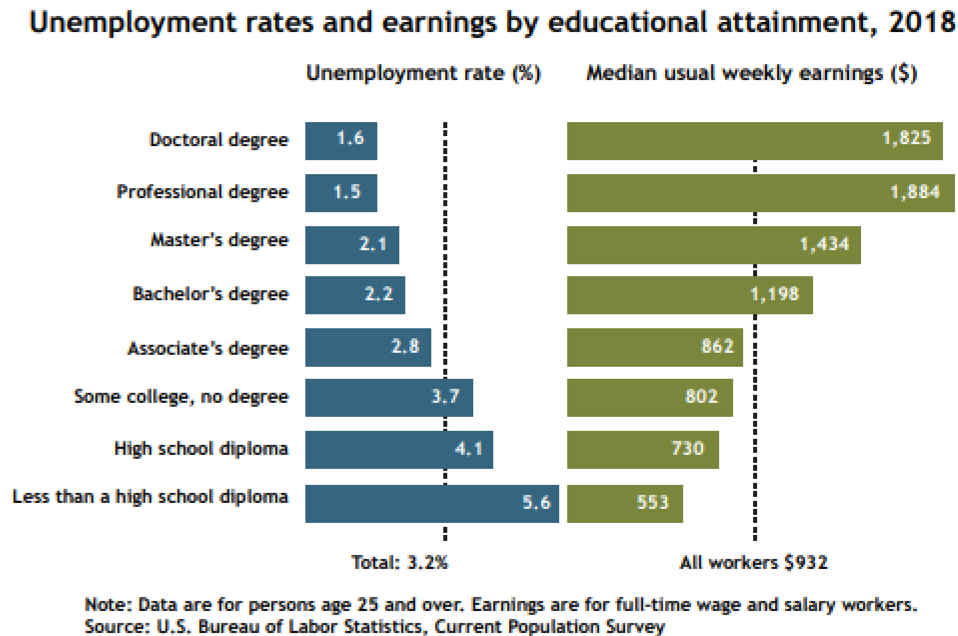
ECONOMIC CONDITIONS

The Department reports that historically caseload and associated expenditures have increased rapidly when the economy declines, but when the economy recovers the impact on program caseloads is delayed. This is due in part to federal and state requirements for transitional programs that allow people to continue receiving benefits for up to a year after their income improves. Also, the impact of economic recoveries is not even across all populations and people with less education and

[4] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20Long-Range-Financial-Plan.pdf

competing for low wage jobs tend to take longer to find work. Finally, the people who leave Medicaid and CHP+ during economic recoveries tend to be healthier with lower costs.

The Department provided the following graphic correlating unemployment rates, income, and educational attainment.



DEMOGRAPHICS

Colorado's increasing population and in particular the growth of adults over 65 is likely to impact the Department's spending. The State Demographer projects population growth from 2019 to 2024 of 7.4 percent overall, 23 percent ages 65-74 and 21 percent 75 and older.

HEALTH CARE COSTS

The federal Centers for Medicare and Medicaid Services (CMS) predicts national health spending to grow 5.5 percent per year from 2018 through 2027 with rapid increases in prescription drug spending, hospital spending, and physician and clinical services. For some services the Department is required to pay rates that keep pace with provider costs and the Department highlighted nursing facilities, pharmaceuticals, behavioral health services, and federally qualified health center payments as examples. For other providers the rates are dependent on appropriations from the General Assembly, but failure to adjust the rates can potentially create issues with provider retention and access to care. When clients face access to care issues it can decrease health outcomes and lead to substitutions of preventive or community-based care with higher cost alternatives.

FEDERAL POLICY

The Department describes a lack of clear consensus at the federal level of how Medicaid and CHP+ may change in the future. The Department highlighted the following potential federal policies that could significantly impact expenditures:

- Repealing the federal Affordable Care Act (ACA)
- Converting Medicaid to a block grant

- Creating a comprehensive public health care program (such as Medicare for all)
- Medicaid waivers and executive branch regulation

ECONOMIC SHOCK

As part of the long range financial plan, the Department provided an estimate of Medicaid expenditures assuming an economic downturn similar to the one in FY 2002-03. The Department's models predict a similar downturn would increase FY 2020-21 expenditures for Medicaid and CHP+ by $678.6 million total funds, including $174.9 million General Fund, compared to the November 2019 forecast. This is just the one year impact. For the reasons described above, increases in caseload due to an economic downturn tend to persist for several years after.

Based on prior experience, the Department assumes an economic downturn would have limited effects on the enrollment of people with disabilities and the elderly. The enrollment of children and parents with low income would drive the majority of General Fund increases in an economic downturn.

COLORADO'S HEALTHCARE LANDSCAPE

In addition to the risk factors identified above, the Department discussed potential changes to Colorado's healthcare landscape that could significantly impact service delivery and expenditures.

- Closure of a rural hospital – This would impact access to services within a reasonable travel distance, increase transportation costs, and could stress the capacity of neighboring providers.
- Closure of a Regional Accountable Entity – Loss of a RAE would impact coordination of care for high needs and complex clients and in particular it could jeopardize access to behavioral health services until an alternative is identified.
- Provider shortages – This is a risk across all providers, but the Department highlighted skilled nursing services and home- and community-based services in rural areas as well as behavioral health services as areas.
- Legality of the Healthcare Affordability and Sustainability enterprise – The Department projects to collect $1.0 billion in fees from hospitals in FY 2020-21 and receive $2.6 billion in federal funds. The money is used to pay for expansion populations and to make supplemental payments to hospitals. The $1.0 billion in fee revenue is currently considered exempt from TABOR as part of an enterprise. If this were reversed by a court ruling it would increase TABOR refunds for money inappropriately retained by the state in prior years and any future growth of the HAS fee would be subject to the TABOR limit.

EMERGING TRENDS

Finally, the Department's long range financial report identified emerging trends that could impact future expenditures.

- Prescription drug costs – The Department is especially concerned about high cost drugs for rare conditions. The Department's ability to constrain pharmacy expenditures is limited by federal requirements that require Medicaid to cover any drug approved by the Federal Drug Administration that has a rebate agreement in place.
- Minimum wages – Statewide and local minimum wage increases put upward pressure on rates for some services, including personal care and homemaker services.
- Waiting lists for people with intellectual and developmental disabilities – The General Assembly has reduced or eliminated many waiting lists for services, but the Department still has over 3,000

people with intellectual and developmental disabilities who are eligible for services that they cannot access due to a lack of appropriations, particularly for residential services.

- Participant directed services – The Department spends more on average for people accessing participant directed services than agency based services. Utilization of participant directed services is growing rapidly.
- Program for All-inclusive Care for the Elderly (PACE) – Enrollment in PACE is growing quickly. Providers receive a set rate that is higher than what the Department would spend on home- and community-based services, but the rate does not change if an individual requires nursing home care. Whether the higher initial investment in PACE pays off for the state in the long run depends on assumptions about what portion of the clients would otherwise have needed nursing care and for how long.

ISSUE: LONG-TERM SERVICES AND SUPPORTS (R13, R17)

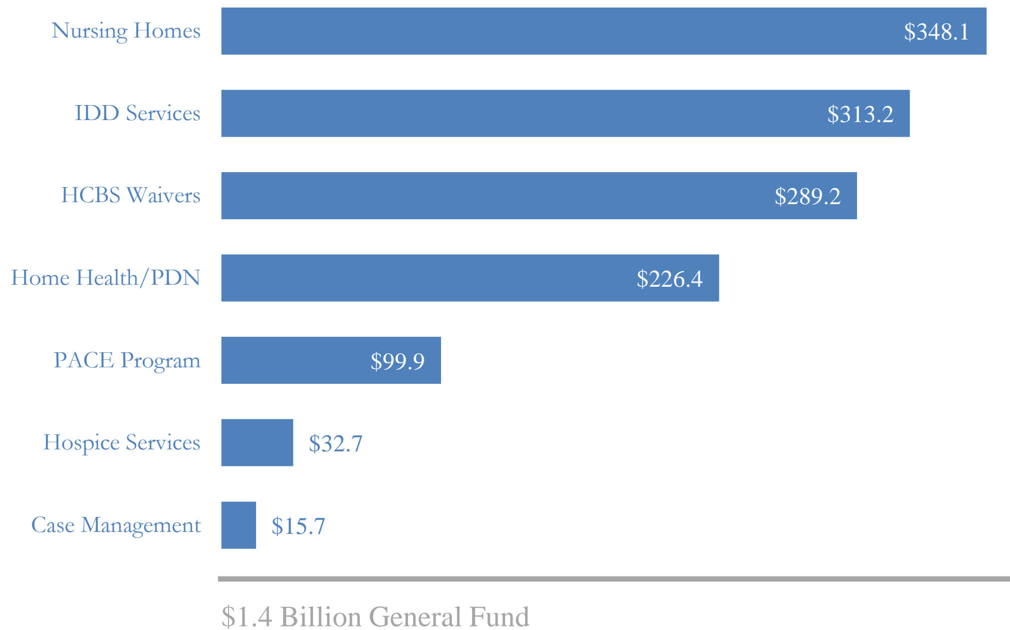
Long-term services and supports represent 47 percent of Department General Fund expenditures and 27 percent of total fund expenditures. To control costs the Department proposes centralized reviews of service authorizations for skilled home care in participant directed services and studying alternative payment methods for nursing home rates.

SUMMARY

- In FY 2018-19 the Department spent approximately $2.8 billion total funds, including $1.4 billion General Fund, on long-term services and supports.
- Enrollment of the elderly and people with disabilities has grown at a steady pace and is relatively insensitive to changes in the economy.
- Major expenditure categories within long-term services and supports include nursing homes, services for people with intellectual and developmental disabilities, Home- and Community-Based Services waivers, home health and private duty nursing, and the Program of All-Inclusive Care for the Elderly.
- Expenditures for all these categories except nursing homes are growing faster than enrollment of the elderly and people with disabilities.
- To control costs the Department proposes centralized reviews of service authorizations for skilled home care in participant directed services.
- Also, the Department proposes studying alternative payment methods for nursing homes that would incorporate performance metrics to provide incentives for quality care.

DISCUSSION

In the most recent actual year (FY 2018-19), long-term services and supports (LTSS) represent roughly 47 percent of Department General Fund expenditures and 27 percent of total funds expenditures. Apart from a few nuances (for nursing provider fees, disabled buy-in, and certified public expenditures), the federal match rate for LTSS is 50 percent and the fund source for the state match is by and large the General Fund. The total funds expenditure was $2.8 billion and the General Fund expenditure was $1.4 billion.



Enrollment of the elderly and people with disabilities, which are the populations that are the primary users of long-term services and supports, has been growing steadily with a compound average annual growth rate of 4.7 percent from FY 2009-10 to FY 2018-19. The Department indicates that the growth rate for these populations has been largely independent of short-term changes in the economy.

NURSING HOMES

While nursing homes are expensive per utilizer, the utilization has been growing very slowly, at a 0.7 percent CAAGR from FY 2009-10 to FY 2018-19. A bigger driver of nursing home expenditures is rates. Nursing home rates are adjusted annually according to a statutory formula based on the lesser of actual costs or a 3.0 percent increase in the General Fund. Changing the nursing home rates would require a statutory change.

In addition to standard payments, the total expenditure for nursing homes includes a little more than $100 million in supplemental payments where the state match comes from a provider fee that operates similarly to the provider fee on hospitals, except on a much smaller scale. Statutes allow the nursing provider fee supplemental payments to fill in the difference when actual allowable costs exceed the statutory 3.0 percent cap on growth in the General Fund.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDD) SERVICES

This category includes both community-based services and costs for the state-operated Regional Centers. These services will be discussed in more detail during the 12/12/19 briefing for the Office of Community Living. Both utilization and rates are based on annual funding appropriated by the General Assembly, as the waivers that authorize community-based services allow for caps on enrollment.

HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS
These services assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube. These particular examples fit in categories of services called personal care, homemaker, and health maintenance respectively, which are the most used and frequently referenced categories of services within HCBS. Other examples of the services that might be available through HCBS waivers include adult day services, non-medical transportation, assisted living services (not room and board), and respite care.

In order to use Medicaid to pay for these services, Colorado received waivers from federal Medicaid rules. The federal government allows these waivers in part because the services are expected to reduce costs for nursing homes, which would otherwise be covered for these clients by Medicaid. While the HCBS waivers share many common characteristics, each waiver is reviewed and approved individually and can include unique services or special parameters, such as enrollment or expenditure caps, that do not apply anywhere else within Medicaid.

About half the expenditures are for participant directed services where the Medicaid client is given a budget based on assessed needs and can select, train, and manage attendants. Often in participant directed services clients are paying for family members to provide care. Clients eligible for participant directed services may use Consumer Directed Attendant Support Services (CDASS) that offers full control, or In-Home Support Services (IHSS) where an organization provides assistance with payroll and human resource functions. In CDASS and IHSS the Nurse Practice Act is waived so clients can hire staff without certifications or licensure for routine and repetitive health maintenance that does not require clinical judgement or assessment.

The amount for HCBS Waivers in the JBC staff's chart excludes services for people with intellectual and developmental disabilities. There are HCBS waivers specifically targeted for people with intellectual and developmental disabilities (IDD) that are included under IDD Services. In different contexts the term HCBS Waivers sometimes includes services for people with IDD.

The number of utilizers of HCBS Waivers is growing at about the same pace as enrollment of the elderly and people with disabilities, but expenditures have been growing more rapidly. From FY 2009-10 to FY 20118-19 the cumulative increase in utilizers was 49.3 percent (4.6 percent CAAGR) compared to a 148.5 percent cumulative increase in expenditures (10.6 percent CAAGR). The faster growth in expenditures is partly a result of significant provider rate increases approved by the General Assembly, especially for personal care and homemaker services, but also reflects increases in the units of service per utilizer. For the non-IDD HCBS waivers, utilization is controlled by the Single Entry Point (SEP) agencies that perform needs assessments and provide case management. Rates are set within the annual funding appropriated by the General Assembly.

HOME HEALTH/ PRIVATE DUTY NURSING (PDN)
These are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS waiver services and Home Health and Private Duty Nursing services. The difference between Home Health and Private Duty Nursing is a matter of degree, with Private Duty Nursing the more intensive service and generally limited to people who are machine-dependent

and/or require round-the-clock care. In addition to traditional nursing services, Home Health includes physical therapy, occupational therapy, and speech therapy.

From FY 2009-10 to FY 2018-19 the number of utilizers increased a cumulative 131.2 percent (9.8 percent CAAGR) and expenditures increased a cumulative 181.0 percent (12.2 percent CAAGR). Utilization is currently authorized based on needs assessments by the SEPs, although the Department is developing an assessment tool for administration by nurses and physicians with funding provided by the General Assembly in *FY 19-20 R9 Long-term home health and private duty nursing acuity tool*. Any impact of the new acuity tool on utilization would begin to appear in FY 2020-21. Rates are set within annual appropriations by the General Assembly. Average units per utilizer has been relatively constant, but in recent years the General Assembly provided funding to increase rates, resulting in expenditure growth that exceeds growth in the number of utilizers.

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a managed care program with a capitated rate for providers. The PACE providers accept the risk and keep the reward if actual costs are higher or lower than expected in the rate calculation. The JBC staff included all PACE expenditures in the chart above, but in addition to LTSS the capitated rate covers hospital, general health, pharmacy, and behavioral health care. Medicaid clients must be 55 years old or older, live in a PACE facility catchment area, and be assessed by a SEP as needing a nursing facility level of care to qualify. The Medicaid client may then choose to enroll in a PACE program or receive services à la carte.

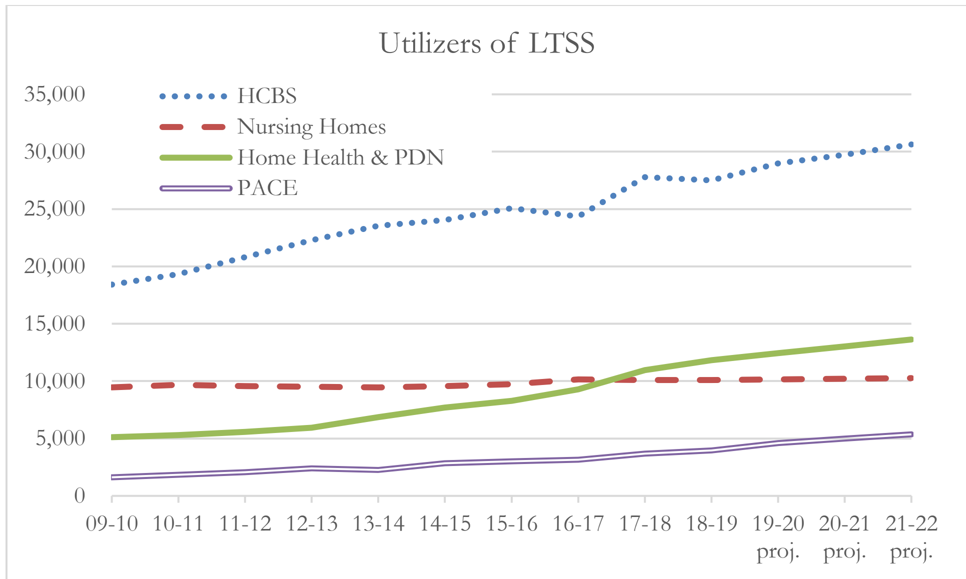
Utilization of PACE increased a cumulative 144.2 percent (10.4 percent CAAGR) from FY 2009-10 to FY 2018-19 and PACE expenditures increased correspondingly by 188.4 percent (12.5 percent CAAGR) during the same time frame. PACE rates are updated every year to meet federal standards as actuarially sound. The rates relate to assumptions about what the clients would have cost Medicaid outside of the PACE program. Thus, annual budget decisions by the General Assembly about non-PACE rates indirectly influence the PACE rates. A portion of the PACE rates are based on the costs of nursing home care, which adjust annually according to a statutory formula. The primary driver of the increased expenditures for PACE has been the increased utilization.

HOSPICE

The number of hospice utilizers has grown very slowly, by a cumulative 10.7 percent (1.1 percent CAAGR) from FY 2009-10 to FY 2018-19. Expenditures have increased by a cumulative 49.9 percent (4.6 percent CAAGR). Eligibility for hospice is based on physician certification that a client is terminally ill and election for hospice by the client or client representative. Rates are adjusted annually based on a combination of a federal formula and nursing rates, and can potentially go higher with discretionary funds from the General Assembly.

CASE MANAGEMENT

This expenditure is primarily for the SEPs that assess needs and provide case management, but also includes some other very small miscellaneous case management-related services. Expenditures have increased 46.8 percent (4.9 percent CAAGR) in step with increases in enrollment of the elderly and people with disabilities.


Utilizers of LTSS
HCBS
Nursing Homes
Home Health & PDN
PACE
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
09-10
10-11
11-12
12-13
13-14
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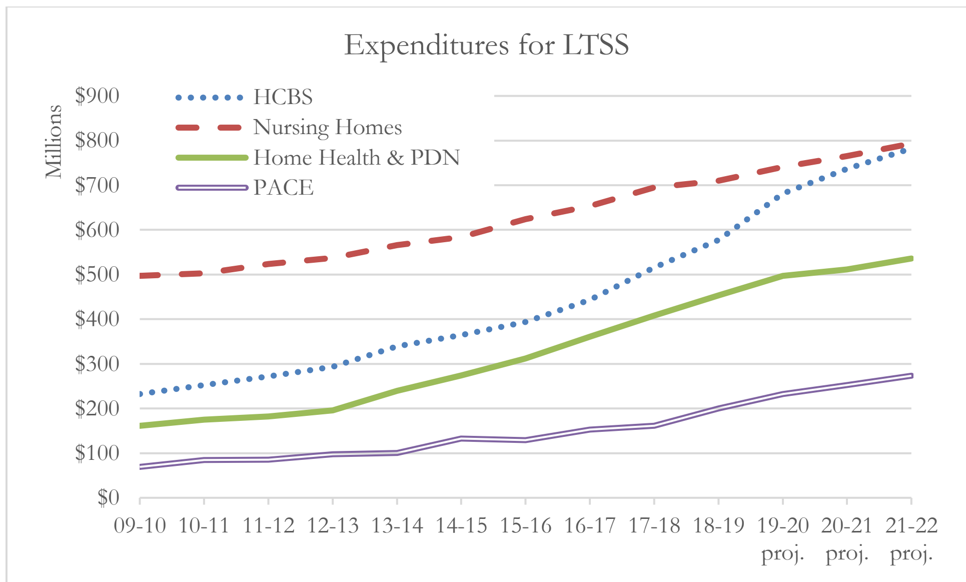
Expenditures for LTSS
Millions
HCBS
Nursing Homes
Home Health & PDN
PACE
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
09-10
10-11
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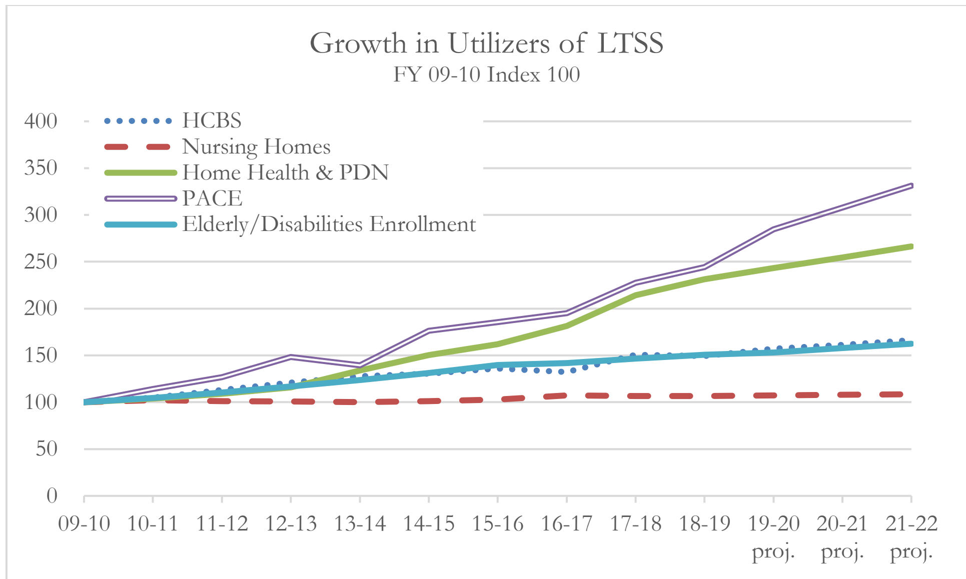
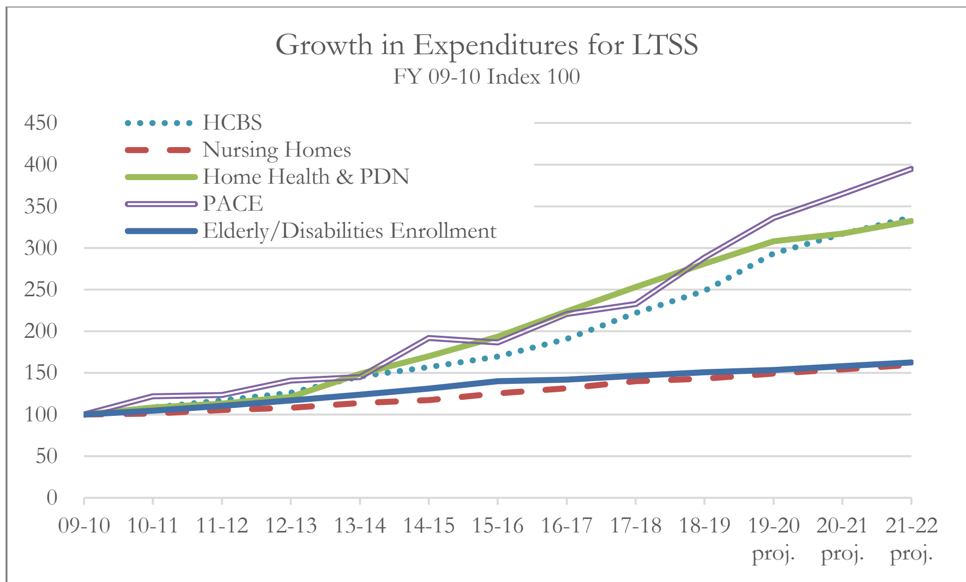
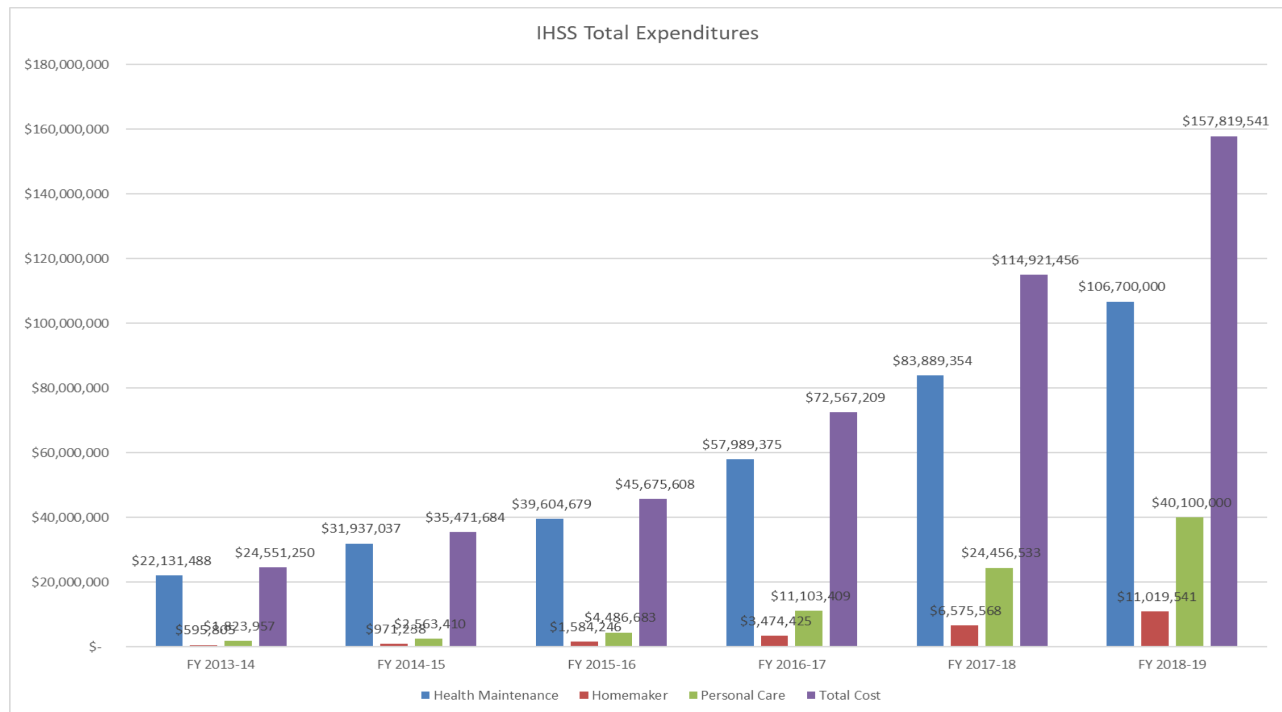




R13 Long-term care utilization management

In *R13 Long-term care utilization management* the Department requests $1.7 million total funds, including $431,632 General Fund, to expand a contract for utilization management to include reviews of in-home skilled care authorizations within the participant directed programs (In-Home Support Services and Consumer Directed Attendant Support Services).

The skilled services are called health maintenance activities. The Department provided the graph below showing that health maintenance activities represent a significant portion of participant directed service expenditures and they are growing quickly.



Currently, the case management agencies (Single Entry Points or Community Centered Boards, depending on the waiver) perform the assessment of need and authorize the service plan that may include a budget for Health Maintenance Activities. The utilization management vendor would review the service plan and associated assessment for consistency with the Department's policies and medical necessity. This review would occur before payments are authorized or reauthorized. The Department anticipates the reviews will be completed within 4 business days, but may be expedited to 2 business days for reasons such as a potential interruption of services for a client.

Although the utilization management vendor would be making the decision on whether Health Maintenance Activities are authorized, the Department explains that the case management agencies would still be performing the assessments and developing the service plans that provide the information for the utilization management vendor to evaluate, and so there is no decrease in the workload for the case management agencies.

The Department claims the review of medical necessity will use evidence-based criteria. However, concerns about a lack of evidence-based research to support current assessment procedures are part of why the Department is currently in the process of developing a new Single Assessment Tool for home- and community-based services, as required by S.B. 16-192. The JBC staff is unsure what "evidence-based criteria" the utilization management vendor would use to determine medical necessity, and whether this would be any more trustworthy than the current methodology that has been criticized as overly subjective. A poorly functioning utilization management review program could increase the administrative burden on providers and clients and create access barriers for services.

The Department says the utilization management will prevent inappropriate authorizations and fraud. It might be easier to achieve standardization with a centralized vendor than with dispersed case

management agencies. The Department acknowledges that reviews might increase or decrease services, but describes the request as likely to generate savings overall.

R17 Program capacity for older adults

In *R17 Program capacity for older adults* the Department requests $558,020 total funds, including $184,146 General Fund, and 0.9 FTE for oversight of both the Program of All-Inclusive Care for the Elderly (PACE) and nursing homes. Of the total, $294,820 total funds and $97,291 General Fund and the 0.9 FTE are to compensate for a decrease in federal oversight audits of PACE facilities, to contract for a satisfaction survey, and to create performance measures for PACE. The remaining $263,200 total funds and $86,856 General Fund is for contract resources to study potential performance-based reimbursement options for nursing homes to replace the current statutory cost-based reimbursement. Finally, ***the Department proposes legislation to make budget-neutral technical changes to the nursing home rate statutes.***

PACE Oversight

The Program for All-Inclusive Care for the Elderly (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.

In the past the Department piggybacked on Medicare audits of PACE providers to ensure proper services and expenditures for Medicaid clients. However, the federal government decreased the scale of Medicare audits of PACE, including reductions in time spent onsite and collaboration with state Medicaid administrators in identifying compliance issues and developing corrective action plans. Current Medicare corrective action plans require only agreement from PACE providers to the plan, with no monitoring to ensure compliance.

In part because of the decrease in federal auditing, the Department received an FTE and contract resources last year to increase oversight of PACE. The FTE was to help ensure that members receive the services they need, that providers are correctly billing, that providers are correctly enrolling and disenrolling members, and that the Department's policies and payments incentivize member well-being. The additional FTE brought the staffing level to 2.0 FTE, which the Department argued was significantly less than other state programs of a similar size, noting that Virginia and North Carolina have 5.0 FTE each for oversight of PACE programs serving 1,500 clients and 2,000 clients respectively. In addition, a Department-initiated review of the PACE program identified issues with a lack of care transitions following disenrollment from PACE and a need for simplification of the enrollment process into PACE. Finally, the Department was concerned that existing risk reserve fund requirements to ensure the fiscal soundness of PACE organizations were insufficiently defined and enforced.

In August 2019 the federal Centers for Medicare and Medicaid Services (CMS) implemented a new rule regarding the PACE program that among other things eliminated the requirement that PACE organizations be audited every two years and replaced it with a risk-based review. CMS then canceled all scheduled audits. The proposed risk-based review process has not been defined or created yet by CMS. The Department argues this effectively shifted the burden of oversight to states.

After reviewing the rule, the Department believes it needs additional resources to conduct audits of the PACE organizations. The audits will include both desk and onsite reviews. The scope of the PACE program means there will be many different operations the Department will need to review from adult day programs to transportation to subcontractors.

NURSING HOMES

The proposed $263,200 total funds, including $86,856 General Fund, for contract resources would be used to review existing rate reimbursement components, compare Colorado's rate structure to other states, identify potential improvements that incorporate quality metrics, analyze the fiscal impact of the options, and research the statutory changes and state plan amendments needed to implement the options. The request includes funding to facilitate stakeholder feedback. The Department describes the goal as creating a payment methodology that would require nursing facilities to carefully manage how they deliver services in order to provide the most appropriate level of care for each resident.

Currently, only supplemental payments financed with the nursing home provider fee include any component based on performance, quality of care, or health outcomes. The per diem rates for nursing homes are based on cost and constrained by the lesser of actual allowable costs or 3.0 percent annual growth. The contractor would look at per diem payments and supplemental payments as a whole and may recommend changes that would impact both the per diem and the supplemental payments.

BUDGET NEUTRAL TECHNICAL CHANGE TO STATUTE

Part of the budget neutral technical changes the Department proposes are to clean up archaic references, such as references to the "Boeckh tool" for determining fair rental value. The "Boeckh tool" no longer exists and has been replaced by a similar tool with a different name.

Another part of the proposal would exempt facilities with fewer than six beds for Medicaid clients from the nursing home rate setting methodology and instead allow payments for these facilities using the statewide average rates. The Department explains there are 30 nursing facilities that are not Medicaid providers. If clients in these facilities outlive their resources, the facility must discharge them. Under the new rule, these facilities could have up to 5 Medicaid beds without needing to go through the administratively intense rate setting process for standard Medicaid nursing providers. This would eliminate the need for people to migrate from a nursing provider that does not accept Medicaid clients due to the administrative burden of rate setting to another facility that does accept Medicaid clients.

Finally, the Department proposes adding language requiring the Department to pursue options for changing the nursing facility reimbursement methodology. A statutory change is not necessary for the Department to study alternative reimbursement methodologies, but it would provide legislative backing for the Department's exploratory work.

The Department believes these changes are necessary and appropriate whether or not the JBC or any other legislator carries the legislation proposed in *R10 Provider rates* to eliminate the allowable growth factor for nursing home rates and instead make rates subject to annual appropriation. In follow up communication, the Department clarified that they are pursuing sponsors and not necessarily asking the JBC to carry the technical changes legislation.

ISSUE: COMMUNITY FIRST CHOICE

The Community First Choice option in federal law provides an additional 6 percent federal match for certain long-term services and supports that a state provides as benefits for all Medicaid clients demonstrating need. Implementing Community First Choice in Colorado could increase utilization, particularly of high cost participant directed services, and there is uncertainty about the net fiscal impact.

SUMMARY

- The Community First Choice option in federal law provides an additional 6 percent federal match for home- and community-based attendant services and supports that a state provides as benefits for all Medicaid clients demonstrating need.
- The minimum services include assistance with activities of daily living (personal care and homemaker services), back-up systems like medical alert buttons, and options for participant direction of services.
- Currently, there are people who could likely demonstrate need who do not have access to participant directed services and so expanding access may increase utilization of these popular services.
- The average expenditure for people using participant directed services is roughly double the average expenditure for people using agency based care. This basic comparison may not capture differences in costs in other areas of Medicaid.
- Conflict-free case management and a reliable assessment tool are prerequisites for Community First Choice and the Department projects these will not be fully implemented until 2022 or 2023.

DISCUSSION

DESCRIPTION

The Community First Choice option in federal law allows states to offer home- and community-based attendant services and supports as a state plan benefit. In Colorado these services are currently part of select waivers and only available to people who qualify for those specific waivers. Making them a state plan benefit would allow all Medicaid clients with a demonstrated need for that level of care to access the services. States that pick the Community First Choice option are eligible for an additional six percent federal match for the services.

The additional six percent federal match provides a financial incentive to implement Community First Choice (CFC), but the program could also potentially significantly increase utilization of high cost services. Uncertainty about how CFC might change Medicaid client behavior and utilization makes it difficult to forecast whether the net result would be more or less expenditures, and introduces a large margin of error to any forecast of the impact of CFC.

The minimum services that must be part of any CFC proposal from a state include assistance with activities of daily living (personal care and homemaker services), back-up systems like medical alert buttons, and options for participant direction of services. People on waivers are those most likely to qualify for the level of care to access CFC benefits. Waiver participants in Colorado already have access to personal care and homemaker services. However, not all waiver participants have access to

participant direction of services. Including options for participant direction of services as part of CFC is what would generate most of the potential for increased utilization that would drive additional costs.

Expanding Access to Participant Directed Services

The table below summarizes the waivers currently without access to participant directed services and the enrollment in those waivers. These are the populations most likely to qualify for participant directed services and take advantage of increased access if CFC were implemented.

Participant Directed Services			
Waiver	IHSS?	CDASS?	Projected FY 20-21 Enrollment
Supported Living Services	No	Yes	5,063
Community Mental Health Supports	No	Yes	3,673
Children's Extensive Supports	No	No	2,147
Children's Home and Community Based Services	Yes	No	1,836
Brain Injury	No	Yes	576
Children with Life Limiting Illness	No	No	187
Children's Habilitation Residential Program	No	No	81
Subtotal			13,563
Elderly, Blind, and Disabled	Yes	Yes	25,665
Spinal Cord Injury	Yes	Yes	243
Adult Comprehensive Waiver	N/A Residential		6,834

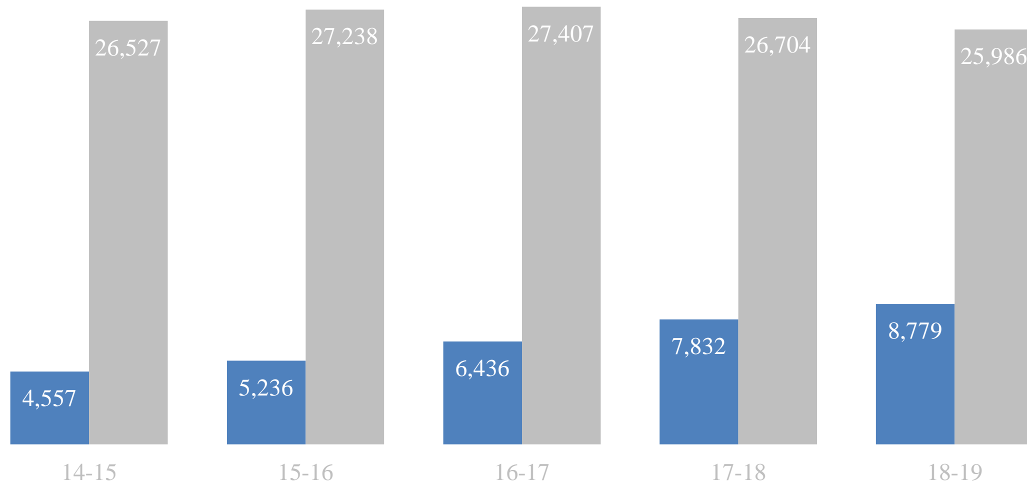
Expenditures per utilizer for participant directed services are more than for agency based services. The average per month cost for an individual receiving agency based care is $1,870, including $1,015 in home- and community-based services and $855 in long-term home health/private duty nursing. This compares to an average cost of $3,380 per month for Consumer Directed Attendant Support Services and an average cost of $4,017 per month for In-Home Support Services. This basic comparison may not capture differences in costs in other areas of Medicaid.

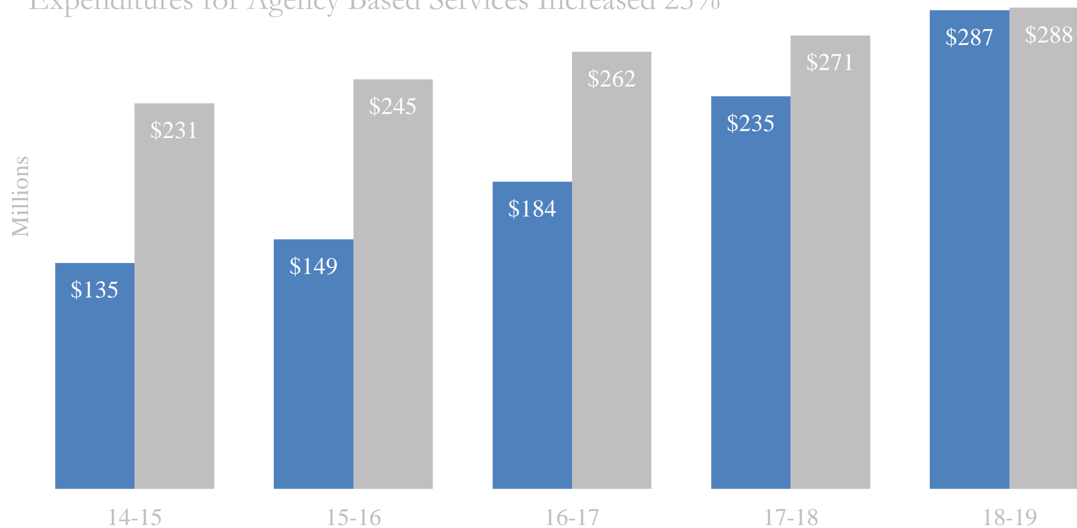
Program costs for participant directed services are higher than agency based services due to higher service utilization. The rates are not higher. There are many possible explanations for the differences in service utilization. For example, it could be that participant directed services remove barriers to finding trusted attendants and getting the right mix of services to fully utilize the authorized benefits. It might be due to self-selection where people attracted to participant directed care are more sophisticated at navigating Medicaid to maximize their benefits. It might be that case managers are overauthorizing participant directed care or underauthorizing agency-based care and assessment tools are not reliable or consistent. There might be differences in the acuity of patients typically receiving participant directed services versus agency based services. These are just examples of a few of the possible explanations. The Department has not identified data that would definitively substantiate or refute any of these possible explanations of the differences in cost per capita. The overwhelming feedback from advocates is that the flexibility of participant directed services makes it easier to access care, leading to higher utilization of services. The advocates also argue this results in a higher quality of life and better health outcomes.

In addition to providing a participant directed care option for people who are currently not eligible, CFC might make it easier to access services because it removes the administrative step of qualifying

for a waiver. A client would still need an assessment to demonstrate need for the level of care, but this might be easier, or be perceived as easier, than qualifying for a waiver, thereby increasing utilization.

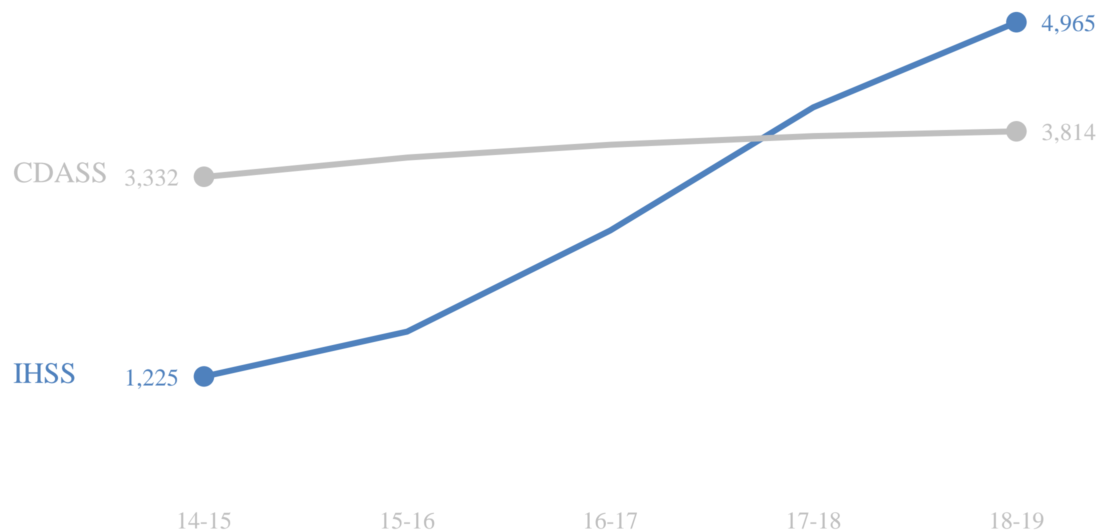
Participant directed services are a popular option compared to agency based services, suggesting that expanding access to participant directed services may result in increased utilization.





Within participant directed services, the utilization of In-Home Support Services (IHSS) has been growing faster than Consumer Directed Attendant Support Services (CDASS). With CDASS the

Medicaid client is responsible for all aspects of managing attendants, but with In-Home Support Services (IHSS) an organization provides assistance with payroll and human resource functions. There might be people on waivers who would not choose participant directed services if CDASS is the only option, but would chose participant directed services with IHSS as an option.



Fiscal Impact and Timeline

The Department has met with advocates and provided feedback on draft legislation to implement Community First Choice, including identifying some issues with the initially proposed timeline that the Department believes made the original draft impossible to implement. The Department has not reviewed any revisions to the draft legislation since providing feedback on the original. Projecting the costs is complex and without a revised specific proposal to analyze, the Department expressed reluctance to speculate whether the net impact will increase or decrease costs.

There are likely to be upfront costs for information technology systems and staff support. Whether the program is expected to save money in the long run, break even, or increase expenditures, will depend in part on the structure of the benefits. There is a provision in the federal regulations requiring that in the first year of implementing CFC a state must maintain or exceed historic expenditures for the services.

There are more levers available to control costs of a waiver service than a state plan benefit. For example, participation in a waiver can be capped. Creating wait lists might not be politically popular, but it is an option for controlling costs of waiver services and it is not an option for state plan benefits.

Federal guidance on CFC indicates Colorado will need to be in compliance with a 2014 final rule on home- and community-based services before federal approval for a CFC option will be granted. The

federal rule includes provisions around conflict-free case management that the Department expects will not be implemented in Colorado until 2022. In addition, to ensure appropriate utilization, the Department needs a reliable, consistent, and accepted assessment tool. The Department has been working on a single assessment tool pursuant to S.B. 16-192 with a planned pilot and testing phase followed by statewide implementation sometime in 2022 or 2023. It is too soon to predict what impact the single assessment tool might have on utilization patterns. A change in utilization patterns due to the new assessment tool would change projections of the impact of implementing CFC. These issues alone would likely push implementation and any associated savings or costs out to FY 2022-23.

Other States

The Department is aware of approximately a dozen states pursuing CFC and five states that have implemented CFC. The fiscal impact in states that have implemented CFC has varied from a significant savings in Washington to significant increased utilization and costs in Oregon. The unique characteristics of those other state Medicaid programs makes it difficult to generalize from their experience and predict what might happen in Colorado. For example, in Washington personal care, homemaker, and participant directed services were already state plan benefits before implementing CFC, and so the main impact was the change in the federal match rate. Oregon offered several optional services beyond the minimum, simultaneously implemented a new assessment tool, and for some services removed a requirement that natural supports (family help) be counted against service plan budgets, resulting in higher than expected utilization and expenditures.

ISSUE: PROVIDER RATES (R8, R9, R10)

This issue brief discusses proposed changes in provider rates. Through *R10 Provider rates* the Department requests a net increase of $2.1 million total funds, including $538,753 General Fund, for both positive and negative changes to provider rates. Through *R8 Accountability and compliance resources* the Department proposes resources to ensure rate increases are passed through to wages and to support the S.B. 15-228 rate review process. Through *R9 Bundled payments* the Department proposes bundled payments for maternity services.

SUMMARY

- The General Assembly established a process in S.B. 15-228 for the Department to review rates on a five-year cycle. The review includes benchmark comparisons and analysis of whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services.
- Through *R10 Provider rates* the Department requests a net increase of $2.1 million total funds, including $538,753 General Fund, for both positive and negative changes to provider rates, including:
    - An increase of $6.9 million total funds, including $4.9 million General Fund, for adjustments to rates based on the review by the Medicaid Provider Rate Review Advisory Committee.
    - A decrease of $19.0 million total funds, including $9.5 million General Fund, for legislation to eliminate a statutory requirement that nursing home rates adjust based on the lesser of allowable costs or 3.0 percent General Fund growth
    - $14.1 million total funds, including $5.1 million General Fund, for an across-the-board 0.29 percent increase.
- In *R8 Accountability and compliance resources* the Department requests resources related to monitor that rate increases are being passed through to wages and to support the Medicaid Provider Rate Review Advisory Committee, among other provisions.
- In *R9 Bundled payments* the Department proposes bundled payments for maternity services.

DISCUSSION

PROVIDER RATE REVIEW PROCESS UNDER S.B. 15-228

In developing the request, the Department leaned on recommendations from the provider rate review process created by S.B. 15-228. The JBC sponsored S.B. 15-228 to assist the legislature in evaluating rate change proposals. Medicaid is becoming an increasingly important payer for medical services, JBC members frequently hear complaints about the insufficiency of reimbursement rates, and the Department has brought forth several proposals in recent years to target certain rates for increases, but not others. The process established by S.B. 15-228 was intended to address these issues by providing data to support rate setting decisions, and by establishing formal procedures for the Department to engage with providers regarding rate setting priorities.

Some of the key features of S.B. 15-228 include:

- Five-year review cycle – The requirement that rates be reviewed at least once every five years ensures that all rates covered by S.B. 15-228 get a day in the sun, while spreading the workload out for the Department, the advisory committee, and the General Assembly.
- Analysis report – The bill requires an analysis report by May 1 each year that provides information for the rates under review on the level of access, service, quality, and utilization provided, as well as comparisons of the rates with available benchmarks, including Medicare and usual and customary rates paid by private payers. The report must assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. If a rate is identified as needing adjustment, but the budget does not support a change, the annual reports ensure the data and analysis remain available to inform decision making in future years.
- Recommendation report - A second report, due by November 1 each year, explains the Department's recommendations on the rates.
- Medicaid Provider Rate Review Advisory Committee (MPRRAC) – This 24 member advisory committee, appointed by the House and Senate leadership and composed of providers and stakeholders, reviews the Department's May 1 report and helps the Department devise strategies for responding to the findings, including non-fiscal approaches or rebalancing of rates. The Advisory Committee also holds meetings with the Department to solicit public comment on the rates under review. The MPRRAC may direct the Department to change the rate review schedule and may make recommendations to the General Assembly for how to improve the rate review process.

Concurrent with the passage of S.B. 15-228, the federal government issued new rules requiring states to conduct periodic rate reviews. The federal rules require states to review certain rates at least once every three years. There is some overlap, but also variation, between the rate reviews required by federal regulation and those required by S.B. 15-228. The federal rules emphasize analysis of regional variations in access, and so the Department has incorporated a discussion of regional access in the S.B. 15-228 process. Significantly, the federal rules require an analysis of the expected effect on member access to services prior to any reduction in Medicaid rates.

Evaluating Rate Sufficiency

Statutes direct the Department and the MPRRAC to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. To do this the Department makes comparisons to benchmark rates, analyzes claims data for access issues, and solicits stakeholder feedback.

The Department's reports emphasize that there are a number of limitations to claims-based analysis of access to consider before drawing conclusions. First, factors other than rates may influence observed access issues, such as the administrative burden of participation in Medicaid, client characteristics and behaviors, provider outreach efforts, and provider scheduling practices. Second, rates may not be optimal when there are no observed access issues. For example, rates can drive over utilization or underutilization of services in a manner inconsistent with best practices. Third, claims data alone does not reveal potentially important information such as the number of providers accepting new clients, the supply of providers not participating in Medicaid, appointment wait times, the level of care provided compared to the level of need, or the portion of payments passed on to employee wages. For these reasons, the Department encourages looking at the claims-based analysis

of access in context of the other information available, including the benchmark comparisons and stakeholder input.

The service categories that were reviewed in 2019, which is year 4 of the review cycle, include:

- Ambulatory surgical centers
- Fee-for-service behavioral health services
- Residential Child Care Facilities
- Special Connections Program Services
- Dialysis and End-Stage Renal Disease Treatment Services
- Durable Medical Equipment

The Department's provider rate request includes components that touch all of these service categories. It also includes several changes based on rates reviewed in prior years. All of the MPRRAC reports are available from the Department's web site at: https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

R10 Provider Rates

The table below summarizes the dollar changes requested in the Department's *R10 Provider rates.*

R10 Provider Rate Adjustments					
Rate	Proposed Change	Total Funds	General Fund	Cash Funds	Federal Funds
Personal Care and Homemaker	2.75% inflation	$4,534,519	$2,267,259	$0	$2,267,260
Alternative care facility	6.4%	3,693,258	1,846,629	0	1,846,629
Adult day programs	19.0%	3,444,422	1,722,211	0	1,722,211
Behavioral health fee-for-service (mostly impacts RCCFs)	Rebalance to within 80-100% Medicare	1,586,971	875,964	(20,264)	731,271
Children's Habilitation Residential Program waiver	Increase rates based on support level for habilitation through RCCFs	532,362	266,181	0	266,181
Family planning	Pay evaluation and management consistent with other family planning	97,092	9,709	0	87,383
Ambulatory surgical centers	Add services otherwise paid at hospital	0	0	0	0
Nursing home	Bill to remove statutory 3% increase and for FY 20-21 instead provide 0.29%	(18,967,828)	(9,483,914)	0	(9,483,914)
Anesthesia	Reduce to Medicare	(5,977,532)	(1,789,672)	(320,397)	(3,867,463)
In-home dialysis	Align reimburseable units with Medicare	(929,537)	(292,415)	(34,471)	(602,651)
Durable medical equipment	Rebalance to within 80-100% Medicare	(49,244)	(17,432)	(3,733)	(28,079)
Subtotal - Targeted Adjustments		**($12,035,517)**	**($4,595,480)**	**($378,865)**	**($7,061,172)**
Across-the-board adjustment	0.29%	14,126,117	5,134,233	645,142	8,346,742
TOTAL		**$2,090,600**	**$538,753**	**$266,277**	**$1,285,570**

Personal care/Homemaker

The Department request $4.5 million total funds, including $2.3 million General Fund, to increase rates for personal care and homemaker services and equivalent consumer directed services by 2.75 percent in FY 2020-21. 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 proposed increase

is intended to keep pace with changes in the state minimum wage and to attract a quality workforce. Providers are required to use at least 85 percent of any increase in rates approved in FY 2020-21 to increase compensation for direct care employees pursuant to S.B. 19-238.

The request indicates that the employees providing personal care and homemaker services are often paid at or near minimum wage. The Department describes the work as physically and emotionally challenging. According to the Department, if rates do not keep pace with rising wages around the state, it can become more difficult to hire and retain quality direct support staff who may choose other alternative employment options, resulting in access to care issues for Medicaid clients that need these services.

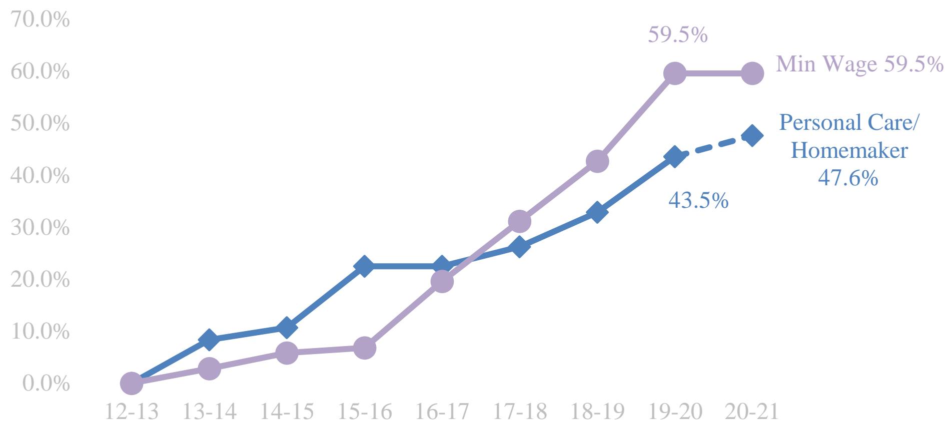
Personal care and homemaker rates were last reviewed through the S.B. 15-228 process in 2017. For personal care, rates were identified as ranging from 80.9 percent to 140.9 percent of the five benchmark comparison states. For homemaker services, rates were identified as ranging from 81.0 percent to 133.7 percent of the five benchmark comparison states. The rates are scheduled for review again in 2021 with the recommendation report due November 2021.

S.B. 19-238 Improve Wages and Accountability Home Care Workers

Senate Bill 19-238 (Kennedy & Duran/Danielson & Moreno) required the Department to implement an 8.1 percent increase in personal care and homemaker rates in FY 2019-20 and required 100 percent of the increase be passed through to direct care staff wages. It also required that in FY 2020-21 85 percent of any increase in rates be passed through to direct care employees. Providers are required to submit reports by December 2020 and December 2021 documenting compliance with the wage pass through requirements. The pass through requirements do not extend beyond FY 2020-21, but the Department may request information from providers in subsequent years to document that wage gains are maintained.

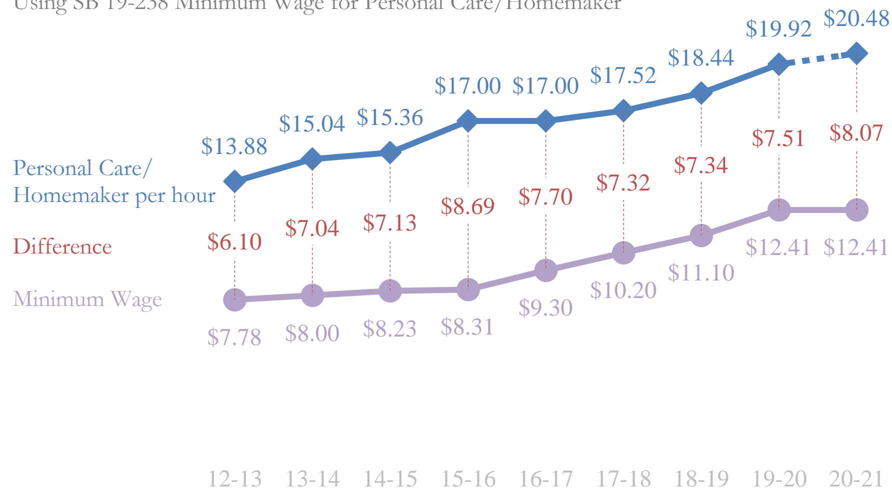
In addition, the bill established a minimum wage for personal care and homemaker services of $12.41 for agencies that receive Medicaid, effective July 1, 2020 and beyond. The minimum wage does not apply to Consumer Directed Attendant Support Services. This compares to the statewide minimum wage of $12.00 in 2020 (Amendment 70 on 2016 ballot) and to the local minimum wage under consideration in Denver of $12.85 in 2020 and rising to $15.87 by 2022. Unlike the statewide and proposed Denver minimum wage, the minimum wage for personal care and homemaker services does not increase annually by inflation in future years.

Since FY 15-16 Personal Care/Homemaker rates grew more slowly than the minimum wage, eroding earlier gains



Personal Care Rates Remain Higher than the Minimum Wage

Using SB 19-238 Minimum Wage for Personal Care/Homemaker



H.B. 19-1210 LOCAL GOVERNMENT MINIMUM WAGE

House Bill 19-1210 (Melton & Galindo/Danielson & Moreno) allows local governments to implement a local minimum wage. If a local government enacts a minimum wage, the bill requires an increase in nursing home provider rates. In addition, as soon as practicable after receiving notification of an enacted local minimum wage, the Department of Health Care Policy and Financing must submit a report to the Joint Budget Committee with recommendations on whether other provider rates need to be increased.

In testimony to the JBC the Department mentioned personal care, homemaker, health maintenance assistance, and residential rehabilitation as rates that might need adjusting. The Department estimated it could cost $10.0 to $15.0 million General Fund to increase these rates in the metro area (Denver and surrounding communities that are likely competitive for workers) to account for the increase in the local minimum wage. This is based on increasing the component of the rate for compensation by the increase in the minimum wage. This is approximately a 5% increase in the rates. Department staff

emphasized that this is one scenario the Department modeled and the Department is still analyzing which rates might need to be adjusted, the best methodology for calculating the adjustment, and what would be required to get approval from the federal Centers for Medicare and Medicaid Services (CMS) for a regional rate adjustment.

ALTERNATIVE CARE FACILITY

The Department requests $3.7 million total funds, including $1.8 million General Fund, for a 6.4 percent increase in rates 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. The Medicaid rate covers service costs, but not room and board. 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 as having one of the largest budget neutrality factors. Also, the Department says stakeholders focused on rates for Alternative Care Facilities as among those most in need of adjustment. The Department proposes reducing the budget neutrality factor for Alternative Care Facilities by 18 percent.

Home- and Community-Based Services were reviewed by the MPRRAC in 2017. Rates were identified as ranging from 36.7 percent to 184.6 percent of the relevant benchmark comparison states. As part of the review, the MPRRAC recommended migrating toward using the values from the Department's new rate setting methodology before the budget neutrality factor as the benchmark for HCBS services, rather than other state Medicaid rates.

ADULT DAY PROGRAMS

The Department requests $3.4 million total funds, including $1.4 million General Fund, for 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. 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 adult day programs as having one of the largest budget neutrality factors. Also, the Department says stakeholders focused on rates for adult day programs as among those most in need of adjustment. The Department proposes reducing the budget neutrality factor for adult day programs by 25.0 percent.

Home- and Community-Based Services were reviewed by the MPRRAC in 2017. Rates were identified as ranging from 36.7 percent to 184.6 percent of the relevant benchmark comparison states. As part of the review, the MPRRAC recommended migrating toward using the values from the Department's new rate setting methodology before the budget neutrality factor as the benchmark for HCBS services, rather than other state Medicaid rates.

BEHAVIORAL HEALTH FEE-FOR-SERVICE

The Department requests $1.6 million total funds, including $875,964 General Fund, for the net impact of rebalancing behavioral health fee-for-services rates to within 80-100 percent of equivalent Medicare rates. The Department indicates that 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. The Medicaid rate covers service costs, but not room and board.

Behavioral health fee-for-service rates, including rates for RCCFs, were reviewed through the S.B. 15-228 process in 2019. Fee-for-service rates for non-RCCFs were 94.5 percent of the Medicare benchmark overall, but individual rates ranged from 22.7 percent to 231.2 percent of the benchmark. The Department found RCCF rates were 68.6 percent of the Medicare benchmark with individual rates falling in a range of 47.0 percent to 100.6 percent of the Medicare benchmark.

In addition to the requested rate changes, the S.B. 15-228 rate review process generated recommendations to: (1) evaluate regulatory requirements regarding the colocation of RCCFs and Psychiatric Residential Treatment Facilities and the impact of the requirements on service delivery; and (2) perform further analysis of whether RCCF and PRTF rates incentivize proper use of each type of facility.

HABILITATION SERVICES IN RESIDENTIAL CHILD CARE FACILITIES

The Department requests $532,362 total funds, including $266,181 General Fund, to increase 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 Department proposes new rates that would be more consistent with those paid to RCCFs by the Department of Human Services for non-Medicaid clients. The new rates would distinguish based on the level of need for the client

These rates were reviewed through the S.B. 15-228 process in 2017 as part of home- and community-based services and the general findings and recommendations on HCBS apply.

FAMILY PLANNING

The Department requests $97,092 total funds, including $9,709 General Fund to increase 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.

AMBULATORY SURGICAL CENTERS

The Department proposes 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. The Department is not proposing any change to the base rates for ambulatory surgical centers other than the across-the-board increase.

Rates for ambulatory surgical centers were reviewed through the S.B. 15-228 process in 2019.

NURSING HOMES

The Department proposes legislation to eliminate a provision in statute that requires nursing home rates to adjust annually by the lesser of actual costs or 3 percent General Fund growth. The proposed change would apply to FY 2020-21 and beyond. Instead, the Department proposes that nursing home rates would be adjusted annually based on appropriations by the General Assembly.

The Department's *R1 Medical Services Premiums* includes an increase of $21.0 million total funds, including $10.5 million General Fund, for the nursing home rate adjustment required by statute. If the General Assembly passed the proposed nursing home legislation, it would undo this increase. Instead, the Department proposes a 0.29 percent increase for nursing homes, consistent with the across-the-board rate increase requested for other services at a cost of $2.0 million total funds, including $1.0 million General Fund. The net result is the requested reduction of $19.0 million total funds, including $9.5 million General Fund.

The Department explains that the request is to address equity issues where other providers do not receive automatic annual increases in rates. According to the Department, the change would not impact service delivery, as providers would still be required to provide the same level of care defined in statute and regulation.

Nursing homes provide 24/7 care to vulnerable populations. Inadequate rates could increase the likelihood of abuse and neglect. Other providers of 24/7 care to vulnerable populations do not receive automatic annual cost-based rate adjustments, such as the Regional Centers, Mental Health Institutes, Private Duty Nursing, and Alternative Care Facilities. These are examples within Medicaid, but there are also examples in other parts of the state budget, such child welfare and community corrections.

Nursing rates are not reviewed through the S.B. 15-228 process, since they adjust annually based on a statutory formula.

H.B. 19-1210 LOCAL GOVERNMENT MINIMUM WAGE

Pursuant to H.B. 19-1210 (Melton & Galindo/Danielson & Moreno), if a local government implements a minimum wage that exceeds the state minimum wage, then the General Assembly "shall" appropriate sufficient funds to pay nursing homes in the jurisdiction the difference in their costs for Medicaid clients.

The final Legislative Council Staff Fiscal Note for H.B. 19-1210 assumed no appropriations for nursing home or other provider rate increases, or administrative costs, would be needed until FY 2020-21, based on the following parameters in the bill:

- House Bill 19-1210 does not take effect until January 1, 2020
- Pursuant to Section 8-6-101 (3)(d), C.R.S.: "Before enacting a minimum wage law, a local government shall consult with surrounding local governments and engage stakeholders, including chambers of commerce, small and large businesses, businesses that employ tipped workers, workers, labor unions, and community groups."

- The only date a local government minimum wage increase can become effective is the same date as a scheduled increase to the statewide minimum wage, i.e. January 1 of each year

There was not a JBC Staff Appropriations Analysis, as the bill was not referred to an appropriations committee in either chamber, but the JBC staff concurs with the Legislative Council Staff Analysis.

Denver's City Council voted to implement a local minimum wage of $12.85 (versus the state rate of $12.00) in 2020. The Denver minimum wage would rise to $14.77 in 2021, $15.87 in 2022, and increase by inflation thereafter. The Colorado Restaurant Association has raised legal questions about whether Denver's process, especially the stakeholder engagement, is consistent with the bill. The Department is still gathering information to estimate the fiscal impact.

ANESTHESIA

The Department proposes a reduction of $6.0 million total funds, including $1.8 million General Fund, to reduce anesthesia rates to 100 percent of Medicare rates. The Department submitted a similar request last year and the General Assembly reduced rates to 120.0 percent of Medicare. As further background, in FY 2015-16 the JBC added money to the budget to increase rates for anesthesia services. This was just prior to the creation of the MPRRAC and the rate review process established in S.B. 15-228. The Department did not submit any new information that differs from last year in support of the request.

Anesthesia rates were reviewed by the MPRRAC in 2017. Aggregate payments were identified as 131.6 percent of the benchmark and no individual service rate was below 100 percent of the benchmark. No issues with access to care were identified, but the way anesthesia services are structured patient panels are determined by the hospital and anesthesiologists do not deny based on insufficient rates paid by particular insurance carriers. The MPRRAC recommended reducing anesthesia rates to 100 percent of the benchmark.

IN-HOME DIALYSIS

The Department requests a reduction of $929,537 total funds, including $292,415 General Fund, to change the way in-home dialysis is billed to align with Medicare practices.

In-home dialysis rates were reviewed through the S.B. 15-228 process in 2019.

DURABLE MEDICAL EQUIPMENT

The Department requests a reduction of $49,244 total funds, including $17,432 General Fund, for the net impact of 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 Upper Payment Limit established by Section 1903(i)(27) of the Social Security Act.

Durable medical equipment rates were reviewed through the S.B. 15-228 process in 2019.

ACROSS-THE-BOARD INCREASE

For providers in other departments, the Governor's request includes a 0.5 percent across-the-board increase, but for providers paid by the Department of Health Care Policy and Financing, the request is for a 0.29 percent across-the-board increase. The reduced amount is to make room in the budget

for the targeted rate increases described above. Rates receiving a targeted increase described above would not be eligible for the across-the-board increase.

As an across-the-board increase, the request does not relate to any specific recommendation from the S.B. 15-228 rate review process.

R8 Accountability and compliance resources

Wage pass through monitoring

The General Assembly has passed multiple bills imposing somewhat similar, but differing requirements for the Department to monitor private entity expenditures on compensation and report to the General Assembly. In some cases, the Department is required to recover funds that are not correctly passed through to employee compensation.

- H.B. 18-1407 Access to disability services and stable workforce (Young & Rankin/Lambert & Moreno) – Required, among other provisions, that the Department increase rates for select home- and community-based services for people with intellectual and developmental disabilities by 6.5 percent and that all of the increase be passed through to compensation for direct support professionals. The bill required the increase in compensation in FY 2018-19 and maintenance of the increase in compensation in FY 2019-20 and FY 2020-21. The Department has "ongoing discretion" to request information about how agencies maintain the wage increases beyond FY 2020-21. The Department is required to recoup costs from agencies that do not pass the increase through to compensation. The Department interprets the recoupment requirement as applying indefinitely. The bill prescribes an appeal process.
- S.B. 19-238 Improve wages and accountability home care workers (Kennedy & Duran/Danielson & Moreno) – Required, among other provisions, that the Department increase rates for personal care and homemaker services by 8.1 percent in FY 2019-20, and that all of the increase be passed through to compensation for personal care and homemaker workers. The bill set an hourly minimum wage for personal care and homemaker workers of $12.41 beginning July 1, 2020. Also, the bill requires that 85 percent of any increase in rates approved by the General Assembly in FY 2020-21 for personal care and homemaker services be used for compensation of non-administrative employees. There are specific reporting requirements to demonstrate compliance for FY 2019-20 and FY 2020-21 and the Department has "ongoing discretion" to request information about how agencies maintain the wage increases beyond FY 2020-21. The Department is required to recoup costs from agencies that do not pass the increase through to compensation in the manner required by the bill, or fail to report. The Department interprets the recoupment requirement as applying indefinitely. The bill prescribes an appeal process.
- H.B. 19-1210 Local government minimum wage (Melton & Galindo/Danielson & Moreno) – Requires, among other provisions, that the Department make enhanced payments to nursing homes equal to the Medicaid share of increased costs for a nursing home that are attributable to a local minimum wage. Eligible nursing homes include those in or adjacent to a local jurisdiction enacting a local minimum wage. The Department may request information from providers on the use of enhanced payments and must recoup payments not used for increased compensation.

The Department was appropriated 2.0 FTE to implement the wage pass-through requirement of H.B. 18-1407. No FTE were initially requested or appropriated to implement S.B. 19-238, but this year the Department is requesting 1.0 FTE as part of *R8 Accountability and compliance resources* for monitoring

adherence to the wage pass-through requirement of S.B. 19-238. The fiscal note for H.B. 19-1210 assumed the Department would need 1.0 FTE to administer the enhanced payments to nursing homes when a local government approved a local minimum wage. The Department requested an annualization of S.B. 19-238 to add the 1.0 FTE in FY 2020-21. With Denver's recent action on a local minimum wage, the JBC staff suspects the Department may submit a supplemental in January requesting the FTE begin in FY 2019-20.

In addition to these statutory requirements for the Department to monitor private entity expenditures on compensation, JBC members have expressed interest in the percentage of provider expenditures on compensation versus other costs. This interest has been expressed in the context of community provider rate setting.

It might be useful for the JBC to discuss with the Department:

1. How could/should the General Assembly minimize the workload for both providers and the Department to comply with the provisions of H.B. 18-1407, S.B. 19-238, and H.B. 19-1210 regarding expenditures on compensation, while maintaining the legislative intent that the specific rate increases be passed through to compensation?
2. What is a reasonable amount of time to track whether providers maintain the compensation increases required by H.B. 18-1407, S.B. 19-238, and H.B. 19-1210? For example, should the compensation requirements of H.B. 18-1407 and S.B. 19-238 expire after FY 2020-21 when the statutory reporting requirements end, or maybe three years later to be consistent with the record retention requirements, or continue indefinitely?
3. How could the General Assembly get more information about the approximate percentage of provider payments used for compensation in the least invasive and burdensome way? For example, could the Department include a survey of a representative sample of the categories of providers under review in a given year as part of the S.B. 15-228 rate review process?

MPRRAC RATE REVIEW SUPPORT

According to the Department, the current level of staffing is barely sufficient to complete the annual rate reviews and required reports. Often the analysis generates additional questions from the MPRRAC and department staff that require follow up to provide a more complete view of the sufficiency of a category of rates. The Department's capacity to research and respond to these questions, and do it in a timely manner, is constrained by a lack of resources. As part of *R8 Accountability and compliance resources*, the Department requests an additional 1.0 FTE to support the S.B. 15-228 rate review process.

MPRRAC CONTRACT RESOURCES

The Department currently has contract resources for actuary services to help with rate comparisons. The Department identified opportunities to enhance the analysis of whether rates are sufficient for provider retention and client access by piggybacking on existing statewide surveys of access to care. The Department would pay for Medicaid-specific questions on the surveys and/or Medicaid specific data analysis of the results from the surveys to explore potential barriers to care such as child care, cultural competency of providers, and transportation as well as population-specific analysis for eligibility categories such as individuals on waivers or immigrants.

R9 BUNDLED PAYMENTS

In *R9 Bundled payments* Department requests $743,065 total funds, including $63,224 General Fund, and 1.9 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.

Under bundled payments a main provider is held accountable for a budgeted cost for the episode of care. The budgeted cost would include a marginal reduction from the current average expenditure based on targeted decreases in potentially avoidable costs. The Department proposes initially paying on the fee-for-service schedule, but with a reconciliation at the end of the episode of care. If costs are lower than the budget, the Department would share some of the savings with the provider. If costs are higher, there would be no penalty for the main provider in the first year, but over time the Department plans to move to a model where the main provider would owe some or all of the difference to the Department. Participation in the bundled payments would be voluntary for providers.

The Department projects modest savings beginning in FY 2020-21, based on conservative estimates of the number of providers who would participate and the targeted reductions. The Department expects the savings would increase over time.

Maternity rates were reviewed by the MPRRAC in 2018. Rates were identified as 69.5 percent of the benchmark, but in FY 2019-20 the Department received funding to increase rates to 80 percent of the benchmark. Medicaid is the largest payer of maternity services in Colorado and covers roughly 45 percent of births. The MPRRAC recommended increasing rates to 90 percent of the benchmark, arguing that access may appear sufficient because Medicaid is the largest payer and so providers have limited alternatives. Also, individual rates appear uniformly lower than the relevant benchmark comparison. The Department proposed and the General Assembly approved a more limited increase. In addition, the Department proposed incorporating maternity services into performance based payments. Bundled payments is a type of performance payment. House Bill 17-1353 authorized the Department to make performance-based payments. Prior to implementing a new performance-based payment, the Department must submit to the JBC either evidence that the payments are designed to achieve budget savings or a budget request for costs associated with the performance-based payments, an estimate of the performance-based payments compared to total reimbursements for the affected service, and a description of the stakeholder engagement process and the Department's response to stakeholder feedback.

ISSUE: PHARMACY (R7)

The Department proposes initiatives to contain pharmaceutical costs.

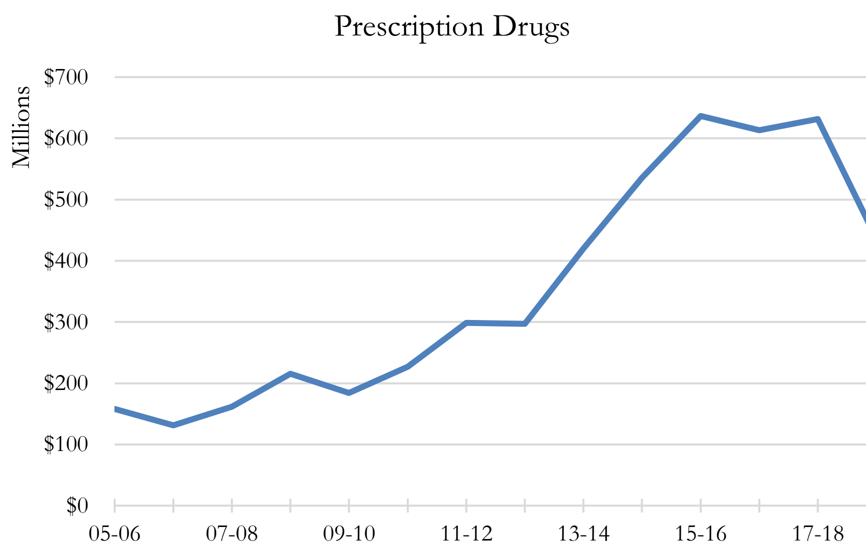
SUMMARY

- A theme throughout the Department's request is containing the increasing costs of pharmaceuticals, but the expenditures per enrollee have remained relatively constant.
- In *R7 Pharmacy pricing and technology* the Department proposes: decreasing rates for new specialty drugs and physician administered drugs; legislation to allow the Department to access the Prescription Drug Monitoring Program; a true-up for delays in implementing a prescriber tool and increased development and maintenance costs for the tool; and additional FTE to administer the pharmacy benefit.
- The Department continues to work on a plan to import prescription drugs from Canada pursuant to S.B. 19-005 and expects to submit an application for federal approval in February 2020.

DISCUSSION

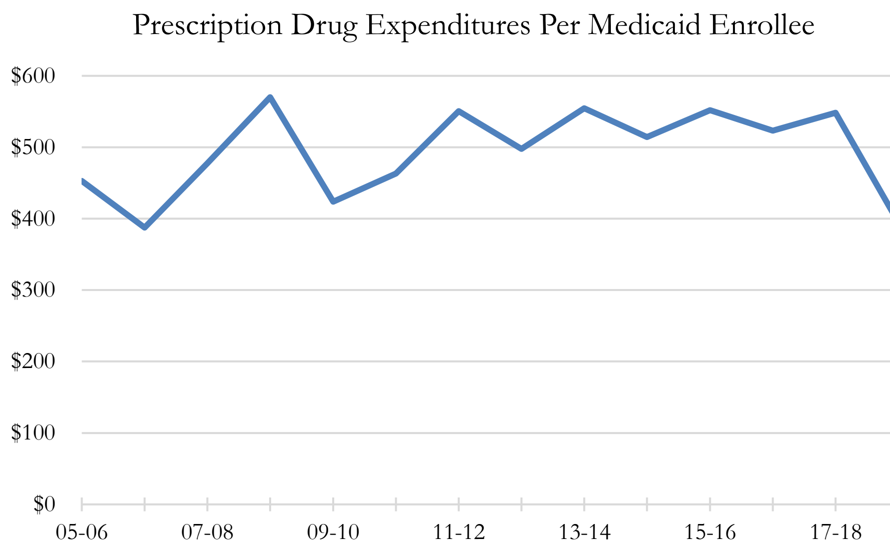
A theme in the Department's request and long-range financial plan is controlling the cost of pharmaceuticals. The Department specifically highlights the increasing costs for physician administered drugs and new specialty drugs for rare conditions. The Department is required by federal regulation to cover the specialty drugs if the drugs are approved by the federal Food and Drug Administration and provide a rebate.

The table below shows the net Medicaid expenditure for prescription drugs after rebates and illustrates a dramatic rise in costs, at least until FY 2018-19. The Department does not forecast prescription drug expenditures separately from per capita expenditures for acute care.



The next table shows the prescription drug expenditures per Medicaid enrollee. There are some data inconsistency issues as the analysis reaches further back in time, beginning in FY 2014-15 and in FY

2011-12, but the impact on the overall trend is marginal and the JBC staff decided to include the older years to show how stable the expenditures per capita have been over time.



These tables say nothing qualitative about whether the current level of expenditure for pharmaceuticals is appropriate. Nor do they explain why the expenditure per capita has remained within a relatively narrow band. It may have something to do with cost containment measures the Department has implemented over the years. However, the tables do provide an interesting counter narrative to the Department's alarms that prescription drug expenditures are exploding. Yes, utilization and expenditures for physician administered drugs are increasing rapidly and yes the prices for new specialty drugs for rare conditions are often astronomical, but the program is achieving higher adherence to drug regimens with long lasting physician administered drugs and people are getting miracle cures from new specialty drugs and all the while the net cost per capita after rebates remains largely unchanged for Medicaid.

R7 Pharmacy pricing and technology

Through *R7 Pharmacy pricing and technology* the Department requests $4.6 million total funds, including $1.2 General Fund, and 5.0 FTE for initiatives to ensure appropriate utilization of drugs and to control pharmacy and physician administered drug expenditures.

- Prescription drug rate setting – $124,813 total funds, including $41,191 General Fund, and 1.0 FTE, for a different methodology for pricing new drugs when the Average Acquisition Cost is not known. Beginning in FY 2021-22 the Department would need an additional $250,000 total funds, including $82,500 General Fund, for contractor costs for the initiative.
- Physician administered drug rate setting – $138,000 total funds, including $20,752 General Fund, for a different methodology for pricing physician administered drugs. The amount required increases to $300,000 total funds and $99,000 General Fund in FY 2021-22,
- Prescription Drug Monitoring Program – $907,142 total funds, including $89,866 General Fund, to integrate data from the Prescription Drug Monitoring Program into the Department's pharmacy claims processing system. ***This requires a statutory change to allow the Department access to the statutorily restricted Prescription Drug Monitoring Program.***

- Prescriber tool true-up – $2.9 million total funds, including $833,910 General Fund, primarily for higher than expected costs for a prescriber tool required by S.B. 18-266 (Controlling Medicaid Costs, sponsored by the JBC) that will help providers identify the most cost effective medications based on diagnosis information, but including $406,800 total funds and $24,258 General Fund to expand the scope of the prescriber tool to integrate enrollment and eligibility information for other public benefits that may improve health outcomes for the patient. An associated supplemental will be submitted in January for $7.1 million total funds, including $1.4 million General Fund, in FY 2019-20. The supplemental includes $1.8 million federal funds for additional development costs and $5.3 million total funds and $1.4 million General Fund for delays in achieving the projected savings from implementing the prescriber tool.
- Administration – $506,150 total funds, including $167,031 General Fund, and 4.0 FTE to address pharmacy appeals claims and expand the capacity of the Department to study and pursue pharmacy cost containment initiatives.

RATE SETTING

For the prescription drug rate setting and physician administered drug rate setting the Department is proposing methodologies that will decrease overall payments to providers, although the rates for some drugs may increase. In both cases the goal is to pay at cost.

For prescription drugs the issue is with new drugs where the Department's survey tools have not had a chance to determine cost and so the rate defaults to essentially the manufacturer's list price, which the Department believes is inflated. The Department proposes a method that would establish a maximum allowable cost for each of these new drugs that would be below the manufacturer's list price. The maximum allowable cost would control the price until the Department's survey tools establish average acquisition cost. The Department expects rates will decrease across the board.

For physician administered drugs the concern is that the Department does not currently have survey tools to determine cost and so the rate defaults to a national average sales price that is self-reported by manufacturers plus 2.5 percent. The Department proposes a Colorado-specific survey tool to establish cost for physician administered drugs just like the survey tool used to determine cost for prescription drugs. Some rates may increase and some may decrease, but the Department expects a net reduction in expenditures.

PRESCRIPTION DRUG MONITORING

The Department proposes legislation to allow the Department access to the Prescription Drug Monitoring Program (PDMP) that contains information from pharmacies on prescriptions for controlled medications. The Department currently has access to Medicaid claims for controlled medications, but cannot collect data on prescriptions outside of Medicaid. The Department is concerned this hides the full impact of changes in prescription drug policies, misses opportunities to coordinate care for people with substance use disorders, prevents the Department from identifying fraud, and inhibits the Department's ability to enforce federal requirements for providers to consult the PDMP before prescribing.

PRESCRIBER TOOL

The Department was appropriated $1.0 million to develop a prescriber tool in FY 2018-19 as part of S.B. 18-266 (Controlling Medicaid Costs, sponsored by the JBC). The Department spent $89,000 to gather information, facilitate stakeholder engagement, draft requests for information from potential

vendors, and draft an Invitation to Negotiate. The remainder reverted due to an inability to reach an agreement with a contractor within the appropriated funding.

The Department now projects development will cost $2.3 million. Similarly, ongoing costs were originally estimated at $500,000 annually and now the Department is projecting ongoing costs of $3.0 million annually. The Department explains that it did not fully understand the scope of development work and did not account for costs to create necessary data interfaces. As for ongoing maintenance costs, the Department did not have information from potential vendors when it submitted the request and is not aware of any other states that have implemented a similar tool.

The Department is still negotiating with vendors and the revised estimates are based on feedback from the vendors and experience with the assessment tool authorized by S.B. 16-192 for people with intellectual and developmental disabilities.

Of the development cost, $406,800 is to expand the scope of the project and the remaining $1,799,357 (plus the $89,000 already spent in FY 2018-19) is for delivery of the originally envisioned prescriber tool. The new functionality the Department proposes adding is an interface with the Joint Agency Interoperability (JAI) project. The JAI contains information on whether a member is eligible for other social services. Linking the prescriber tool to the JAI would give physicians access to information about other public benefits that might improve a member's health and well being.

IMPORT PRESCRIPTION DRUGS

Senate Bill 19-005 Import prescription drugs from Canada (Jaquez Lewis/Rodriquez & Ginal) requires the Department to submit a request for federal approval of a program to import prescription drugs from Canada. The Department reports that it has been gathering information and soliciting feedback from stakeholders. Requests for Information closed November 8, 2019 and the Department recently started drafting an application with a goal of submitting it in mid-February. The federal government announced plans to issue draft importation regulations in January that may require the Department to revise the application before submission.

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Kim Bimestefer, Executive Director

(1) EXECUTIVE DIRECTOR'S OFFICE

Primary functions: Provides all of the administrative, audit and oversight functions for the Department.

(A) General Administration

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Personal Services	35,581,470	37,703,273	38,610,714	43,328,051 *	
FTE	467.3	487.2	500.0	538.3	
General Fund	10,518,571	12,462,698	13,478,948	15,511,417	
Cash Funds	2,985,184	3,139,901	3,571,232	4,094,384	
Reappropriated Funds	1,253,594	1,504,656	2,436,543	2,305,357	
Federal Funds	20,824,121	20,596,018	19,123,991	21,416,893	
Health, Life, and Dental	3,637,126	4,647,883	4,790,328	6,401,225 *	
General Fund	1,305,776	1,582,649	1,700,447	2,339,493	
Cash Funds	344,132	399,501	421,237	575,032	
Reappropriated Funds	103,855	120,704	126,088	138,532	
Federal Funds	1,883,363	2,545,029	2,542,556	3,348,168	
Short-term Disability	58,060	60,727	66,598	76,334 *	
General Fund	21,586	21,164	24,002	28,480	
Cash Funds	4,802	5,213	5,301	6,070	
Reappropriated Funds	1,364	1,241	2,206	1,639	
Federal Funds	30,308	33,109	35,089	40,145	

Appendix A: Numbers Pages

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	1,615,047	1,855,596	1,984,802	2,304,395	*
General Fund	600,398	645,855	722,807	859,057	
Cash Funds	133,634	159,439	159,398	183,229	
Reappropriated Funds	37,970	39,274	46,310	49,606	
Federal Funds	843,045	1,011,028	1,056,287	1,212,503	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	1,615,047	1,855,596	1,984,802	2,304,395	*
General Fund	600,398	645,856	722,807	859,057	
Cash Funds	133,634	159,439	159,398	183,229	
Reappropriated Funds	37,970	39,271	46,310	49,606	
Federal Funds	843,045	1,011,030	1,056,287	1,212,503	
PERA Direct Distribution	0	0	1,010,190	978,380	
General Fund	0	0	369,193	363,859	
Cash Funds	0	0	81,734	74,861	
Reappropriated Funds	0	0	20,451	22,307	
Federal Funds	0	0	538,812	517,353	
Salary Survey	614,974	1,203,861	1,305,312	957,481	
General Fund	228,651	416,661	478,526	356,514	
Cash Funds	50,834	103,653	104,700	72,776	
Reappropriated Funds	14,443	29,534	26,282	21,855	
Federal Funds	321,046	654,013	695,804	506,336	

Appendix A: Numbers Pages

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Worker's Compensation	65,937	98,914	110,194	128,681	
General Fund	32,969	40,940	45,686	53,352	
Cash Funds	0	8,517	9,410	10,988	
Reappropriated Funds	0	0	0	0	
Federal Funds	32,968	49,457	55,098	64,341	
Parental Leave	0	0	0	33,121	
General Fund	0	0	0	12,331	
Cash Funds	0	0	0	2,518	
Reappropriated Funds	0	0	0	757	
Federal Funds	0	0	0	17,515	
Operating Expenses	2,010,100	2,319,600	2,506,384	2,551,971 *	
General Fund	903,223	936,623	1,014,866	1,044,581	
Cash Funds	74,170	239,823	243,961	234,953	
Reappropriated Funds	26,219	13,297	13,297	13,297	
Federal Funds	1,006,488	1,129,857	1,234,260	1,259,140	
Legal Services	1,114,404	1,287,013	1,622,537	1,319,398	
General Fund	360,582	415,700	616,206	524,513	
Cash Funds	196,620	227,806	262,423	207,727	
Reappropriated Funds	0	0	0	0	
Federal Funds	557,202	643,507	743,908	587,158	
Administrative Law Judge Services	647,622	589,791	664,251	736,736	
General Fund	251,642	244,113	275,398	305,450	
Cash Funds	72,169	50,782	56,728	62,918	
Reappropriated Funds	0	0	0	0	
Federal Funds	323,811	294,896	332,125	368,368	

Appendix A: Numbers Pages

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Payment to Risk Management and Property Funds	128,274	93,002	121,583	113,058	
General Fund	64,137	38,495	50,411	46,878	
Cash Funds	0	8,006	10,381	9,652	
Reappropriated Funds	0	0	0	0	
Federal Funds	64,137	46,501	60,791	56,528	
Leased Space	2,303,824	2,379,673	2,514,035	2,625,154 *	
General Fund	904,547	988,946	1,042,319	1,088,389	
Cash Funds	247,365	216,459	214,699	224,189	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,151,912	1,174,268	1,257,017	1,312,576	
Capitol Complex Leased Space	666,217	612,044	548,523	578,729	
General Fund	333,109	253,325	227,415	239,939	
Cash Funds	0	52,697	46,846	49,425	
Reappropriated Funds	0	0	0	0	
Federal Funds	333,108	306,022	274,262	289,365	
Payments to OIT	5,314,055	5,551,743	8,377,137	9,921,147 *	
General Fund	2,226,587	2,298,099	3,263,023	4,045,796	
Cash Funds	430,440	477,834	893,637	1,066,678	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,657,028	2,775,810	4,220,477	4,808,673	
CORE Operations	1,583,166	1,376,873	139,804	185,135	
General Fund	577,669	607,623	61,794	81,830	
Cash Funds	257,301	118,548	11,940	15,811	
Reappropriated Funds	0	0	0	0	
Federal Funds	748,196	650,702	66,070	87,494	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
General Professional Services and Special Projects	6,518,315	8,341,699	21,581,862	22,625,149 *	
General Fund	2,380,873	2,930,533	6,015,380	6,151,089	
Cash Funds	1,350,247	1,142,096	2,615,231	3,357,404	
Reappropriated Funds	150,000	150,000	150,000	150,000	
Federal Funds	2,637,195	4,119,070	12,801,251	12,966,656	
Merit Pay	291,490	0	0	0	
General Fund	106,662	0	0	0	
Cash Funds	25,682	0	0	0	
Reappropriated Funds	7,235	0	0	0	
Federal Funds	151,911	0	0	0	
Scholarships for research using the All-Payer Claims Database	524,656	0	0	0	
General Fund	524,656	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (A) General Administration	64,289,784	69,977,288	87,939,056	97,168,540	10.5%
FTE	467.3	487.2	500.0	538.3	7.7%
General Fund	21,942,036	24,529,280	30,109,228	33,912,025	12.6%
Cash Funds	6,306,214	6,509,714	8,868,256	10,431,844	17.6%
Reappropriated Funds	1,632,650	1,897,977	2,867,487	2,752,956	(4.0%)
Federal Funds	34,408,884	37,040,317	46,094,085	50,071,715	8.6%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	179,365	183,818	185,814	185,814	
General Fund	0	91,909	92,907	92,907	
Cash Funds	0	0	0	0	
Reappropriated Funds	179,365	0	0	0	
Federal Funds	0	91,909	92,907	92,907	
Nurse Home Visitor Program, Human Services	47,012	146,921	3,010,000	3,010,000	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	23,128	73,711	1,505,000	1,505,000	
Federal Funds	23,884	73,210	1,505,000	1,505,000	
Host Home Regulation, Local Affairs	0	0	112,029	117,264	
General Fund	0	0	56,015	58,632	
Federal Funds	0	0	56,014	58,632	
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	219,356	219,356	280,396	294,627	
General Fund	109,678	109,678	140,198	147,314	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	109,678	109,678	140,198	147,313	

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Facility Survey and Certification, Public Health and Environment	6,773,203	7,189,497	8,328,694	8,904,679 *	
General Fund	2,343,497	2,450,839	3,139,116	3,381,182	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,429,706	4,738,658	5,189,578	5,523,497	
Local Public Health Agencies, Public Health and Environment	360,484	364,089	735,459	739,136 *	
General Fund	360,484	364,089	367,730	369,567	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	367,729	369,569	
Prenatal Statistical Information, Public Health and Environment	5,887	5,887	5,887	5,887	
General Fund	2,943	2,943	2,944	2,944	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,944	2,944	2,943	2,943	
Nurse Aide Certification, Regulatory Agencies	324,041	324,041	324,041	324,041	
General Fund	147,368	147,369	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,652	14,651	14,652	14,652	
Federal Funds	162,021	162,021	162,020	162,020	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Regulation of Medicaid Transportation Providers, Regulatory Agencies	93,027	98,369	103,503	103,503	
General Fund	55,528	60,869	66,003	66,003	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	37,499	37,500	37,500	37,500	
Reviews, Regulatory Agencies	5,120	0	3,750	3,750	
General Fund	2,560	0	1,875	1,875	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,560	0	1,875	1,875	
OeHI Operating, Governor's Office	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (B) Transfers to Other Departments	8,007,495	8,531,978	13,089,573	13,688,701	4.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	3,022,058	3,227,696	4,014,157	4,267,793	6.3%
Cash Funds	0	0	0	0	0.0%
Reappropriated Funds	217,145	88,362	1,519,652	1,519,652	0.0%
Federal Funds	4,768,292	5,215,920	7,555,764	7,901,256	4.6%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	33,149,521	36,020,880	74,893,151	84,742,876 *	
General Fund	4,951,401	4,872,910	9,972,677	11,382,852	
Cash Funds	3,584,734	3,018,314	6,385,552	7,209,438	
Reappropriated Funds	11,808	12,182	12,204	12,204	
Federal Funds	24,601,578	28,117,474	58,522,718	66,138,382	
Colorado Benefits Management Systems, Operating and Contract Expenses	25,851,203	38,745,510	48,948,646	48,832,438 *	
General Fund	4,914,547	7,485,104	10,408,786	10,275,439	
Cash Funds	2,721,479	2,955,099	5,665,211	5,926,858	
Reappropriated Funds	8,740	295	2,563	2,577	
Federal Funds	18,206,437	28,305,012	32,872,086	32,627,564	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	861,539	1,683,161	1,958,393	2,022,423 *	
General Fund	312,261	543,479	632,172	653,040	
Cash Funds	149,609	268,358	320,480	341,206	
Reappropriated Funds	260	105	105	107	
Federal Funds	399,409	871,219	1,005,636	1,028,070	
Health Information Exchange Maintenance and Projects	7,481,177	8,551,960	7,603,629	7,603,629	
General Fund	821,423	1,904,121	1,916,101	1,916,101	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,659,754	6,647,839	5,687,528	5,687,528	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Office of eHealth Innovations Operations	0	0	1,958,154	6,465,845	
FTE	0.0	0.0	2.7	3.0	
General Fund	0	0	961,017	3,372,367	
Federal Funds	0	0	997,137	3,093,478	
State Innovation Model Operations	0	0	202,434	0	
FTE	0.0	0.0	1.5	0.0	
General Fund	0	0	202,434	0	
Connect for Health Colorado Systems	669,757	669,757	669,757	669,757	
General Fund	0	0	0	0	
Cash Funds	122,690	122,690	122,690	122,690	
Reappropriated Funds	0	0	0	0	
Federal Funds	547,067	547,067	547,067	547,067	
All-Payer Claims Database	0	2,281,218	4,869,731	5,005,153	
General Fund	0	1,390,609	4,036,464	4,171,886	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	890,609	833,267	833,267	
Fraud Detection Software Contract	115,000	0	0	0	
General Fund	28,345	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	86,655	0	0	0	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
MMIS Reprocurement Contracts	11,338,757	0	0	0	
General Fund	500,311	0	0	0	
Cash Funds	748,910	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	10,089,536	0	0	0	
MMIS Reprocurement Contracted Staff	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (C) Information Technology Contracts and Projects	79,466,954	87,952,486	141,103,895	155,342,121	10.1%
FTE	0.0	0.0	4.2	3.0	(28.6%)
General Fund	11,528,288	16,196,223	28,129,651	31,771,685	12.9%
Cash Funds	7,327,422	6,364,461	12,493,933	13,600,192	8.9%
Reappropriated Funds	20,808	12,582	14,872	14,888	0.1%
Federal Funds	60,590,436	65,379,220	100,465,439	109,955,356	9.4%
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	127,993	79,329	278,974	278,974	
General Fund	40,299	23,557	90,988	90,988	
Cash Funds	20,749	13,201	44,587	44,587	
Reappropriated Funds	13	8	28	28	
Federal Funds	66,932	42,563	143,371	143,371	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Contracts for Special Eligibility Determinations	8,650,653	7,880,842	11,402,297	11,402,297	
General Fund	969,756	725,932	969,756	969,756	
Cash Funds	2,968,513	2,714,397	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,712,384	4,440,513	6,089,073	6,089,073	
County Administration	62,286,444	72,446,452	88,984,286	89,323,459 *	
General Fund	12,003,877	11,114,448	12,590,592	12,638,698	
Cash Funds	4,945,446	13,304,380	21,423,565	21,505,191	
Reappropriated Funds	0	0	0	0	
Federal Funds	45,337,121	48,027,624	54,970,129	55,179,570	
Medical Assistance Sites	1,517,448	868,269	1,531,968	1,531,968	
General Fund	0	0	0	0	
Cash Funds	402,984	402,984	402,984	402,984	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,114,464	465,285	1,128,984	1,128,984	
Administrative Case Management	2,344,964	895,924	869,744	869,744	
General Fund	1,172,482	447,962	434,872	434,872	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,172,482	447,962	434,872	434,872	
Customer Outreach	5,634,464	5,039,568	6,117,542	6,110,445	
General Fund	2,477,718	2,183,163	2,722,151	2,718,602	
Cash Funds	336,621	336,620	336,621	336,621	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,820,125	2,519,785	3,058,770	3,055,222	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Centralized Eligibility Vendor Contract Project	3,475,879	3,546,710	5,053,644	5,053,644	
General Fund	0	0	0	0	
Cash Funds	1,189,823	1,132,409	1,745,342	1,745,342	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,286,056	2,414,301	3,308,302	3,308,302	
Connect for Health Colorado Eligibility Determination	4,474,451	4,474,451	4,474,451	4,474,451	
General Fund	0	0	0	0	
Cash Funds	1,667,767	1,667,767	1,667,767	1,667,767	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,806,684	2,806,684	2,806,684	2,806,684	
Retuned Mail Processing	0	0	0	3,298,808	
General Fund	0	0	0	985,808	
Cash Funds	0	0	0	244,919	
Reappropriated Funds	0	0	0	111,942	
Federal Funds	0	0	0	1,956,139	
Work Number Verification	0	0	0	1,531,649 *	
General Fund	0	0	0	505,040	
Cash Funds	0	0	0	252,569	
Federal Funds	0	0	0	774,040	
Hospital Provider Fee County Administration	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
SUBTOTAL - (D) Eligibility Determinations and Client Services	88,512,296	95,231,545	118,712,906	123,875,439	4.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	16,664,132	14,495,062	16,808,359	18,343,764	9.1%
Cash Funds	11,531,903	19,571,758	29,964,334	30,543,448	1.9%
Reappropriated Funds	13	8	28	111,970	399792.9%
Federal Funds	60,316,248	61,164,717	71,940,185	74,876,257	4.1%

(E) Utilization and Quality Review Contracts

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Professional Service Contracts	10,001,762	13,483,877	22,864,305	23,007,308 *	
General Fund	3,331,922	5,064,552	5,808,855	6,697,615	
Cash Funds	386,847	777,576	1,587,101	1,671,546	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,282,993	7,641,749	15,468,349	14,638,147	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
SUBTOTAL - (E) Utilization and Quality Review Contracts	10,001,762	13,483,877	22,864,305	23,007,308	0.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	3,331,922	5,064,552	5,808,855	6,697,615	15.3%
Cash Funds	386,847	777,576	1,587,101	1,671,546	5.3%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	6,282,993	7,641,749	15,468,349	14,638,147	(5.4%)

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(F) Provider Audits and Services					
Professional Audit Contracts	3,096,366	3,222,331	4,891,358	5,564,382	
General Fund	1,244,805	1,284,922	1,758,484	1,947,780	
Cash Funds	312,420	418,931	629,262	741,195	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,539,141	1,518,478	2,503,612	2,875,407	
SUBTOTAL - (F) Provider Audits and Services	3,096,366	3,222,331	4,891,358	5,564,382	13.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,244,805	1,284,922	1,758,484	1,947,780	10.8%
Cash Funds	312,420	418,931	629,262	741,195	17.8%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,539,141	1,518,478	2,503,612	2,875,407	14.9%
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	657,215	979,058	700,000	700,000	
General Fund	0	0	0	0	
Cash Funds	328,880	489,529	350,000	350,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	328,335	489,529	350,000	350,000	
Third-Party Liability Cost Avoidance Contract	0	0	0	16,337,967 *	
General Fund	0	0	0	5,391,529	
Cash Funds	0	0	0	2,777,454	
Federal Funds	0	0	0	8,168,984	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	657,215	979,058	700,000	17,037,967	2334.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	5,391,529	0.0%
Cash Funds	328,880	489,529	350,000	3,127,454	793.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	328,335	489,529	350,000	8,518,984	2334.0%
(H) Indirect Cost Assessment					
Indirect Cost Assessment	695,563	742,653	1,465,996	1,303,087	
General Fund	0	0	0	0	
Cash Funds	257,456	305,445	304,937	364,495	
Reappropriated Funds	0	0	112,343	0	
Federal Funds	438,107	437,208	1,048,716	938,592	
SUBTOTAL - (H) Indirect Cost Assessment	695,563	742,653	1,465,996	1,303,087	(11.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	257,456	305,445	304,937	364,495	19.5%
Reappropriated Funds	0	0	112,343	0	(100.0%)
Federal Funds	438,107	437,208	1,048,716	938,592	(10.5%)
TOTAL - (1) Executive Director's Office	254,727,435	280,121,216	390,767,089	436,987,545	11.8%
FTE	467.3	487.2	504.2	541.3	7.4%
General Fund	57,733,241	64,797,735	86,628,734	102,332,191	18.1%
Cash Funds	26,451,142	34,437,414	54,197,823	60,480,174	11.6%
Reappropriated Funds	1,870,616	1,998,929	4,514,382	4,399,466	(2.5%)
Federal Funds	168,672,436	178,887,138	245,426,150	269,775,714	9.9%

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request		Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS						
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.						
Medical and Long-Term Care Services for Medicaid Eligible Individuals	7,479,971,210	7,765,936,096	7,895,417,528	8,214,276,465	*	
General Fund	1,273,703,036	1,313,952,241	1,387,975,341	1,477,971,305		
General Fund Exempt	820,701,666	885,333,333	897,710,833	897,710,833		
Cash Funds	879,977,682	1,044,630,341	983,543,298	1,139,165,014		
Reappropriated Funds	71,040,487	79,143,322	88,876,290	88,876,290		
Federal Funds	4,434,548,339	4,442,876,859	4,537,311,766	4,610,553,023		
TOTAL - (2) Medical Services Premiums	7,479,971,210	7,765,936,096	7,895,417,528	8,214,276,465		4.0%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	1,273,703,036	1,313,952,241	1,387,975,341	1,477,971,305		6.5%
General Fund Exempt	820,701,666	885,333,333	897,710,833	897,710,833		0.0%
Cash Funds	879,977,682	1,044,630,341	983,543,298	1,139,165,014		15.8%
Reappropriated Funds	71,040,487	79,143,322	88,876,290	88,876,290		0.0%
Federal Funds	4,434,548,339	4,442,876,859	4,537,311,766	4,610,553,023		1.6%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request		Request vs. Appropriation

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

This section provides funding for the purchase of behavioral healthcare services through administrative entities. Prior to July 1, 2018, these entities were "behavioral health organizations" (BHOs); as of July 1, 2018, "regional accountable entities" (RAEs) perform this function. Each RAE manages mental health and substance use disorder services for eligible Medicaid clients within a specified region through a capitated, risk-based funding model. This section of the budget also provides funding for Medicaid behavioral health fee-for-service programs for those mental health and substance use disorder services not covered within the capitation contracts and rates. This section is primarily supported by federal Medicaid funds, General Fund, and the Colorado Healthcare Affordability and Sustainability Cash Fund.

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request		Request vs. Appropriation
Behavioral Health Capitation Payments	512,884,063	615,097,094	712,830,202	840,856,117	*	
General Fund	171,717,548	179,075,725	199,508,367	229,776,392		
Cash Funds	21,637,199	28,513,064	37,852,285	50,995,361		
Reappropriated Funds	0	0	0	0		
Federal Funds	319,529,316	407,508,305	475,469,550	560,084,364		
Behavioral Health Fee-for-service Payments	9,300,665	10,625,080	10,244,233	10,467,522	*	
General Fund	2,093,383	2,465,737	2,363,894	2,443,428		
Cash Funds	355,200	336,984	533,495	685,708		
Reappropriated Funds	0	0	0	0		
Federal Funds	6,852,082	7,822,359	7,346,844	7,338,386		
TOTAL - (3) Behavioral Health Community Programs	522,184,728	625,722,174	723,074,435	851,323,639		17.7%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	173,810,931	181,541,462	201,872,261	232,219,820		15.0%
Cash Funds	21,992,399	28,850,048	38,385,780	51,681,069		34.6%
Reappropriated Funds	0	0	0	0		0.0%
Federal Funds	326,381,398	415,330,664	482,816,394	567,422,750		17.5%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	3,285,003	3,517,058	3,600,329	3,469,613	
FTE	36.3	40.4	40.4	37.5	
General Fund	1,572,568	1,609,873	1,678,414	1,604,210	
Cash Funds	189,649	309,731	247,286	254,270	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,522,786	1,597,454	1,674,629	1,611,133	
Operating Expenses	180,695	290,560	297,166	281,510	
General Fund	120,935	116,311	120,089	112,261	
Cash Funds	850	53,325	52,375	52,375	
Reappropriated Funds	0	0	0	0	
Federal Funds	58,910	120,924	124,702	116,874	
Community and Contract Management System	61,583	120,153	137,480	137,480	
General Fund	34,532	89,362	89,362	89,362	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	27,051	30,791	48,118	48,118	
Support Level Administration	48,284	41,504	57,437	57,437	
General Fund	23,966	20,752	28,463	28,463	
Cash Funds	176	0	255	255	
Reappropriated Funds	0	0	0	0	
Federal Funds	24,142	20,752	28,719	28,719	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Cross-system Response for behavioral Health Crises Pilot Program	0	0	0	0	
FTE	0.0	0.0	0.0	0.0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Cross-System Response Pilot Program Services	836,976	294,797	0	0	
General Fund	0	0	0	0	
Cash Funds	836,976	294,797	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	4,412,541	4,264,072	4,092,412	3,946,040	(3.6%)
FTE	36.3	40.4	40.4	37.5	(7.2%)
General Fund	1,752,001	1,836,298	1,916,328	1,834,296	(4.3%)
Cash Funds	1,027,651	657,853	299,916	306,900	2.3%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,632,889	1,769,921	1,876,168	1,804,844	(3.8%)
Medicaid Programs					
Home and Community Based Services for People with Intellectual and Developmental Disabilities	611,865,306 *				
General Fund	304,609,815				
Cash Funds	1,528,123				
Federal Funds	305,727,368				

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Case Management Services	91,916,420	*			
General Fund	46,921,092				
Cash Funds	150,471				
Federal Funds	44,844,857				
SUBTOTAL -	703,781,726				0.0%
FTE	0.0				0.0%
General Fund	351,530,907				0.0%
Cash Funds	1,678,594				0.0%
Federal Funds	350,572,225				0.0%
State-only Programs					
State-only Programs for People with Intellectual and Developmental Disabilities	20,430,614	*			
General Fund	17,867,092				
Cash Funds	2,563,522				
SUBTOTAL -	20,430,614				0.0%
FTE	0.0				0.0%
General Fund	17,867,092				0.0%
Cash Funds	2,563,522				0.0%
(ii) Program Costs					
Adult Comprehensive Services	376,789,194	422,158,278	503,255,278	33,893,795 *	
General Fund	185,276,275	211,075,860	248,117,256	16,946,897	
Cash Funds	5,237,790	1	3,510,383	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	186,275,129	211,082,417	251,627,639	16,946,898	

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Adult Supported Living Services	73,391,697	71,923,084	86,732,157	2,885,938	*
General Fund	41,146,345	39,692,898	45,959,837	1,583,633	
Cash Funds	98,901	215,121	2,676,085	(448,762)	
Reappropriated Funds	0	0	0	0	
Federal Funds	32,146,451	32,015,065	38,096,235	1,751,067	
Children's Extensive Support Services	25,698,430	23,559,172	27,062,419	3,073,232	*
General Fund	13,377,407	11,779,537	13,531,210	1,536,617	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	12,321,023	11,779,635	13,531,209	1,536,615	
Children's Habilitation Residential Program	0	1,587,406	5,152,220	257,093	*
General Fund	0	793,703	2,576,110	128,546	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	793,703	2,576,110	128,547	
Case Management	32,189,643	37,005,361	45,206,293	(1,989,807)	*
General Fund	17,123,782	19,503,120	23,571,393	(1,227,599)	
Cash Funds	7,879	55,288	150,346	194,546	
Reappropriated Funds	0	0	0	0	
Federal Funds	15,057,982	17,446,953	21,484,554	(956,754)	
Family Support Services	7,058,033	7,055,036	7,811,600	(213,308)	*
General Fund	7,058,033	7,055,036	7,196,645	19,150	
Cash Funds	0	0	614,955	(232,458)	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request		Request vs. Appropriation
Preventive Dental Hygiene	64,199	64,792	65,445	65,673	*	
General Fund	64,199	64,792	65,445	65,673		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	0	0	0	0		
Eligibility Determination and Waiting List Management	3,141,113	2,926,331	3,197,573	8,427	*	
General Fund	3,119,752	2,906,118	3,197,573	8,371		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	21,361	20,213	0	56		
Supported Employment Provider and Certification Reimbursement	0	0	303,158	303,158		
General Fund	0	0	303,158	303,158		
Supported Employment Pilot Program	0	0	500,000	500,000		
Cash Funds	0	0	500,000	500,000		
SUBTOTAL -	518,332,309	566,279,460	679,286,143	38,784,201		(94.3%)
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	267,165,793	292,871,064	344,518,627	19,364,446		(94.4%)
Cash Funds	5,344,570	270,410	7,451,769	13,326		(99.8%)
Reappropriated Funds	0	0	0	0		0.0%
Federal Funds	245,821,946	273,137,986	327,315,747	19,406,429		(94.1%)

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
TOTAL - (4) Office of Community Living	522,744,850	570,543,532	683,378,555	766,942,581	12.2%
FTE	36.3	40.4	40.4	37.5	(7.2%)
General Fund	268,917,794	294,707,362	346,434,955	390,596,741	12.7%
Cash Funds	6,372,221	928,263	7,751,685	4,562,342	(41.1%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	247,454,835	274,907,907	329,191,915	371,783,498	12.9%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	298,355,771	310,821,868	311,296,186	219,536,613 *	
General Fund	0	0	0	0	
Cash Funds	149,107,296	155,410,934	155,648,093	109,768,307	
Reappropriated Funds	0	0	0	0	
Federal Funds	149,248,475	155,410,934	155,648,093	109,768,306	
Clinic Based Indigent Care	6,119,760	6,062,032	6,079,573	6,079,573	
General Fund	3,059,579	3,031,016	3,019,693	3,019,693	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,060,181	3,031,016	3,059,880	3,059,880	
Pediatric Specialty Hospital	13,455,012	13,455,012	13,455,012	13,455,012	
General Fund	6,726,833	6,727,506	6,727,506	6,727,506	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,728,179	6,727,506	6,727,506	6,727,506	
Appropriation from Tobacco Tax Fund to the General Fund	413,092	401,922	407,703	388,452	
General Fund	0	(27,987)	0	0	
Cash Funds	413,092	429,909	407,703	388,452	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Primary Care Fund	26,709,204	25,168,168	27,714,032	27,714,032	
General Fund	0	0	0	0	
Cash Funds	26,709,204	25,168,168	27,714,032	27,714,032	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Administration	1,664,454	2,258,568	5,083,274	4,901,415 *	
General Fund	0	0	0	0	
Cash Funds	205,206	271,028	1,048,171	1,574,335	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,459,248	1,987,540	4,035,103	3,327,080	
Children's Basic Health Plan Medical and Dental Costs	194,266,268	188,678,836	209,101,718	218,031,616 *	
General Fund	181,276	0	0	25,576,937	
General Fund Exempt	440,340	429,909	407,703	407,703	
Cash Funds	24,790,795	23,300,744	43,737,397	44,865,706	
Reappropriated Funds	0	0	0	0	
Federal Funds	168,853,857	164,948,183	164,956,618	147,181,270	
TOTAL - (4) Indigent Care Program	540,983,561	546,846,406	573,137,498	490,106,713	(14.5%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	9,967,688	9,730,535	9,747,199	35,324,136	262.4%
General Fund Exempt	440,340	429,909	407,703	407,703	0.0%
Cash Funds	201,225,593	204,580,783	228,555,396	184,310,832	(19.4%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	329,349,940	332,105,179	334,427,200	270,064,042	(19.2%)

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	3,400,279	108,722	10,000,000	10,000,000	
General Fund	2,940,155	0	0	0	
Cash Funds	460,124	108,722	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Senior Dental Program	0	2,960,505	3,990,358	3,990,358	
General Fund	0	2,960,505	3,962,510	3,962,510	
Cash Funds	0	0	27,848	27,848	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	7,596,518	8,196,518	8,196,518	8,196,518	
General Fund	3,797,879	4,098,259	4,098,259	4,098,259	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,798,639	4,098,259	4,098,259	4,098,259	
State University Teaching Hospitals Denver Health and Hospital Authority	2,804,714	2,804,714	2,804,714	2,804,714	
General Fund	1,402,217	1,402,357	1,402,357	1,402,357	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,402,497	1,402,357	1,402,357	1,402,357	

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	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
State University Teaching Hospitals University of Colorado Hospital	1,331,984	1,481,984	1,631,984	1,631,984	
General Fund	590,926	590,992	590,992	590,992	
Cash Funds	0	0	0	0	
Reappropriated Funds	75,000	150,000	225,000	225,000	
Federal Funds	666,058	740,992	815,992	815,992	
Medicare Modernization Act State Contribution Payment	143,579,022	148,853,569	151,073,595	169,003,401 *	
General Fund	143,579,022	148,853,569	151,073,595	169,003,401	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Public School Health Services Contract Administration	1,055,162	1,031,412	1,750,000	1,900,000 *	
General Fund	0	515,706	875,000	950,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	1,055,162	0	0	0	
Federal Funds	0	515,706	875,000	950,000	
Public School Health Services	104,194,094	114,602,180	120,880,730	132,480,170	
General Fund	0	0	0	0	
Cash Funds	52,039,318	57,295,552	60,440,365	66,240,084	
Reappropriated Funds	0	0	0	0	
Federal Funds	52,154,776	57,306,628	60,440,365	66,240,086	

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	750,000	1,675,000	1,500,000	1,500,000	
General Fund	0	0	0	0	
Cash Funds	750,000	1,675,000	1,500,000	1,500,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Office Administered Drugs Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Durable Medical Equipment Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
TOTAL - (5) Other Medical Services	264,711,773	281,714,604	301,827,899	331,507,145	9.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	152,310,199	158,421,388	162,002,713	180,007,519	11.1%
Cash Funds	53,249,442	59,079,274	71,968,213	77,767,932	8.1%
Reappropriated Funds	1,130,162	150,000	225,000	225,000	0.0%
Federal Funds	58,021,970	64,063,942	67,631,973	73,506,694	8.7%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	102,390,767	92,760,785	121,458,860	126,226,998	3.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	48,024,411	47,663,317	58,590,525	60,974,578	4.1%
Cash Funds	1,888,903	1,888,903	1,888,903	1,888,903	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	52,477,453	43,208,565	60,979,432	63,363,517	3.9%

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
TOTAL - Department of Health Care Policy and Financing	9,687,714,324	10,163,644,813	10,689,061,864	11,217,371,086	4.9%
FTE	503.6	527.6	544.6	578.8	6.3%
General Fund	1,984,467,300	2,070,814,040	2,253,251,728	2,479,426,290	10.0%
General Fund Exempt	821,142,006	885,763,242	898,118,536	898,118,536	0.0%
Cash Funds	1,191,157,382	1,374,395,026	1,386,291,098	1,519,856,266	9.6%
Reappropriated Funds	74,041,265	81,292,251	93,615,672	93,500,756	(0.1%)
Federal Funds	5,616,906,371	5,751,380,254	6,057,784,830	6,226,469,238	2.8%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2018 SESSION BILLS

SB 18-145 (IMPLEMENT EMPLOYMENT FIRST RECOMMENDATIONS): Requires the Department of Labor and Employment (CDLE) and the Medical Services Board in the Department of Health Care Policy and Financing (HCPF) to promulgate rules by July 1, 2019 requiring training or certification for certain providers of supported employment services for persons with disabilities. These requirements are contingent upon appropriations to HCPF to reimburse vendors of supported employment services for the cost of training and certification. Also expands HCPF reporting requirements. Provides the following appropriations for FY 2018-19:

- $27,675 General Fund and 0.4 FTE to HCPF;
- $2,131 General Fund to CDLE for legal services; and
- $2,131 reappropriated funds to the Department of law for legal services to CDLE.

Appropriations to HCPF are expected to increase to $331,200 General Fund and 0.5 FTE in FY 2019-20.

S.B. 18-195 (HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE CASH FUND APPROPRIATIONS): Makes money in the Healthcare Affordability and Sustainability Fee (HAS Fee) Cash Fund subject to annual appropriation by the General Assembly, rather than continuously appropriated to the Colorado Healthcare Affordability and Sustainability Enterprise. The bill does not change the statutory allowable uses of the HAS Fee and any appropriations by the General Assembly would need to comply with those allowable uses.

S.B. 18-231 (TRANSITION TO COMMUNITY-BASED SERVICES TASK FORCE): Establishes a task force for transition planning to make recommendations on improvements for the transition of individuals with disabilities who are receiving services and supports in an educational setting to receiving services and supports through home- and community-based services. It specifies membership on the task force and duties including making a report to specified committees of the general assembly. Appropriates $109,500 General Fund to the Department of Health Care Policy and Financing in FY 2018-19.

SB 18-266 (CONTROLLING MEDICAID COSTS): Authorizes four new initiatives intended to control Medicaid expenditures:

- Create a resource control unit of six people (5.4 FTE in the first year) dedicated to controlling costs
- Deploy cost and quality technology for the Regional Accountable Entities and providers that identifies the most effective providers and medications to help steer clients to the best health outcomes and reduce expenditures
- Implement a comprehensive hospital admission review program, including pre-admission certification, continued stay reviews, discharge planning, and retrospective claims reviews

- Purchase commercial technology that would periodically update billing system safeguards that identify and reject inappropriate claims

The bill includes requirements for stakeholder engagement, technology testing, and reporting to the General Assembly, and parameters around coverage determinations for hospital stays. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of a decrease of $2,061,973 total funds, including a decrease of $730,316 General Fund, an increase of $222,613 cash funds, a decrease of $1,554,270 federal funds, and an increase of 6.8 FTE.

HB 18-1003 (Opioid Misuse Prevention): Implements several policies related to the prevention of opioid and substance misuse. Makes appropriations to several departments, including an appropriation of $925,000 cash funds from the Marijuana Tax Cash Fund to the Department of Health Care Policy and Financing for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) training program for the development of a training module on substance-exposed pregnancies and additional funding for SBIRT grants. For additional information, see the "Recent Legislation" section at the end of Part III for the Department of Public Health and Environment.

H.B. 18-1136 (Expand Medicaid Benefit for Substance Use Disorder): Adds residential and inpatient substance use disorder treatment and medical detoxification services as a benefit under the Colorado Medicaid Program, conditional upon federal approval. If the new benefit is enacted, requires Managed Service Organizations (MSOs) to determine to what extent money allocated from the MTCF may be used to assist in providing substance use disorder services if those services are not otherwise covered by private or public insurance. Appropriates a total of $236,827 in state funds to the Department of Health Care Policy and Financing (HCPF) for FY 2018-19 (including $155,193 General Fund and $81,634 cash funds from the Healthcare Affordability and Sustainability Fee Cash Fund), and states the assumption that HCPF will receive $236,828 federal funds for FY 2018-19.

HB 18-1161 (Supplemental Bill): Modifies FY 2017-18 appropriations to the Department.

HB 18-1321 (Efficient Administration Medicaid Transportation): Requires that the Department of Health Care Policy and Financing (HCPF) create and implement an efficient and cost-effective method to meet urgent transportation needs within the existing Medicaid non-medical transportation benefit. This method must include medical service provider and facility access to approved transportation providers and an efficient method for obtaining and paying for transportation services. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of a decrease of $104,303 total funds, including a decrease of $34,052 cash funds, a decrease of $70,251 federal funds, and an increase of 0.8 FTE.

H.B. 18-1322 (Long Bill): General appropriations act for FY 2018-19. Includes provisions modifying FY 2016-17 and FY 2017-18 appropriations to the Department.

HB 18-1326 (Support for Transition from Institutional Settings): Allows Medicaid clients moving from an institutional setting to a community setting to access the following transition services:

- Intensive case management
- Household set-up
- Home delivered meals
- Peer mentorship
- Independent living skills training

For FY 2018-19 the bill includes appropriations and assumptions about federal funds with a net result for the Department of Health Care Policy and Financing of a decrease of $684,116 total funds, including a decrease of $477,058 General Fund and a decrease of $207,058 federal funds. Appropriates $306,000 General Fund to the Department of Local Affairs' Division of Housing for FY 2018-19 to provide housing vouchers for HCPF transition clients.

HB 18-1327 (ALL-PAYER HEALTH CLAIMS DATABASE): Allows the General Assembly to appropriate General Fund for the operations of the All-Payer Claims Database (APCD) and establishes a scholarship grant program to support research using the APCD. The Department of Health Care Policy and Financing distributes the scholarship grants to nonprofits and governmental entities to defray the cost of research using the APCD, except that the Department may not make grants back to itself. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of $2,640,790 total funds, including $1,570,395 General Fund, $1,070,395 federal funds, and 0.9 FTE.

H.B. 18-1328 (REDESIGN RESIDENTIAL CHILD HEALTH CARE WAIVER): Directs the Department of Health Care Policy and Financing (HCPF) to initiate a stakeholder process for purposes of preparing and submitting a redesigned Children's Habilitation Residential Program (CHRP) waiver for federal approval that allows for home- and community-based services for children with intellectual and developmental disabilities who have complex behavioral support needs. HCPF may also request federal authorization to change the agency designated to administer and operate the program from the Department of Human Services to HCPF. Includes language creating the redesigned program, relocates the program in statute, and makes conforming changes in statute to reflect the new location of the program. The new program will become effective once federal approval has been granted for the redesigned CHRP waiver. Appropriates $97,263 total funds, including $48,633 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will require an additional 1.8 FTE.

HB 18-1329 (SUPPLEMENTAL PAYMENT DURABLE MEDICAL EQUIPMENT): Authorizes the Department of Health Care Policy and Financing to make General Fund payments, with no matching federal funds, in FY 2017-18 to providers who were negatively affected by a federal law that requires Medicaid rates for durable medical equipment not exceed comparable Medicare rates. Appropriates $7,591,815 General Fund to the Department of Health Care Policy and Financing in FY 2017-18.

HB 18-1330 (SUPPLEMENTAL PAYMENT OFFICE-ADMINISTERED DRUGS MEDICAID): Authorizes the Department of Health Care Policy and Financing to make General Fund payments, with no matching federal funds, in FY 2017-18 to providers who were negatively affected by implementation of a federal rule that required a planned change to physician-administered drug rates to be implemented six months sooner than authorized by the General Assembly. Appropriates $754,000 General Fund to the Department of Health Care Policy and Financing in FY 2017-18.

H.B. 18-1407 (ACCESS TO DISABILITY SERVICES AND STABLE WORKFORCE): Requires the Department of Health Care Policy and Financing (HCPF) to seek federal approval for a 6.5 percent increase in the reimbursement rate for certain services specified in the bill that are delivered through the home- and community-based services intellectual and developmental disabilities, supported living services, and children's extensive supports waivers. Service agencies are required to use 100 percent of the increased funding for compensation for direct support professionals as defined in the bill. Requires service agencies to document the use of the increased funding for compensation using a reporting tool developed by the Department and the service agencies. Allows the Department to recoup from the service agency the amount of funding resulting from the reimbursement rate increase that is not used for compensation for direct support professionals. Requires the Department to assess the impact and outcomes of the reimbursement rate increase on persons with intellectual and developmental disabilities and to include the impact and outcome data, including staff stability survey data, in its annual report to the general assembly concerning the waiting list for intellectual and developmental disability services. Requires the Department to initiate 300 nonemergency enrollments from the waiting list for the home- and community-based services developmental disabilities waiver in the 2018-19 state fiscal year. Appropriates $24,586,381 total funds, including $12,185,446 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will receive $12,400,935 federal funds and will require an additional 2.7 FTE.

2019 SESSION BILLS

S.B. 19-005 (IMPORT PRESCRIPTION DRUGS FROM CANADA): Requires the Department of Health Care Policy and Financing to submit a request for federal approval for a program to import prescription drugs from Canada. Establishes parameters for the importation program. Allows expenditures for preparation of the request for federal approval, but prohibits expenditures for implementation until federal approval is received. Provides a net increase of $971,802 total funds and 4.1 FTE to the Department of Health Care Policy and Financing, including an increase of $1,041,802 General Fund and a decrease of $70,000 federal funds. Also, provides $134,719 reappropriated funds and 0.7 FTE for the Department of Law.

S.B. 19-113 (SUPPLEMENTAL BILL): Modifies FY 2018-19 and FY 2017-18 appropriations to the Department.

S.B. 19-195 (BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH): 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. Requires HCPF to seek federal authorization to provide such services by July 1, 2020, and upon federal authorization, requires that managed care entities implement such services. Appropriates $619,484 General Fund to HCPF for FY 2019-20, and states the assumptions that HCPF will receive $771,903 federal funds and require 3.9 FTE. For additional information, see the "Recent Legislation" section at the end of Part III for DHS.

S.B. 19-207 (LONG BILL): General appropriations act for FY 2019-20. Includes provisions modifying FY 2017-18 and FY 2018-19 appropriations to the Department.

S.B. 19-209 (PACE PROGRAM FUNDING METHODOLOGY): Repeals a statutory requirement that the Department of Health Care Policy and Financing use a "grade of membership" method in determining rates for the Program for All-Inclusive Care for the Elderly (PACE) and instead requires the Department to meet with PACE organizations to consider funding methodologies for future years. Provides $13,510,958 total funds, including $6,755,479 General Fund and $6,755,479 federal funds, based on estimated PACE rates without the change to the "grade of membership" method.

S.B. 19-222 (BEHAVIORAL HEALTH CARE FOR INDIVIDUALS AT RISK): Requires the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) to improve access to behavioral health services for individuals at risk of institutionalization. Also requires the Office of Behavioral Health in DHS to collaborate with HCPF to develop an implementation plan to increase the number of high-intensity behavioral health treatment programs statewide. Appropriates $51,000 General Fund and $24,000 cash funds to HCPF for FY 2019-20, and states the assumption that HCPF will receive $75,000 federal funds. For additional information, see the "Recent Legislation" section at the end of Part III for DHS.

SB 19-238 (IMPROVE WAGES AND ACCOUNTABILITY HOME CARE WORKERS): Requires the Department of Health Care Policy and Financing to request federal approval to increase certain personal care and homemaker rates by 8.1 percent in FY 2019-20 and requires agencies receiving Medicaid compensation for these services to use the rate increase for compensation of non-administrative employees. Beginning July 1, 2020, sets a minimum hourly wage of $12.41 for people providing personal care, homemaker, or in-home support services and requires that at least 85 percent of any increase in funding for these services in FY 2020-21 be used to increase compensation for non-administrative employees. Requires the Department in cooperation with the Department of Public Health and Environment to establish a process for reviewing and enforcing initial and ongoing training requirements for employees providing personal care, homemaker, and respite care services. Provides $11,427,252 total funds to the Department of Health Care Policy and Financing for the rate increase and stakeholder outreach costs, including $5,682,377 General Fund and $5,744,875 federal funds.

SB 19-254 (NURSING HOME PENALTY CASH FUND): Repeals certain statutory limits on the Nursing Home Penalty Cash Fund, including a minimum reserve requirement of $1.0 million, an annual expenditure limit of $250,000 or 25 percent of prior year revenue if the fund balance is less than $2.0 million, and a sunset of the grant program and the Nursing Home Innovations Grant Board. Instead, requires the Medical Services Board to set a minimum reserve requirement to ensure sufficient funds to protect the health or property of individuals residing in nursing facilities. Increases the FY 2019-20 cash funds appropriation out of the Nursing Home Penalty Cash Fund from $250,000 to $500,000.

H.B. 19-1001 (HOSPITAL TRANSPARENCY MEASURES TO ANALYZE EFFICACY): Requires hospitals to report certain financial information to the Department of Health Care Policy and Financing and requires the Department to prepare an annual hospital expenditure report. Requires the Department in consultation with the Department of Public Health and Environment to make recommendations to the General Assembly regarding the structure of the statutory Hospital Report Card and Hospital Charge Report.

H.B. 19-1004 (PROPOSAL FOR AFFORDABLE HEALTH COVERAGE OPTION): Requires the Department of Health Care Policy and Financing and the Department of Regulatory Agencies to develop a proposal for a state option for health care coverage by November 15, 2019, and after presenting the plan to submit requests for federal approval to implement it. For consulting services to

help develop the proposal and the request for federal approval, the bill appropriates to the Department of Health Care Policy and Financing $75,000 General Fund in FY 2018-19 and $150,000 General Fund in FY 2019-20 and to the Department of Regulatory Agencies $115,500 General Fund in FY 2018-19 and $231,000 General Fund in FY 2019-20.

H.B. 19-1038 (DENTAL SERVICES FOR PREGNANT WOMEN ON CHP+): Expands benefits under the Children's Basic Health Plan to include dental services for enrolled prenatal and postpartum women. Provides $439,425 total funds to the Department of Health Care Policy and Financing in FY 2019-20, including $66,955 cash funds and $372,470 federal funds.

H.B. 19-1176 (HEALTH CARE COST SAVINGS): Creates a task force to study and compare the current method of financing health care in Colorado with: (1) a multi-payer universal health care system that has a mandated set of benefits; and (2) a publicly financed and privately delivered universal health care system that directly compensates providers. Requires reports to the General Assembly by January 1, 2021 and September 1, 2021. For FY 2019-20, appropriates $92,649 General Fund to the Department of Health Care Policy and Financing to support the task force and $7,351 General Fund to the Legislative Department for per diem costs for legislators participating in the task force.

H.B. 19-1210 (LOCAL GOVERNMENT MINIMUM WAGE): Repeals an existing provision that prevents local governments from enacting minimum wage laws separate from those of the State, and allows local governments to establish minimum wage laws for individuals performing work while physically present within their jurisdictions through their governing body, an initiative, or referendum. Local minimum wages may exceed the state and federal minimum wages. The bill includes a provision requiring the Department of Health Care Policy and Financing to implement a local minimum wage enhancement payment for eligible nursing facilities, if a local government increases its minimum wage above the statewide minimum wage.

H.B. 19-1269 (BEHAVIORAL HEALTH CARE COVERAGE): Requires private health insurers and the State's Medicaid plan to provide medically necessary coverage for behavioral, mental health, and substance use disorder services on par with the coverage for physical health services and to demonstrate compliance through new reporting requirements. Appropriates $113,560 General Fund and $53,440 cash funds to the Department of Health Care Policy and Financing (HCPF) for FY 2019-20, and states the assumptions that HCPF will receive $167,001 federal funds and require 3.0 FTE. For additional information, see the "Recent Legislation" section at the end of Part III for the Department of Regulatory Agencies.

H.B. 19-1287 (TREATMENT FOR SUBSTANCE USE DISORDERS): Enacts several initiatives to improve access to behavioral health and substance use disorder treatment, including requiring the Department of Human Services (DHS) to establish a care navigation system to assist individuals in accessing substance use disorder treatment. Appropriates $21,733 General Fund and $10,228 cash funds to the Department of Health Care Policy and Financing (HCPF) for FY 2019-20 to assist in care coordination for Medicaid clients, and states the assumptions that HCPF will receive $31,961 federal funds and require 0.8 FTE. For additional information, see the "Recent Legislation" section at the end of Part III for DHS.

H.B. 19-1302 (CANCER TREATMENT & LICENSE PLATE SURCHARGE: Reauthorizes the Breast and Cervical Cancer Treatment and Prevention Program and Fund in the Department of Health Care

Policy and Financing. Provides $2,425,021 to the Department in FY 2019-20, including $857,783 cash funds and $1,567,238 federal funds.

H.B. 19-1320 (HOSPITAL COMMUNITY BENEFIT ACCOUNTABILITY): Requires nonprofit hospitals to perform a community health needs assessment, create a community benefit implementation plan, solicit annual feedback on community benefit activities, and submit annual reports to the Department of Health Care Policy and Financing.

H.B. 19-1326 (RATES FOR SENIOR LOW-INCOME DENTAL PROGRAM): Changes the statutory minimum rates for the senior dental program from the rates paid by a predecessor program to equivalent rates paid by Medicaid and requires the Department of Health Care Policy and financing to review and make recommendations regarding the operation and effectiveness of the program.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

10 **Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects** -- This line item includes $62,000 total funds, including $31,000 General Fund, the purpose of which is the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. It is the General Assembly's intent that the Department also use the $62,000 total funds to evaluate the new behavioral therapy benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Comment:

11 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – Of this appropriation, $5,288,258 remains available for expenditure on the single assessment tool project through the completion of the project or the close of the 2020-21 state fiscal year, whichever comes first.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the single assessment tool. The Department is complying with the footnote.

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

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

13 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2020-21 state fiscal year.

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

14 Department of Health Care Policy and Financing, Executive Director's Office, Eligibility Determinations and Client Services, County Administration -- It is the General Assembly's intent that quality incentive payments made from this line item be aligned with and complementary to: (1) the continuous quality improvement plan developed pursuant to Section 26-1-122.3 (3), C.R.S.; (2) the mutually agreed upon method for distributing federal performance bonus money developed pursuant to Section 26-2-301.5 (1)(d), C.R.S.; and (3) the mutually agreed upon method for charging counties for federal monetary sanctions for failing to meet performance measures pursuant to Section 26-2-301.5 (2)(b), C.R.S.

Comment: The Governor provided the following response to this footnote:

> **The footnote conflicts with Section 25.5-4-205, C.R.S. The Department of Human Services is required to pass on federal sanctions to counties for inaccurate eligibility determinations, but Section 25.5-4-205, C.R.S. does not give the Department of Health Care Policy and Financing that authority. The Department will design requirements that are as similar as possible to these requirements within the bounds of its statutory authority.**

The Department says it continues to support continuous quality improvement (CQI) efforts at the county level through CQI sessions with counties. However, the Department reports a CQI session has not been held for calendar year 2019 due to the focus on system implementation for the new Colorado Benefits Management System. Going forward the Department plans to integrate CQI with the management evaluation review program. However, the Department indicates that full implementation of the management evaluation review program is dependent on the resources requested in *R8 Accountability and compliance resources* around the county scorecard and performance. *The JBC may want to discuss the Department's compliance with this footnote further with the Department at the hearing.*

15 Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals – Of this appropriation, $3,643,468 remains available for expenditure on the single assessment tool project through the completion of the project or the close of the 2020-21 state fiscal year, whichever comes first.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the single assessment tool. The Department is complying with the footnote.

15c Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals; and Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs, Adult Supported Living Services -- These line items include $9,164,665 total funds, including $4,582,333 General Fund, for the purpose of increasing provider rates for the portion of Consumer Directed Attendant Support Services and In-Home Support Services that pays for personal care and homemaker services.

Comment: This footnote explains that the purpose of a portion of the appropriation is to increase provider rates for participant directed services. The Department is expecting federal CMS approval

to implement the increase January 1, 2020, which is 3 months later than assumed in the budget. The difference in projected expenditures is accounted for in R1.

16 **Department of Health Care Policy and Financing, Behavioral Health Community Programs, Behavioral Health Capitation Payments –** It is the General Assembly's intent that a 2.0 percent increase in community-based provider workforce salaries be passed through in its entirety to Community Mental Health Centers and other mental health and substance use disorder providers, excluding hospitals and Federally Qualified Health Centers. The Department of Health Care Policy and Financing is expected to increase rates for Community Mental Health Centers and other mental health and substance use disorder providers impacted by the policy to reflect the entire 2.0 percent workforce salary increase.

Comment: This footnote expresses the intent of the General Assembly regarding community-based provider workforce salaries and mental health and substance use disorder provider rates. Implemented 7/1/2019 as intended.

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

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

18 **Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs, Case Management –** Of this appropriation, $1,896,609 remains available for expenditure on the single assessment tool project through the completion of the project or the close of the 2020-21 state fiscal year, whichever comes first.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the single assessment tool. The Department is complying with the footnote.

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

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

20 **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 that the appropriation sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk for substance abuse. The Department is using the money as intended.

21 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding --** The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the definition of "centralized appropriation" that applies, pursuant to section 24-75-112 (1)(b), C.R.S., to the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is authorized by section 24-75-105 (1), C.R.S., to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

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

22 **Department of Health Care Policy and Financing, Grand Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; and Governing Boards, Regents of the University of Colorado --** The Department of Higher Education shall transfer $821,060 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $77,998,160, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $77,998,160 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

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

UPDATE ON REQUESTS FOR INFORMATION

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

1 Department of Health Care Policy and Financing, Executive Director's Office; and Department of Military Affairs, Executive Director and Army National Guard -- The Departments are requested to explore further the potential benefits to veterans and the State of a pilot program to identify and conduct outreach to veterans enrolled in the Medicaid program who may be able to make better use of their federal Veterans Administration (VA) benefits.

- The two departments are requested to work together to refine the process for identifying which veterans might benefit from further outreach. This may include individuals with high prescription drug costs to determine if they would benefit from accessing VA prescription drug benefits; ensuring that veterans who are discharged from a nursing facility have their pension and aid and attendance benefits restored from the $90 institutionalized amount; outreach to individuals receiving $0 monthly VA compensation benefits; outreach to Vietnam-era veterans to ensure they are receiving benefits related to "agent orange" exposure, when relevant; exploring opportunities to increase veterans' service-connected disability ratings; and any other categories the departments believe should be targeted.
- HCPF is requested to extract relevant data samples and to work closely with DMVA to help refine the process for identifying veterans most suitable for outreach.
- The DMVA is requested to conduct outreach to a small sample of veterans, such as those with high Medicaid pharmacy costs, to test the lists provided and veterans' responses.
- The DMVA is also requested to investigate the potential for using work-study students, funded by the federal Veterans Administration, to assist in outreach to veterans.
- Based on the results of this preliminary research, by October 1, 2019, the Departments are requested to submit a report to the Joint Budget Committee with recommendations on how the State should proceed. If the Departments continue to recommend a pilot program, they are requested to submit a detailed plan for how the pilot will be structured, including how they will identify veterans who should receive outreach, the estimated number who will receive outreach, the form of such outreach (letter/phone/etc.), the recommended length of the pilot, and how they will assess the impact of the pilot. The plan should include the proposed mechanism for determining whether a veteran has increased VA benefits as a result of the Department's outreach and a plan for determining whether the program has resulted in any General Fund savings to the State. The assessment may include a comparison with a randomized control group, if appropriate.

Comment: The Departments submitted the report as requested and a copy is available from the Department's legislator resource center web page:
https://www.colorado.gov/hcpf/fy-2019-20-legislative-requests-information-reports.
See the briefing for the Department of Military Affairs for more information.

5 Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the

Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1, 2019.

Comment: The departments submitted the report as requested and it is available from the Department's web site: https://www.colorado.gov/pacific/hcpf/fy-2019-20-legislative-requests-information-reports The JBC staff will be coordinating with the analyst for the Department of Higher Education to provide a full analysis for figure setting.

6 Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of Human Services, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Department of Military and Veterans Affairs, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of Personnel, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division, Administration, General Disease Control, and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by **October 1, 2019** for each program funded with Tobacco Master Settlement Agreement money: the name of the program; the amount of Tobacco Master Settlement Agreement money received and expended by the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals.

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

7 Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1 of each fiscal year, the status of the implementation of Regional Center Task Force recommendations.

Comment: *See the briefing for department of Human Services, Services for People with Disabilities for a discussion of this request for information.*

DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

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

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

2 Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by December 1, 2019, concerning the savings related to transitioning clients out of institutions into the community through the Colorado Choice Transitions (CCT) program. The report should include the following information:

- the number of CCT clients who transitioned or were in the process of transitioning to the community in FY 2018-19;
- the number of CCT clients who returned to an institution in FY 2018-19 after transitioning to the community;
- expenditures of state and federal funds for transition services provided to CCT clients in FY 2018-19;
- the average per person expenditure of state and federal funds for medical and home and community based services provided to CCT clients in FY 2018-19; and
- the average per person expenditure of state and federal funds for comparable institutional services for CCT clients in FY 2018-19.

Comment: The Department submitted the report as requested.

- Out of 259 clients enrolled in the CCT 259 transitioned in FY 2018-19
- Out of 569 clients who transitioned since the beginning of the program, 61 were reinstitutionalized and 39 returned within one year
- The state spent $3.9 million total funds, including $2.0 million General Fund on the program in FY 2018-19
- The average per person for medical services was $2,545 and for HCBS $1,086
- The average per person for comparable institutional services was $6,201

3 Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit reports by November 1, 2020 and 2021 on the actual savings achieved by

all initiatives that the Department projected would achieve savings in the FY 2019-20 budget request.

Comment: These reports are not due until November 2020 and 2021.

4 Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments -- The Department is requested to submit a report by February 1 of each year to the Joint Budget Committee estimating the disbursement to each hospital from the Safety Net Provider Payments line item.

Comment: The requested report is not due until February 1, 2020.

5 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 health services to public school children with disabilities, as required by federal and state law[5], and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

Schools pay for the services and then complete documentation to get the costs certified as public expenditures by the Department of Health Care Policy and Financing in order to claim the matching federal funds. Under state law, schools must use the additional federal funds to expand or enhance health services for all students through a Local Services Plan developed with community input.

Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, and specialized non-emergency transportation services. Primary care and behavioral health services that are not part of an IEP or IFSP do not qualify through this program.

Services must be "medically necessary" as determined by a referral and authorization process. A qualified practitioner of the healing arts refers a client for services and the services become

[5] Individuals with Disabilities Education Act, Section 504 of the Rehabilitation act of 1973, and Title 22, C.R.S.

authorized when included in the IEP or IFSP. The Public School Health Services program defines "medically necessary" in Colorado regulation[6] as a service expected to:

> *. . . prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.*

[6] 10 CCR 2505-10, Section 8.290.1.

APPENDIX D
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 of Health Care Policy and Financing 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 2020-21 budget request, the FY 2018-19 Annual Performance Report dated October 2019 and the FY 2019-20 Performance Plan dated November 2019 can be found at the following link:

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