Department of Health Care Policy & Financing
Long Range Financial Plan FY 2024-25
November 1, 2023

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Section 1: Financial Forecast, Caseload and Other Cost Drivers

Department Baseline Forecast

	General Fund (Caseload-Driven)	General Fund Non-Caseload (Operating)	Cash Funds	Reappropriated Funds	Federal Funds	Total Funds
FY 2023-24	$4,273,589,754	$230,039,026	$1,801,949,987	$105,145,755	$8,929,642,441	$15,340,366,963
FY 2024-25	$4,731,215,851	$234,657,022	$1,819,098,149	$121,939,372	$9,480,579,294	$16,387,489,688
FY 2025-26	$4,984,733,848	$234,657,022	$2,075,047,998	$129,698,644	$9,944,873,942	$17,369,011,454
FY 2026-27	$5,323,168,587	$234,657,022	$2,158,724,082	$135,102,183	$10,665,034,340	$18,516,686,214
FY 2027-28*	$5,637,542,022	$234,657,022	$2,246,900,084	$140,743,829	$11,268,355,575	$19,528,198,532

* See Appendix A for more detailed tables.

Non-Caseload General Fund Operating Growth

- Expected to increase by 2 percent in FY 2024-25, which is driven by the Department's requests for increased funding for several key initiatives in the November 1, 2023 deliverable, dampened by the impact of annualizing out one-time funding from FY 2023-24.

Caseload General Fund Growth

- Estimated 10.7 percent increase in caseload-driven General Fund in FY 2024-25 driven by the expiration of the federal enhanced COVID FMAP in FY 2023-24, an extra payment week for Medicaid fee-for-service expenditures in FY 2024-25, and provider rate increases anticipated in FY 2024-25. Note - caseload growth in the absence of these three changes would be 3.7 percent, based on OSPB estimates.
- Estimated 5.4 percent growth in FY 2025-26, estimated 6.8 percent growth in FY 2026-27, primarily based on increased utilization of long term services and supports, such as nursing homes and HCBS waiver services, as well as moderate caseload growth. HCPF continues to research and implement new cost-saving efforts including prescription drug price reductions; improved payment methodologies; conditional reimbursements on outcomes and performance metrics; and regulatory structures that prioritize member health, hospital efficiency, and innovation.

Cash Fund Growth

- An increase in cash funds in FY 2024-25 due to increase in the supplemental payments paid to the hospitals from the Healthcare Affordability and Sustainability Fee will offset the end of ARPA HCBS projects.

Federal Funds and Reappropriated Funds

- Funding expected to increase based on Department forecasting, largely due to increases in Medicaid and CHP+ caseload and expenditure, and despite the impact of FMAP rolloff.

Department Major Budget Drivers

HCPF Cost Drivers

Division	Cost Driver	Driving Factors	Forward-Looking Considerations	Caseload?
Multiple	Medical Services Premiums (Health First Colorado/Medicaid)	65+ population, utilization, health care costs, income, insurance, eligibility	Very likely to increase as the aging population & health care costs continue to grow; dependent on economic conditions and eligibility	Yes
Multiple	Child Health Plan Plus (CHP+)	Low-income minor (<18) and pregnant population, income, insurance, eligibility	Likely to increase as the population and health care costs continue to grow; dependent on economic conditions and eligibility	Yes
Multiple	Behavioral & Mental Health Care (Health First Colorado/Medicaid)	Population, utilization, health care costs	Likely to increase as the population and health care costs continue to grow	Yes
Multiple	Medicare Modernization Act	Dual eligibility, 65+ population, utilization, prescription drug costs,	Likely to increase as more individuals become dual-eligible. HCPF makes mandatory federal payments to help finance Medicare Part D for dual-eligible members, which covers outpatient prescription drugs.	Yes
Multiple	Office of Community Living Cost and Caseload (Health First Colorado/Medicaid)	Disabled and 65+ population; long term service utilization, health care costs	Likely to increase based on increased utilization of long-term services and supports for members with intellectual and developmental disabilities, as well as moderate caseload growth	Yes

- HCPF's costs are driven primarily by caseload for Medicaid and CHP+. Caseload drivers for these programs include (1) growth in specific populations that drive program utilization (e.g. older Coloradans or low-income minors) and (2) health care costs, including costs related to prescription drug prices, labor market conditions for health care and effects on worker salaries. HCPF's costs associated with these caseload pressures are trending upward across most categories.
- As the department responds to caseload pressures on Colorado health care programming, it is focused specifically on making investments that improve the affordability of health care in Colorado and reduce long term costs, especially as state hospital prices are some of the highest in the country (ranked 6th in 2021) alongside national trends that anticipate further increases to health care costs going forward. Specifically, HCPF continues to research and implement new cost-saving efforts including prescription drug price reductions; improved

payment methodologies; conditional reimbursements on outcomes and performance metrics; and regulatory structures that prioritize member health, hospital efficiency, and innovations such as telemedicine services to reduce barriers to care like transportation, childcare, or inclement weather.
- Outside of general trends in caseload growth, HCPF expects a lower Medicaid caseload in FY 2023-24 and declining caseload FY 2024-25 due to the end of the continuous coverage requirement on April 1, 2023. These forecasts also account for a reduction due to lower costs for nursing homes and PACE due to lower enrollment and fewer patient days despite higher utilization in long term home health and the HCBS waivers and higher acute care per capita costs in FY 2024-25.
- CHP+ caseload has been particularly volatile in the past 15 years due to increases in Medicaid eligibility (FY 2012-2013), economic growth, and Medicaid continuous coverage requirement (FY 2019-2020). Going forward, it is anticipated that CHP+ enrollment will grow as members are reassessed for Medicaid eligibility over the next year.

HCPF Revenue Drivers (Including Inflows of Federal Funding)

Revenue Source	Driving Factors	Forward-Looking Considerations
Federal Funding	Caseload, funding formulas, state matching funds, eligibility requirements	Federal funding levels are expected to increase, based on internal HCPF forecasts of Medicaid and CHP+.
CO Healthcare Affordability and Sustainability Enterprise (CHASE)	Hospital and health care service utilization, net patient revenues, Medicaid costs, federal disproportionate share allotments	Very likely to increase as Medicaid costs and hospital net patient revenue increase

- HCPF revenues and fund inflows stem largely from federal matching funds and cash fund revenues to the CHASE enterprise. Due to the matching federal funding structure, the funding levels that support HFC and CHP+ face some uncertainty in the coming years given their responsiveness to changes in federal funding, though no major changes are anticipated in the baseline forecast outside of the foreseen reduction in additional FMAP matching that began in April 2023 and will wind down by end of year.
- Both CHASE fees and matching federal dollars are primarily determined by net patient revenues and care days at Colorado hospitals and the federal matching formulas.
- On net, HCPF anticipates increases in cash funds in FY2024-25 due to an increase in the supplemental payments paid to the hospitals from the Healthcare Affordability and Sustainability Fee, but a decrease in cash funds in FY 2024-25 due to the end of ARPA HCBS funded projects.

The following section provides additional context on the economic and demographic trends that can impact HCPF caseload.

COVID-19 - Changes in Economic Conditions

The COVID-19 pandemic that emerged in early 2020 continues to have an unprecedented impact on the health care sector, the economy, and the most vulnerable Coloradans. A large majority of the people enrolled in the Medicaid and Children's Health Insurance Program (CHIP)[1] qualify because their income is below specific thresholds. Colorado expanded eligibility criteria under federal law, therefore adults and children must have an income below 133 percent of the federal poverty level to qualify for Medicaid. For CHIP, households must have an income below 250 percent of the federal poverty level to qualify.

As the economy recovers, program caseload falls slowly. There are several key reasons for this. First, federal and state requirements for transitional programs allow people to stay enrolled for up to a year to prevent sharp drops in caseload as people return to work. Second, economic recoveries tend to affect people with lower income expectations more slowly. This means that while major economic indicators (such as unemployment, gross domestic product, and stock market indices) may show that the economy is improving, people with less education and people who are competing for low-wage jobs will generally take longer to find work. As a result, Medicaid caseload tends to continue to increase for up to two years after a recession is officially over. Finally, people who leave public assistance programs during economic recoveries tend to be healthier and have lower costs than those people that remain. As caseload goes down, expenditure decreases by an amount lower than might otherwise be expected, because the people that are leaving have lower than average per capita costs. Collectively, this continues to put pressure on the State's General Fund and limits the opportunity to restore funding to other State programs that received funding reductions during recessions.

COVID-19 has changed utilization patterns due to people not seeking care, and the risk of spread and death in residential facilities, such as nursing homes, assisted living facilities and group homes. Although the reluctance to seek care was a short-term trend during the stay-at-home order and has lessened over the last couple years, particularly with vaccines becoming more available and telemedicine more widely adopted, some members are still slow to return to their previous utilization patterns. Nursing facilities have seen a significant decline in total patients since the beginning of the COVID-19 pandemic. Part of this decline can be attributed to members leaving the nursing facility setting due to COVID-19, as well as workforce shortages leaving nursing facilities unable to intake new patients. While the Department continues to implement initiatives to support nursing facility staffing and intake, it is possible that nursing facility patient populations have reached a new normal and will not return to pre-pandemic levels. Medicaid members are also less likely to be vaccinated than the general Colorado population, which could also be contributing to any reluctance to seek care. The Department is continuing to monitor utilization patterns.

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[1] In Colorado, CHIP recipients can either be enrolled in Health First Colorado or the Child Health Plan Plus (CHP+), depending on their income level.

Changes in Colorado's Demographics and Member Populations

The combination of Colorado's increasing population and a greater proportion of adults over 65 will continue to drive costs in the Department's programs. The State Demography Office predicts a total population growth of more than 630,000 people (11 percent) between 2020 and 2030[2]. Growth rates are even higher among older adults, with 35.6 percent growth of people between the ages of 65-100 which accounts for almost 50 percent of the total growth during the decade. Colorado's population growth rates are expected to exceed national population growth by a significant margin in this time frame. Longer term projections from the State Demography Office indicates that Colorado's population will reach about 7.5 million people by the year 2050. The increasing population, and Colorado's rapidly aging population, will undoubtedly affect the Department's spending. As the population grows, caseload in Medicaid and CHIP will also grow. Critically, the growth in adults 65 and older will continue to create significant budgetary pressure. Older adults have higher per capita costs than adults and children and receive the least amount of federal funding available.

In addition to growth from Colorado's changing population, the Department is working to expand its member population under directives set in H.B. 22-1289, "Health Benefits for Colorado Children and Pregnant Persons."[3] Beginning in 2025, the Department will offer comprehensive health insurance coverage for low-income children and pregnant persons who would be eligible for Medicaid or CHP+ if not for their immigration status. The expansion of health care access to reduce health disparities will likely impact spending. Like with current Medicaid members, the Department has over-expenditure authority for these populations to ensure eligible individuals have appropriate access to care.

On net, HCPF is projecting that Medicaid caseload will grow by 2.3 percent annually in FY 2026-27 and FY 2027-28. HCPF is projecting that General Fund expenditures will grow faster than overall caseload due to increased utilization of long term services and supports (HCBS waivers) and long term care (nursing facilities). In order to reduce utilization growth in those areas, the State would need to implement more restrictive benefits or cut provider rates.

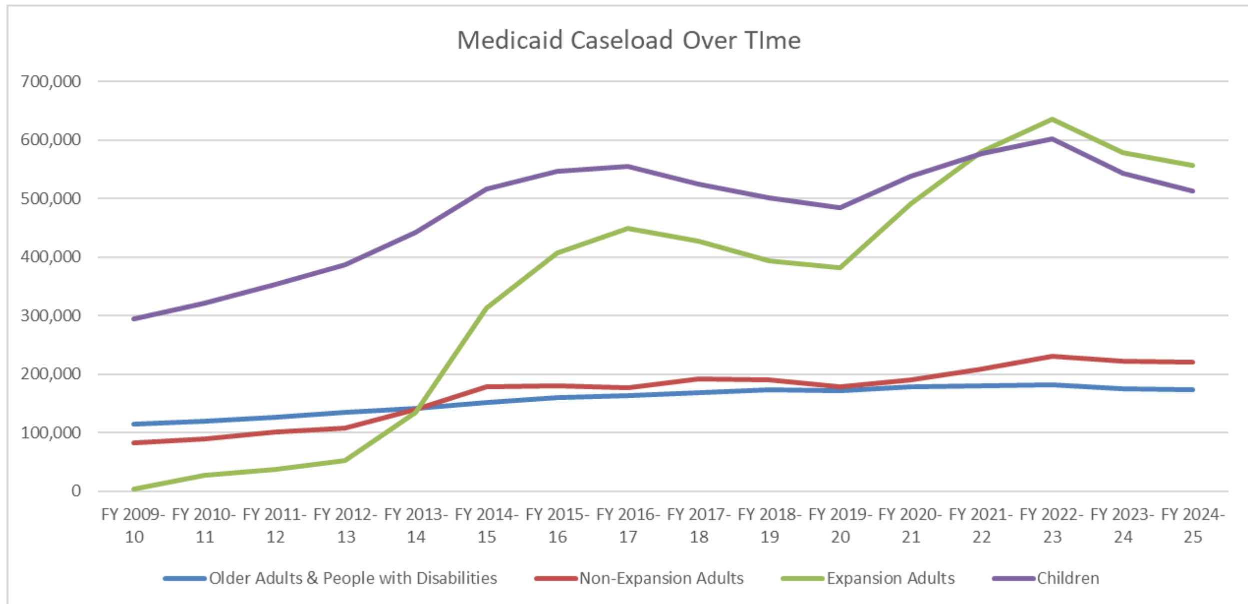
HCPF caseload has gone through various stages of increases and decreases in recent decades. The following section presents historical data and trends in the two major caseload programs.

The demographics changed dramatically with the expansion to adults without dependent children in January 2014 with the implementation of the Affordable Care Act (Expansion Adults on the chart). Enrollment of children also increased significantly during that time frame due to the woodwork effect with more families learning they were eligible for Medicaid. Enrollment for income-sensitive populations declined in the years leading up to the pandemic as the economy recovered from the Great Recession,

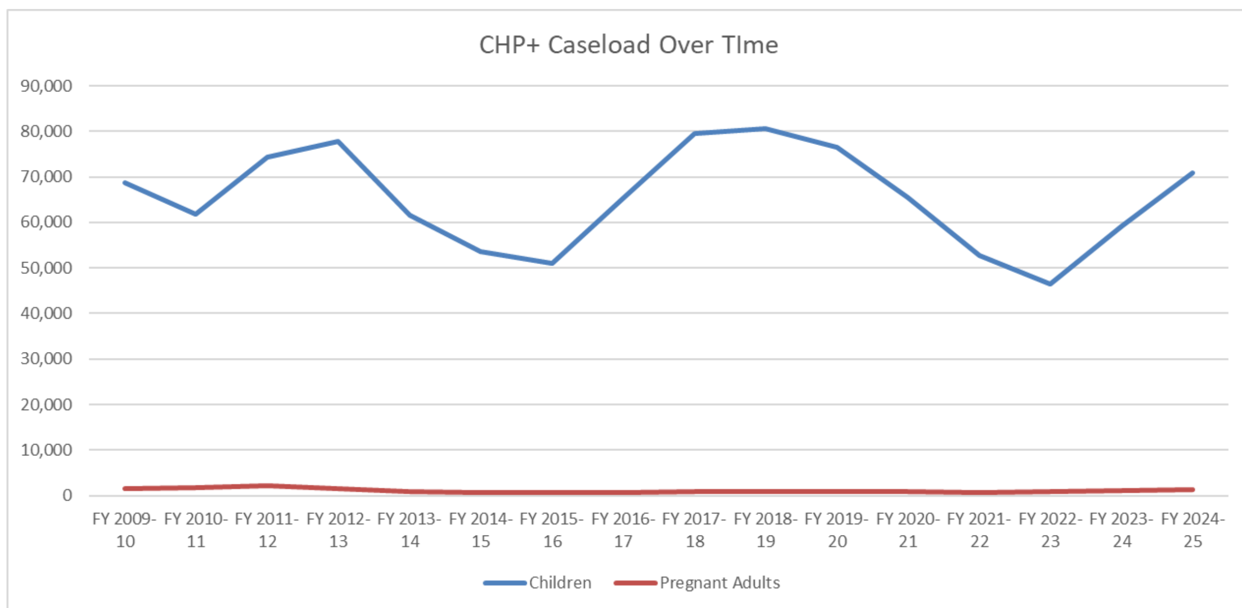
[2] https://demography.dola.colorado.gov/assets/html/demodashboard.html

[3] https://leg.colorado.gov/bills/hb22-1289

then increased again starting in March 2020 with the implementation of the continuous coverage requirement during the Public Health Emergency. HCPF is projecting that caseload will fall over the next year as the Department redetermines members before steadying out to pre-pandemic trends.



CHP+ caseload has been very volatile in the past 15 years. Enrollment declined for several years starting in FY 2012-13 due to two bills that expanded Medicaid eligibility thresholds for children and pregnant adults, which resulted in members churning off of CHP+. Enrollment rebounded after that due to economic growth. Enrollment fell again starting in FY 2019-20 due to the continuous coverage requirement for Medicaid, which resulted in members churning from CHP+ to Medicaid but without any churn from Medicaid to CHP+. HCPF anticipates that CHP+ enrollment will grow as members are redetermined for Medicaid eligibility over the next year.



Increasing Health Care Costs

The affordability of health care in Colorado continues to be one of the most significant challenges facing the Department, the state, and the nation. With the economic downturn, all payers – self-funded employers and Medicaid alike – benefit from a solid affordability strategy. Specific to the Department, the increased need for HCPF programs and services combined with the state's budget restrictions makes the implementation of effective affordability policy more important than ever. As a trusted health care expert, and in partnership with other healthcare thought leaders, the Department is focused on research, analytics and reporting that identifies the drivers of rising health care costs and alternatives to address them. Leveraging insights from this effort serves to support not only Medicaid and CHIP members, but all Coloradans.

The Centers for Medicare and Medicaid Services (CMS) predict that national health spending is projected to grow at an average rate of 5.1 percent per year between 2021 and 2030[4]. Overall, CMS predicts that Medicaid spending will also grow at a rate of 5.6 percent, which is slightly lower than the projected rate of Medicare growth at 7.2 percent and private health insurance growth at 5.7 percent. CMS identifies that key trends involve recovery from the COVID-19 pandemic and growth in input costs such as labor and supplies, leading to a lagged increase in provider service prices. Historically medical inflation has grown faster than overall inflation. This means that the costs incurred by departments paying for medical expenses, including the Department, have grown faster than the TABOR revenue limit over time.

In addition to this growth in projected health spending, in February 2023, national prices rose 6.0 percent across the economy from the previous year. Prices for medical

[4] https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

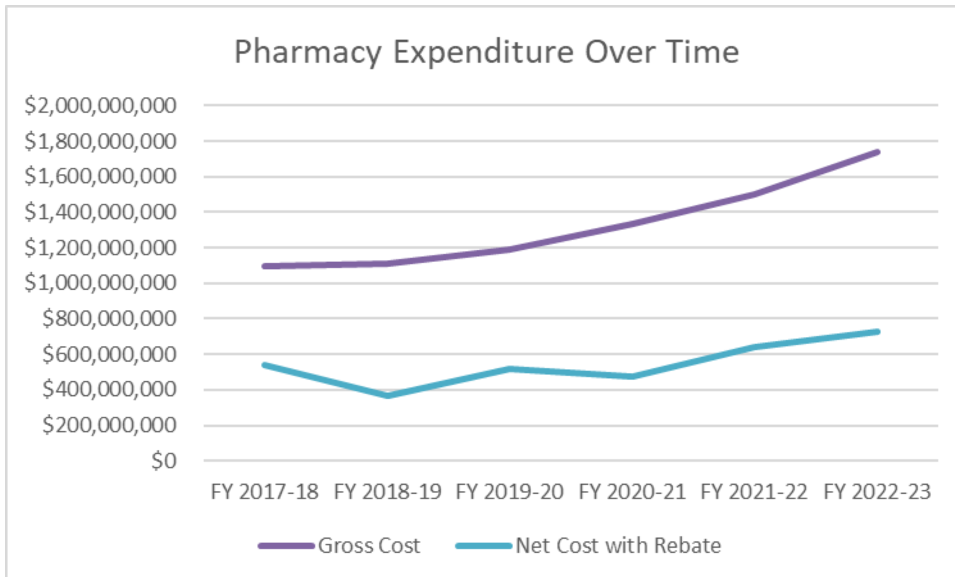
care increased by 2.3 percent over the same period.[5] However, both Medicaid and non-government health care prices are typically set in advance, either administratively or through contracts between providers and insurers. Because of this, the effects of high inflation may take time to permeate through the health care sector, delaying wage increases and other broad increases in health care costs. For Colorado, this will continue to create budgetary pressures. Health care providers will continue to face cost pressures due to the rising cost of wages, capital costs, health insurance, and other factors common to most businesses. Coupled with the ongoing effects of COVID-19, this reality has led to provider consolidation and workforce shortages, which may reduce access to care for Medicaid members. While the Department continues to implement new payment methodologies, condition a portion of reimbursements on outcomes and performance metrics, and implement regulatory structures that prioritize member health, inflationary pressures will continue.

Below are some of the most prominent affordability environmental factors the Department has recently been focused on addressing.

- **Prescription drug costs:** The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid, CHIP, and all health plans. In January 2021, the Department prepared a 2nd edition of its report titled "Reducing the Cost of Prescription Drugs."[6] While the Department continues to address key initiatives to help inform prescribers and update payment structures, high prescription drug costs are still a major factor in the affordability of healthcare. The report lays out a set of comprehensive changes that would favorably impact prescription drug costs and the out-of-pocket costs for families covered by commercial insurance, while achieving a meaningful reduction in the total cost of prescription drugs for Colorado's Medicaid and CHIP programs. Additionally, because the Department must cover any drug that receives approval from the Federal Drug Administration (FDA) and for which a rebate agreement is in place, the recent action of the FDA to lower the threshold of evidence for conditional drug approval may also increase prescription drug costs for the Department as more members utilize high-cost, conditionally approved drug therapies.
- Below is a chart showing prescription drug costs over time, which are adjusted based on average acquisition cost of the drugs.

[5] https://www.kff.org/health-costs/issue-brief/overall-inflation-has-not-yet-flowed-through-to-the-health-sector/#:~:text=A%20new%20KFF%20analysis%20finds,percent%20during%20the%20same%20year.

[6] https://hcpf.colorado.gov/sites/hcpf/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20Second%20Edition.pdf



- **Hospital delivery system:** Colorado's hospital prices are some of the highest in the country. The prices for individual procedures, inpatient and outpatient care, vary widely from hospital to hospital. The report documenting COVID 19's impact on the Colorado hospitals' financing published by the Department in August 2021 provided a thorough analysis of the changing price, costs and profits across the hospital industry in Colorado.[7] The Department has continued to leverage the insights from this report, as well as analyzing the emerging insights from new laws on financial transparency and not-for-profit hospital community investments to drive improved hospital affordability policy to the betterment of Coloradans, their employers, the state, and taxpayers. Based on this continued work, the Department published an additional Hospital Insights Report in January 2023 detailing the current financial positions of hospitals across Colorado.[8]
- **Population health and health outcomes:** The Department has developed data capture infrastructure and analytics to better understand care delivery, utilization, health outcomes and costs. The Department is able to leverage these insights to identify populations that would benefit from increased care support and coordination. Concurrently, the Department has worked with its Regional Accountable Entity (RAE) partners to craft new programs to address these health improvement and affordability opportunities. These are critical innovations that will allow the State's Medicaid program to modernize in alignment with private health insurers and control costs over the long term. The Department is also developing new payment methodologies that move away from traditional fee-for-service payments and towards payment structures that provide payments based on the provider's performance. This includes two tracks of alternative payment methodologies within the primary care system, bundled payments for

[7] https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Cost%20Price%20and%20Profit%20Review%20Full%20Report_withAppendices-0810ac.pdf

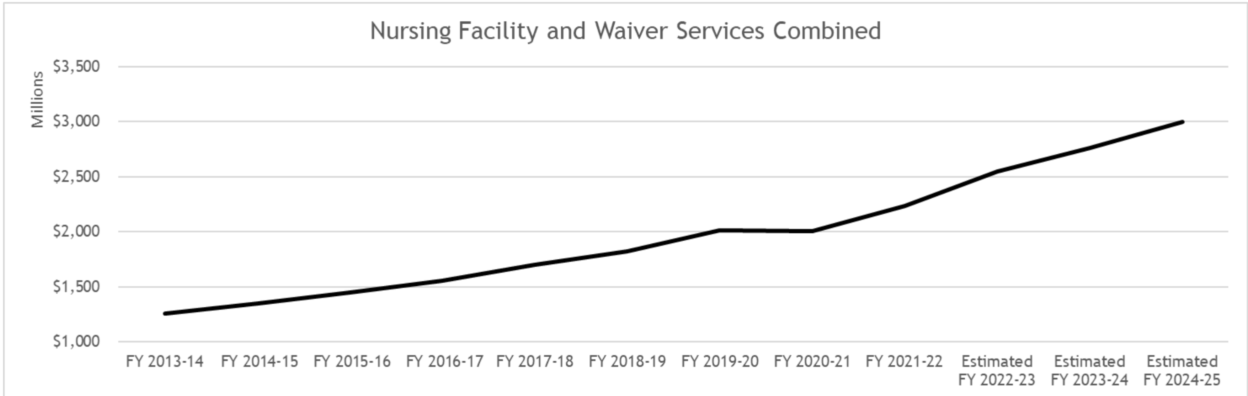
[8] https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Insights%20Bulletin%202023.pdf

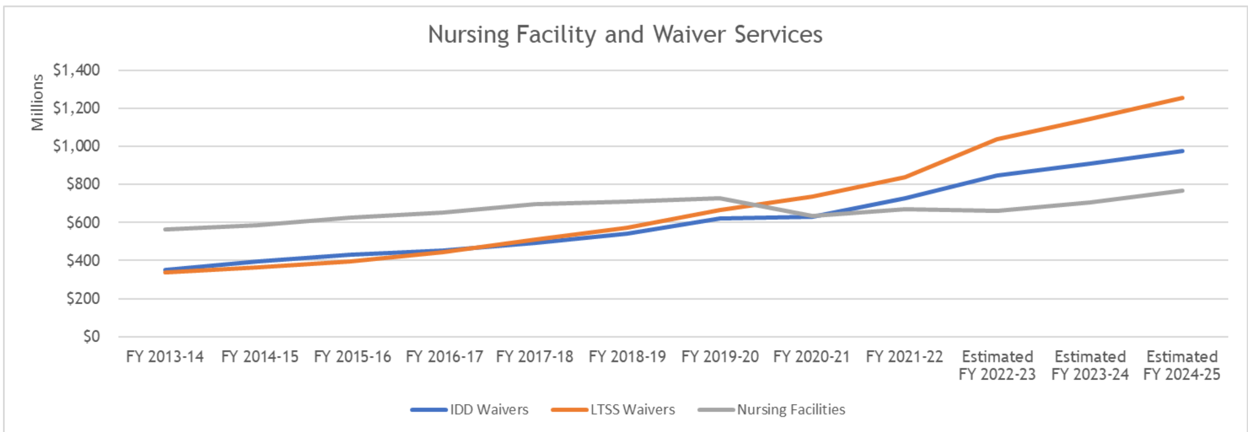
maternity episodes of care, and an alternative payment methodology to support the uptake of the Prescriber Tool and to ensure it meets the needs of providers and members.

- **RAE Accountability:** The Department is in the process of designing and negotiating the third stage of the Accountable Care Collaborative, known as ACC 3.0, with the Regional Accountable Entities (RAEs). The Department's ability to influence and improve member health care outcomes is dependent on its ability to work with these critical contractors to measure outcomes and implement policy interventions. Because the Department does not directly furnish care to members, RAE accountability is a critical strategy to improving health care outcomes and reducing costs.
- **Vertical Integration:** Hospital and hospital systems have been continuing to purchase physician practices leading to an increasingly consolidated market, which in turn leads to a less competitive market. Without appropriate policy guidelines a less competitive market will generally lead to a higher priced market as everyone within that market is working together rather than competing through providing care at a lower cost to the consumer. A recent study has shown that becoming integrated changes physician behaviors through a change in the financial incentive structure which discourages newly integrated practices from allocating expensive resources to relatively unprofitable procedures. Instead of providing a diverse set of procedures, practices are now more likely to only provide the more profitable procedures.[9] One justification for vertical integration is improvements to quality of care. This would be accomplished through reduction in cost inefficiencies and coordination of care, among other things. However, improvements to quality of care have not been measured according to another study.[10]
- **Nursing Home and Waiver Use:** The charts below show the historical and projected expenditure in nursing facilities and waivers. This is based on the FY 2023-24 appropriation; HCPF will update these trends over time. The growth in expenditures year-over-year is shown below as well.

[9] https://www.nber.org/system/files/working_papers/w30928/w30928.pdf

[10] https://journals.sagepub.com/doi/10.1177/1077558719828938


Nursing Facility and Waiver Services Combined
Millions
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
FY 2013-14
FY 2014-15
FY 2015-16
FY 2016-17
FY 2017-18
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
Estimated FY 2022-23
Estimated FY 2023-24
Estimated FY 2024-25


Nursing Facility and Waiver Services
Millions
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
FY 2013-14
FY 2014-15
FY 2015-16
FY 2016-17
FY 2017-18
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
Estimated FY 2022-23
Estimated FY 2023-24
Estimated FY 2024-25
IDD Waivers
LTSS Waivers
Nursing Facilities

Fiscal Year	Community-Based Long-Term Care	Nursing Homes and PACE
FY 2021-22	$1,506.8 M	$883.0 M
FY 2022-23	$1,765.1 M	$937.4 M
% Change	17%	6%
FY 2023-24	$1,921.8 M	$1,024.8 M
% Change	9%	9%
FY 2024-25	$2,092.7 M	$1,121.8 M
% Change	9%	9%

Federal Policy Changes
Medicaid and CHIP are programs that are funded jointly by the federal government and Colorado. As such, any change in federal policy for these programs can have a budgetary impact for the State. Most major policy changes require an act of Congress, and therefore, there is uncertainty in what may occur in the next five years. There is no clear consensus at the federal level about how Medicaid and CHIP may change in the future. Possibilities that have been discussed at the federal level recently include:

Medicaid Waivers and Executive Action
The Social Security Act allows the approval of "experimental, pilot, or demonstration projects that are found by the Secretary [of Health and Human Services] to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations."

The increasing availability of these waivers may provide options for Colorado to reform Medicaid programs beyond what was approved in the past. In addition to waivers, the federal government may change the Medicaid program via new regulations. This type of Executive Action could have significant effects on the operation and financing of the Medicaid program. Often, the changes that are proposed are extremely technical and complex but will likely have significant implications for provider payment rates and state financing of Medicaid by disrupting current arrangements and restricting the future use of such arrangements.

Enacting a Comprehensive Public Health Care Program, such as Medicare-for-All
A public health care program may have the effect of shifting costs from the State to the federal government. This is not certain; for example, when Congress implemented a drug benefit in Medicare (Part D), they imposed a requirement on states to pay for a

portion of the estimated cost of people who were also covered by Medicaid. If enacted federally, a comprehensive public health care program would likely take multiple years to implement and require significant changes in state law to adapt to the new programs.

Scenario Evaluation: Department-specific Contingency

Changes in Colorado's Health Care Landscape
There are a variety of possible changes in Colorado's health care landscape that would impact the Department's ability to meet performance goals. The Department does not provide medical services; rather, it administers a network of public and private providers who render services to members. Changes in the provider landscape can have a dramatic effect on the Department's ability to improve the health of its members. Examples might include:

Closure of a Rural Hospital
COVID-19 has put additional pressure on Colorado's hospital system, especially its rural hospitals. In many areas of the state, there is only a single hospital within a reasonable travel distance. A hospital closure in a rural area could leave a large area of the State without access to hospital services. Some people may end up going without needed services, while the Department may end up paying more for transportation costs to bring people to other hospitals. Further, this may stretch the capacity of other nearby providers.

Provider Shortages and Consolidation
An ongoing concern is that there will not be enough providers available to provide services when members need them. There are already shortages of qualified providers in rural areas, particularly for skilled nursing services and home-and community-based services. The COVID-19 pandemic may exacerbate these shortages if providers are unable to remain in business due to changes in utilization, such as people forgoing care because they are afraid to receive in-person care.

Scenario Evaluation: Economic Downturn

There are a range of caseload scenarios that could occur in the future that can impact Department costs. The Department's caseload forecast is impacted heavily by assumptions of when the PHE will conclude and the subsequent changes in the Department's eligibility policies. The Department's November forecast assumes a moderate rebound in which the economy improves, but not back to pre-pandemic levels. In this scenario, Medicaid enrollment continues to grow after the PHE ends. However, changes in economic conditions and future extensions of the PHE could lead to impacts to caseload, resulting in impacts to Department costs.

During economic downturns, one of the most effective options to balance the budget include reducing Medicaid expenditures by reducing provider rates. In addition, Colorado has often relied on increases in federal funds to offset the need for program

and provider cuts during economic downturns. From FY 2009-10 to FY 2011-12, rates for most Medicaid providers were reduced by approximately 6.1 percent. In FY 2020-21, provider rates were reduced by 1 percent across the board, along with additional targeted rate reductions during budget balancing.

In the past, Colorado has relied on increases in federal funds to offset the need for program and provider cuts during an economic downturn. During the pandemic, the increase in FMAP had the effect of reducing the State's cost for Medicaid, thereby creating General Fund relief.

Historically, economic downturns have led the General Assembly to reduce funding for state-only and cash-funded programs. The Department administers several non-Medicaid programs, such as the Primary Care Fund, the State-Only Supported Living Services Program, the Senior Dental program, and the Old Age Pension Health and Medical program. In the past, the General Assembly has diverted money away from the Department's State-only programs – and other programs around the state – to fund Medicaid programs.

Economic Downturns Spur Innovations

Although economic downturns create significant challenges for the State's entitlement programs, they also create opportunities to find efficiencies and spur innovation. The Department's strategy, starting from the beginning of the COVID-19 pandemic, was adjusted to recognize the emerging "new normal in healthcare," with a focus on sustaining and driving positive changes to the system. This includes policies that assure the right care is occurring at the right place, lowering pharmacy costs and hospital efficiency. For example, telemedicine visits have increased, and inappropriate emergency room visits have decreased as Coloradans avoid unnecessary interactions that increase the risk of COVID-19 transmission. By driving a new normal in health care, the Department can also leverage telemedicine services to reduce barriers to care like transportation, childcare, or inclement weather. Telemedicine can also be used to address traditional care access concerns for people with disabilities, older adults, or rural Coloradans, while also helping to overcome the stigma of accessing behavioral health care by enabling care from the privacy of one's own home. Additionally, the state, vendors and providers may experience benefits due to a broader work base due to employees working remotely which could provide efficiencies in the system.

Capital Construction Funds & Projects

The Department is the fiscal agent of the Office of eHealth Innovation (OeHI). This includes two capital appropriations: Health IT Roadmap, and Rural Connectivity.

Remaining funds for the Colorado Health IT Roadmap infrastructure will be spent in support of a statewide consent architecture and a unifying architecture for Social Health Information Exchange. Any remaining funds in this category are due to revert 6/30/2023; however, OeHI anticipates spending most of the funds.

Rural Connectivity funding will be spent to connect the remaining Critical Access Hospitals and Rural Health Centers to the statewide Health Information Exchange infrastructure and to the rural analytics dashboard. Additionally, the funding will be spent to connect local electronic health records from independent providers to the state's HIE network; onboard those providers to a shared analytics platform between rural providers; and provide technical and workflow support. Any remaining funds are due to revert 6/30/2025; however, OeHI anticipates spending all funds.

The Department submitted and received approval for the CC-01 Medicaid Enterprise Solutions (MES) Re-Procurement capital request for re-procurement funding of the Department's IT systems. These systems costs include funding to transition the Medicaid Management Information System (MMIS), the Pharmacy Benefits Management System (PBMS) and the Enterprise Data Warehouse (EDW) if a new vendor is selected. The Department is beginning work on this in FY 2023-24.

Department Capital and IT Capital Construction History					
	Total Funds	*Controlled Maintenance*	*Capital Renewal*	*Capital Construction*	*IT Projects*
FY 2017-18	*$0*	*$0*	*$0*	*$0*	*$0*
FY 2018-19	*$6,605,000*	*$0*	*$0*	*$0*	*$6,605,000*
FY 2019-20	*$11,508,333*	*$0*	*$0*	*$0*	*$11,508,333*
FY 2020-21	*$4,450,000*	*$0*	*$0*	*$0*	*$4,450,000*
FY 2021-22	*$6,498,000*	*$0*	*$0*	*$0*	*$6,498,000*
FY 2022-23	*$10,978,007*	*$0*	*$0*	*$0*	*$10,978,007*

Ongoing Debt Obligations

The Department has no ongoing debt obligations.

Section 2: Federal Funds, Including Non-Stimulus Programs

This section complies with the requirements of Section 2-3-209 (2)(f), C.R.S. which states the Long Range Financial Plan may include components which describe any programs currently funded in whole or in part with federal funds or gifts, grants, or donations that the department anticipates will decrease in the future and, therefore, may require state money as a backfill.

Rolloff of ARPA and/or Other Federal Stimulus Programs

The American Rescue Plan Act (ARPA) of 2021 provided additional funding to the Department through a variety of initiatives:

- Additional Support for Medicaid Home and Community-Based Services (HCBS) During COVID-19 Emergency (est. $317M),
- Extension of 100 percent Federal Medical Assistance Percentage (FMAP) to Urban Indian Health Organizations and National Hawaiian Health Care Systems (est. $100K),
- Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment (est. $10M),
- Special Rule for the Period of a Declared Public Health Emergency (PHE) Related to Coronavirus – Disproportionate Share Hospitals (DSH) provisions (est. $27.1M),
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program ($250K),
- State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services (est. $820K),
- Rural Healthcare Provider Expanded Access ($10M),
- Healthcare Practice Transformation & Integration ($34.8M),
- ARPA Administration Costs ($80K), and
- Medicaid Member Immunization Effort ($300K).

Each initiative has its own timeline for funding and requirements for spending. This section will identify the potential ongoing costs funded by ARPA stimulus funds and the Department's plans for potential fiscal cliffs.

Additional Support for Home and Community-Based Services
The majority of the ARPA stimulus funds are related to support for Home and Community-Based Services (HCBS). Section 9817 of ARPA provides qualifying states with a temporary 10 percent increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures for HCBS. As part of the requirements in ARPA, the Department must use state funds equivalent to the amount of federal funds attributable

to the increased FMAP on HCBS related projects. The Department is required to spend the entirety of their funds by December 31, 2024.

In FY 2020-21 and FY 2021-22 the Department received an additional $317,962,573 in federal funds for HCBS related to ARPA. After reinvesting the savings and drawing down a federal match on eligible expenditures, the Department estimates having $552M to spend across FY 2021-22, FY 2022-23, and FY 2023-24.

The Department's ARPA Medicaid HCBS spending plan includes 63 individual projects. The Department received approval through the FY 2022-23 long bill to continue the rate increases implemented under the spending plan that support a $15/hour base wage for HCBS workers. The other projects received one-time funding. For each project, the Department has created a sustainability plan that identifies how the Department plans to maintain the work started under each project once the ARPA funding expires.

Funding Type	***Number of Projects***	***Budget Allocated***	***Types of Projects***
One-Time Funding	62	$315,663,613	System Updates, Training, Analyses, Temporary Rate Increases, Surveys, Grant Programs
Projects Continuing - Already Funded	1	$222,312,415	Rate Increases
FTE		$14,953,546	All projects have dedicated FTE hired through ARPA funding

Projects that are identified as "One-Time Funding" create work products that do not need ongoing financial support. Some examples of these products are an equity study that identifies disparities in HCBS using data analysis and stakeholder feedback, an HCBS training module for members and their families to assist in navigating the HCBS system, and the provision of hardware and software to case management agencies to support the new care and case management system. Some projects may result in the Department discovering new or innovative ways to better serve members in the future that require additional funding. In those cases, the Department will request for resources through the regular budget cycle and prioritize them along with other funding needs.

"Projects Continuing – Already Funded" include projects that the Department has already received additional funding to support ongoing efforts. This includes the rate increases to establish a $15/hour base wage for HCBS workers. The Department has already received funding to maintain these rate increases through the FY 2022-23 long bill.

In summary, the total funding for ARPA HCBS projects that will continue after December 31, 2024 equals $222,312,415. This amount is for the HCBS base wage rate increases, which is split between fiscal years with $82,800,679 budgeted for SFY 21-22 and

$132,137,260 budgeted for SFY 22-23. The ongoing funding of $160M annually for this project has already been appropriated to the Department.

Extension of 100 percent Federal Medical Assistance Percentage (FMAP) to Urban Indian Health Organizations and National Hawaiian Health Care Systems
Section 9815 of ARPA extends 100 percent FMAP to State Medicaid Agencies for services received through Urban Indian Health Organizations for the time period between April 1, 2021 and March 31, 2023.

ARPA does not specify any spending requirements for the savings related to the increased FMAP for Urban Indian Health Organization services. Therefore, this section frees up state funds in the form of savings and has no related fiscal cliff. The Department estimates that between April 1, 2021 and March 31, 2023, a total of $180,973 of State funding has been saved. After March 31, 2023, payments for services at Urban Indian Health Organizations have returned to their previous federal match percentages.

HB 22-1190, "Supplemental State Payment To Urban Indian Organizations," appropriated money to the Department to distribute funds to Urban Indian Health Organizations as one-time payments. As of June 30, 2023, the Department has sent $118,850 in payments to Urban Indian Health Organizations. These payments will not continue after the enhanced FMAP ends.

Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment
Section 9811 of ARPA establishes mandatory coverage of Covid-19 Vaccines and Administration and Treatment under Medicaid. This section provides 100 percent federal match for COVID-19 vaccines, including the administration of COVID-19 vaccines. This federal match began March 11, 2021 through the last day of the 1st calendar quarter that begins at least 1 year after the COVID-19 Public Health Emergency (PHE) ends, or July 1, 2024. These sections also add coverage of treatment for COVID-19, including specialized equipment and preventive therapies, along the same timeline.

ARPA did not specify any spending requirements for the savings related to the increased FMAP for Covid-19 vaccines and administration and treatment. The Department estimates that between April 1, 2021 and June 30, 2023, a total of $10,540,878 has been freed up from state funds. The Department accounted for the expiration of the enhanced FMAP in the FY 2023-24 R-1, "Medical Services Premiums."

Special Rule for the Period of a Declared Public Health Emergency (PHE) Related to Coronavirus – Disproportionate Share Hospitals (DSH) provisions
Section 9819 of ARPA recalculates the Disproportionate Share Hospital (DSH) allotment to ensure that total DSH payments going back to January 2020 are adjusted to account for the 6.2 percentage point bump in FMAP associated with the Families First Coronavirus Response Act (FFCRA).

As of June 30, 2023, the Department calculates a total of $47.5M has been returned due to this section of ARPA. This additional funding must be used as General Fund offset per SB 21-213, "Use of Increased Medicaid Match." The Department accounted for the expiration of the enhanced match and resulting impact to the General Fund offset from SB 21-213 in FY 2023-24 R-1, "Medical Services Premiums."

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program
SB 21-137 appropriated $250,000 to train health-care and behavioral health-care professionals in substance use Screening, Brief Intervention, and Referral for Treatment (SBIRT) for FY 2021-22. Any amount not expended prior to July 1, 2022 is rolled forward into the FY 2022-23 budget for the same purpose. This appropriation is from the behavioral and mental health cash fund created in section 24-75-230, C.R.S. through a transfer of funds from the "American Rescue Plan Act of 2021" cash fund.

The total SBIRT training funds have been spent as of June 30, 2022. This represents one-time funding that does not require future State appropriations.

State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services
Section 9813 of ARPA creates a state option to cover community-based mobile crisis intervention units during the 5-year period beginning April 1, 2021. This section offers 85 percent FMAP for the first 12 quarters of implementation of these types of services. Additionally, this section of ARPA made available funding for state planning grants for purposes of developing a State Plan Amendment (SPA) or Section 1115, 1915(b), or 1915(c) waiver request to provide qualifying community-based mobile crisis intervention services.

The Department has received a total of $800K through grant funding for this project. Currently, all $800K has been spent. No additional funding is required for the state planning aspect of this section. The Department implemented changes to its existing mobile crisis benefit to cover it under the State Plan authority available under ARPA and will be able to receive the enhanced 85 percent FMAP for 12 quarters, effective July 1, 2023.

Rural Healthcare Provider Expanded Access
SB 22-200, "Rural Provider Stimulus Grant Program," established a grant program for rural health care providers using money received from the federal government through ARPA. This bill appropriated $10M to the Department to award grants for projects that modernize the affordability solutions and the information technology of health-care providers in rural communities and projects that expand access to health care in rural communities.

The Department is required to adopt guidelines for the grant program and promulgate rules on or before December 31, 2022. The total grant funding is required to be spent by June 30, 2024. This section represents one-time funding that does not require future

State appropriations. As of June 30, 2024, $20K has been encumbered and $10K has been spent.

Healthcare Practice Transformation & Integration
HB 22-1302, “Healthcare Practice Transformation,” created the Primary Care and Behavioral Health Statewide Integration Grant Program to be administered by the Department to provide grants to physical and behavioral health care providers for the implementation of evidence-based clinical integration care models. These grants will be awarded using federal ARPA funds. This program also allocated 5.0 FTE to oversee the grant program and funding for contractors to support the grant program.

A total of $34.8M was appropriated to the Department as a result of this bill. The Department is still in the planning phase for spending. The total Department funds must be expended by December 31, 2026. This section represents one-time funding that does not require future State appropriations. As of June 30, 2023, the Department has encumbered $1.2M and spent $35K.

ARPA Administration Costs
Section 24-75-226 C.R.S. establishes the “American Rescue Plan Act of 2021” cash fund in the state treasury. This section allows for the transfer of money in the fund to another cash fund that is established for the purpose of using the money from the federal coronavirus state fiscal recovery fund. The State transferred $100K in funding to the Department which has been spent as of June 30, 2022. The purpose of this funding was for FTE costs related to the HCBS spending plan that were incurred prior to receiving spending authority for the initiatives proposed under the plan. This section represents one-time funding that does not require future State appropriations.

Medicaid Member Immunization Effort
Section 24-75-226 C.R.S. establishes the “American Rescue Plan Act of 2021” cash fund in the state treasury. This section allows for the transfer of money in the fund to another cash fund that is established for the purpose of using the money from the federal coronavirus state fiscal recovery fund. The State transferred $300K in funding to the Department for the Medicaid member immunization effort. The Department has hired 2.0 FTE for this project. As of June 30, 2023, the Department has encumbered and spent $160K.

Changes to Ongoing Federal Funds Received by Department, e.g. TANF, Medicaid

Following the declaration of a public health emergency by the Secretary of Health and Human Services during the COVID-19 pandemic, CMS notified states that an increased FMAP would be available for each calendar quarter occurring during the public health emergency, including retroactively to January 1, 2020. To be eligible to receive the 6.2 percentage point FMAP increase, states must adhere to a set of requirements which include, but are not limited to, maintaining eligibility standards, methodologies, and procedures; covering medical costs related to the testing, services, and treatment of COVID-19; and not terminating individuals from Medicaid if such individuals were

enrolled in the Medicaid program as of the date of the beginning of the emergency period or during the emergency period. The Department is compliant with all requirements and has been drawing the enhanced federal match accordingly. The Consolidated Appropriations Act of 2023 decoupled the continuous coverage requirement and the additional federal match from the public health emergency declaration. The current 6.2 percent additional match steps down to 5.0 percent from April 1, 2023 through June 2023, 2.5 percent from July through September 2023, and 1.5 percent from October through December 2023, after which there is no more additional match. To deal with the decrease in federal funds, the Department has assumed a greater state percentage of funding needed in its budget forecasts and requests.

Appendix A: Detailed Appropriations Tables

Table 1: FY 2023-24 Appropriations by Division and Fund Source						
Division	**Total**	**FTE**	**GF**	**CF**	**RF**	**FF**
Executive Director's Office	$601,367,240	744.4	$142,349,631	$90,839,665	$5,156,441	$363,021,503
Medical Services Premiums	$11,506,136,779	0.0	$3,216,123,250	$1,248,504,293	$99,768,813	$6,941,740,423
Behavioral Health Community Programs	$1,218,483,080	0.0	$284,702,715	$91,030,034	$0	$842,750,331
Office of Community Living	$1,084,572,880	39.5	$520,202,947	$24,022,216	$0	$540,347,717
Indigent Care Program	$475,996,712	0.0	$31,871,553	$175,771,539	$0	$268,353,620
Other Medical Services	$497,965,338	4.0	$272,176,614	$137,064,721	$220,500	$88,503,503
Department of Human Services Medicaid-Funded Programs	$122,226,550	0.0	$58,091,948	$1,936,723	$0	$62,197,879
Total	**$15,506,748,579**	**787.9**	**$4,525,518,658**	**$1,769,169,191**	**$105,145,754**	**$9,106,914,976**

Table 2: Total Budget Forecast, by Division and Year						
Division	**FY2021-22**	**FY2022-23**	**FY2023-24**	**FY2024-25**	**FY2025-26**	**FY2026-27**
Executive Director's Office	$498,368,286	$525,053,213	$601,367,240	$571,590,798	$571,590,798	$571,590,798
Medical Services Premiums	$10,038,962,570	$11,019,578,742	$11,506,136,779	$12,327,679,826	$13,131,255,767	$14,094,904,214
Behavioral Health Community Programs	$1,076,484,189	$1,138,133,497	$1,218,483,080	$1,199,781,438	$1,310,001,833	$1,398,423,889
Office of Community Living	$859,530,296	$910,383,541	$1,084,572,880	$1,194,500,026	$1,223,288,696	$1,278,462,753
Indigent Care Program	$439,902,383	$442,176,452	$475,996,712	$514,649,958	$534,596,105	$549,503,425
Other Medical Services	$424,875,977	$504,223,710	$497,965,338	$453,560,199	$472,550,812	$498,073,692
Department of Human Services Medicaid-Funded Programs	$123,284,067	$119,227,795	$122,226,550	$125,727,443	$125,727,443	$125,727,443
Total	**$13,461,407,768**	**$14,658,776,950**	**$15,506,748,579**	**$16,387,489,688**	**$17,369,011,454**	**$18,516,686,214**