Department of Health Care Policy and Financing

Line Item Descriptions

FY 2024-25 Budget Request

November 2023

I. LINE ITEM DESCRIPTION

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office Long Bill group of the Department's budget contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determination, client and provider services, utilization and quality review, and information technology contracts. This division is divided into eight subdivisions.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's Full-Time Equivalent (FTE), personal services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department. A description of each line item is presented below.

PERSONAL SERVICES

This line item funds the majority of the Department's expenditures for FTE, temporary staff, and some of its contractors. Allocated Payroll Expenses Other Than Salary (POTS) for the FTE, including Salary Survey, Merit Pay, Health, Life, and Dental, Short-Term Disability, Amortization Equalization Disbursement, and Supplemental Amortization Equalization Disbursement, are paid through this line item.

HEALTH, LIFE, AND DENTAL

This line item funds the Department's health, life, and dental insurance benefits, and is part of the POTS component paid jointly by the State and State employees. The calculated annual appropriation is based upon recommendations contained in the annual Total Compensation Report and associated guidance from the Governor's Office of State Planning and Budgeting (OSPB) and is calculated based upon employee benefit enrollment selections.

SHORT-TERM DISABILITY

This line item, a component of POTS, provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. This benefit is calculated on an annual basis in accordance with OSPB Common Policy instructions.

AMORTIZATION EQUALIZATION DISBURSEMENT

This line item funds the increased employer contribution to the Public Employees' Retirement Association (PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. The request for this line item is computed in accordance with OSPB Common Policy instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. The request for this line item is computed in accordance with OSPB Common Policy instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235, which created this line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY

The Salary Survey appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the Total Compensation survey performed annually by the Department of Personnel and Administration (DPA). The annual request for this line item is calculated based upon the annual Total Compensation recommendations from the State Personnel Director, along with guidance provided via the OSPB Common Policy instructions.

PERA DIRECT DISTRIBUTION

This line item was created in the FY 2019-20 Long Bill (SB 19-207) per SB 18-200. The PERA Direct Distribution is an annual contribution the State must make to PERA until the unfunded liabilities of the State, judicial, school, and Denver Public Schools (DPS) divisional trusts are paid.

TEMPORARY EMPLOYEES RELATED TO AUTHORIZED LEAVE

The enactment of HB 22-166 State Employee Total Compensation Philosophy created a new line-item Temporary Employees Related to Authorized Leave to cover the cost of temporary employees hired to fill positions for permanent employees who are on leave for family or medical reasons. Amendment J.145 to HB 22-1329 authorized the change in the FY 2022-23 Long Bill.

WORKERS' COMPENSATION

This line item provides funding for payments made to the Department of Personnel and Administration (DPA) to support the State's self-insured Worker's Compensation program. Workers' Compensation is a statewide allocation to each Department based upon historic usage. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and Common Policy adjustments. DPA's actuaries determine departmental allocations.

OPERATING EXPENSES

This line item funds the expenses necessary for the Department and its staff to operate. This includes funding for office essentials such as telephones, computers, office furniture, and office supplies as well as requisite travel, both in- and out-of-state, for site visits, public meetings, stakeholder engagement, and training. This line also funds building maintenance and repairs, storage of records, public noticing and postage costs and subscriptions to federal publications.

LEGAL SERVICES

This Common Policy line item funds the Department's expenditures for legal services provided by the Department of Law. The Department is billed based on a blended attorney/paralegal hourly rate developed by the Department of Law.

ADMINISTRATIVE LAW JUDGE SERVICES

This Common Policy line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. Departmental appropriations are based upon historical utilization of these services, by applying the prior year's billable hours to the estimated billable cost for the request year. Adjustments are made based on mid-year reviews by the Department of Personnel and Administration.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

This Common Policy line item is an allocation appropriated to each department based on a shared statewide risk formula for property and liability insurance coverage, also known as the Liability Program and Property Program. In addition, this line item supports common resources for the Colorado State Employee Assistance Program which was transitioned from the Worker's Compensation allocations to the Liability allocations beginning in FY 2013-14.

LEASED SPACE

Previously called Commercial Leased Space, this line item was established in FY 2003-04 as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258). The line item is necessary to pay for the Department's obligations for leases of private office space and other facilities that are not State-owned.

PAYMENTS TO OIT

Starting in FY 2014-15, this Common Policy line item combines four Office of Information Technology (OIT)-related line items that were previously separated in the Long Bill. This line item funds the Department's allocation for services provided by OIT, including centralized computer services, provision and administration of the Colorado State Network, information technology security, new OIT initiatives, and OIT's internal office expenses.

IT ACCESSIBILITY

This line was created in the FY 2023-24 Long Bill, SB 23-214, and provides one-time funding for FY 2023-24, however, any unused funds are authorized to roll forward into FY 2024-25. The line item provides funding so that the Department can be in compliance with HB 21-1110 Colorado Laws for Persons with Disabilities. Funding will be used to implement the IT Accessibility adoption plans, including testing and remediation of websites, applications, documents, and systems, to identify those that are not compliant with state standards and correct the accessibility issues.

CORE OPERATIONS

This Common Policy line item resulted from the FY 2012-13 Long Bill (HB 12-1335) and was renamed from Colorado Financial Reporting System (COFRS) Modernization to Colorado Operations Resource Engine (CORE) Operations in the FY 2015-16 Long Bill (SB 15-234). It funds the Department's allocation for services related to the implementation and ongoing

support of the new statewide accounting system used by the Office of the State Controller to record all State revenues and expenditures. The new system is needed to meet the State's fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in FY 2007-08 and contains appropriations for any special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO/FROM OTHER DEPARTMENTS

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES

This line item funds a portion of the administrative expenses of the Public School Health Services Program created in SB 97-101. The program uses Medicaid funds to support local school health services, increase access to primary and preventive care to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers. The State share of program funding is derived from certification of public expenditures which allows participating school districts to certify their expenditure of eligible Medicaid services and receive a federal match through Title XIX of the Social Security Act. Pursuant to section 25.5-5-318(8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. This line funds the administrative expenses of the Department of Education, including the provision of technical assistance to program coordinators at participating school districts and the review of all local services plans and annual reports.

TRANSFER FROM THE DEPARTMENT OF EARLY CHILDHOOD FOR NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income (below 200% of the federal poverty level), first-time mothers with a baby less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

The trained visiting nurses educate mothers on the importance of nutrition and avoiding alcohol and drugs (including nicotine) and to assist and educate mothers on providing general care for their children and to improve health outcomes for their children. In addition, visiting nurses may help mothers to locate assistance with educational achievement and employment. This type of service is sometimes referred to as "targeted case management," involving a coordinated, ongoing, and personalized strategy for clients with a variety of needs, both medical and non-medical. Each unit of service provided equals 15 minutes and is rated and billed based on that timeframe. In addition to targeted case management, a Department rule change in March 2017 eased physician supervision requirements for nurses, which allows Nurse Home Visitor Program nurses to bill Health First Colorado for direct services, such as preventive counseling and depression screens. The goals of the program are improvements in pregnancy outcomes and the health and development of their children, as well as long-term economic self-sufficiency of their families. Prior to HB 13-1117, the program was funded through the Department of Public Health and Environment. It was then funded through the Department of Human Services until FY 2022-23, when HB 22-1329 created the Department of Early Childhood, which began administering the program.

TRANSFER TO DEPARTMENT OF LOCAL AFFAIRS FOR HOST HOME REGULATION

This line item was created in the FY 2019-20 Long Bill (SB 19-207) from the Department's FY 2019-20 R-14 "Office of Community Living Governance" budget request. It includes funding for the Department of Local Affairs for costs of 1.0 FTE, onsite inspections, and regulation of Medicaid host home providers.

TRANSFER TO DEPARTMENT OF LOCAL AFFAIRS FOR HOME MODIFICATIONS BENEFIT ADMINISTRATION

This line item includes funding for 2.0 FTE within the Division of Housing to administer the home modification benefit under the Elderly, Blind and Disabled, Spinal Cord Injury, Community Mental Health Supports, and Brain Injury Waivers. Funding also ensures that bids for home modifications are correctly structured, and that home modifications are finished timely and meet housing codes.

TRANSFER TO CDPHE FOR FACILITY SURVEY AND CERTIFICATION

The Department of Public Health and Environment (CDPHE) is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. Federal regulations at 42 C.F.R. § 488 authorizes and sets requirements for both Medicare and Medicaid surveys and certification of health facilities. This line item helps to fund the survey and certification of nursing facilities, hospices, home health agencies, and Home- and Community-Based Services agencies (including alternative care facilities, personal care/homemaking agencies, and adult day services) by paying the Medicaid

share. The Department also pays CDPHE to maintain and operate the Minimum Data Set resident assessment instrument, which is used for nursing facility case mix reimbursement methodology. However, the Minimum Data Set resident assessment instrument, from which the data is obtained, is not Medicaid funded. The Department contracts with CDPHE through an interagency agreement for these functions. Federal financial participation is broken into two categories: 1) expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals' expenditures related to long-term care facilities, and 2) expenditures qualifying for a 50% federal financial participation rate to cover POTS and other Common Policies for the FTE that perform these services. While the CDPHE FTE is working in the field to survey and inspect the facilities, that FTE qualifies for 75% federal financial participation. After the FTE returns to the office to complete the paperwork associated with the inspection, the FTE time in the office qualifies for 50% federal financial participation. The FTE uses a time reporting sheet that details how each hour of work is spent, so that Medicare and Medicaid funding can be claimed as applicable.

The federal Centers for Medicare and Medicaid Services (CMS) also requires that the State be in compliance with Medicare requirements for home health and licensure for hospice agencies. Facility surveys associated with compliance for these Medicare requirements are also performed by DPHE; however, they are Medicare funded rather than Medicaid funded.

TRANSFER TO CDPHE FOR PRENATAL STATISTICAL INFORMATION

The Department requires statistical data to evaluate the effectiveness of the Prenatal Plus program that used to be managed by CDPHE but is now managed by the Department, effective FY 2011-12. CDPHE had been measuring the effectiveness of the program by using data supplied by the CDPHE Vital Statistics office. The departments determined that it would be more cost-effective to continue to use the Vital Statistics data rather than to create a new tracking system for this purpose, so funding is allocated to reimburse DPHE for this purpose. This line item was newly established as a result of the Department's FY 2011-12 Budget Request DI-8 "Prenatal Plus Administration Transfer."

TRANSFER TO DORA FOR NURSE AIDE CERTIFICATION

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150(b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (CDPHE). The Department provides Medicaid funding for the program and CDPHE provides Medicare funding for the program. Pursuant to section 12-38-101, C.R.S., the Colorado State Board of Nursing in DORA oversees regulation of certified nurse aides practicing in medical facilities throughout the State. The regulation of nurse aides is carried out under the Nurse

Aide Certification program, which includes a nurse aide training program, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

DORA is required to administer the Nurse Aide Certification program using established standards for the training curriculum to ensure that nurse aides receive federally required training and that nurse aides are tested regularly to assure competency. DORA is also responsible for administering a nurse aide registry program that allows investigations into allegations of abuse by nurse aides, when necessary. The registry also tracks the mandatory criminal background check required for nurse aides per the passage of HB 95-1266.

State funding for this program is comprised of General Fund and fees collected directly from nurse aides. These fees are assessed as part of the required criminal background check. Federal regulations prohibit requiring nurse aides to pay for certification, but requiring non-certified nurse aides to pay the cost of the background check is a permissible exception to these regulations. Many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements. The State funds, consisting of General Fund and reappropriated funds from DORA, are used to draw down federal funds.

TRANSFER TO DORA FOR REVIEWS

The Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies (DORA) conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when the Department had a law requiring a sunset review, a specific line item was established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review.

This line item was established in the FY 2009-10 Long Bill Add-Ons (SB 09-259), beginning with FY 2008-09. The line item name was created to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a type of audit that are performed to provide information to the General Assembly on the effectiveness and efficiencies of particular programs. This information is used by the General Assembly to provide guidance on future legislation or modifications to current legislation. Statutory authority authorizing DORA to conduct these reviews comes from section 24-34-104(8)(a), C.R.S. DORA calculates the anticipated costs for performing particular sunset reviews and notifies the Department by letter so that the costs can be requested in the future year budget submission for the Long Bill.

TRANSFER TO THE DEPARTMENT OF EARLY CHILDHOOD FOR EARLY INTERVENTION SERVICES

This line item was created by HB 22-1295 Department Early Childhood and Universal Preschool Program. The Department provides funding for case management expenses associated with Medicaid eligible programs operated by the Early Intervention Program at the Department of Early Childhood. Community Center Boards (CCBs) are designated by the State to provide case management services, which include intake, developmental disability determination, financial eligibility, service plan development, referral for services, monitoring of services, and many other functions.

TRANSFER TO THE DEPARTMENT OF REVENUE FOR HOSPITAL COMMUNITY BENEFIT

This line item was created during the FY 2023 Legislative Session through HB 23-1243 Hospital Community Benefit. The hospital community benefit program requires non-profit hospitals to make investments that address health needs in their communities. Funding in this line item will be reappropriated to the Department of Revenue so it can calculate the federal, state, and local tax exemption received by each hospital.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

Beginning with the FY 2013-14 Long Bill (SB 13-230), this line item, formerly known as "Information Technology Contracts" was renamed "Medicaid Management Information Systems Maintenance and Projects."

The Medicaid Management Information Systems (MMIS) is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The MMIS processes claims and capitations based on system generated reviews that determine payment or payment denial, and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from MMIS.

The MMIS is federally required for states that participate in the Medicaid program (Section 1903(r) of the Social Security Act). The Centers for Medicare and Medicaid Services' (CMS) *State Medicaid Manual* identifies the specific types of MMIS costs that are allowable for federal reimbursement.

The Department's new MMIS was implemented in November 2016 and consists of three interacting systems. Those systems include:

- Colorado interChange - the core system responsible for claims processing and Fiscal Agent services;
- Pharmacy Benefits Management System (PBMS) - the system responsible for pharmaceutical management services;
- Business Intelligence and Data Management Services (BIDM) - the system responsible for data analytics services.

Beginning in FY 2021-22, funding previously paid from the Health Information Exchange Maintenance and Projects line will be paid out of this line item. As of October 1, 2021, the federal authority for this work will change from Health Information Technology for Economic and Clinical Health Act, which was part of the American Recovery and Reinvestment Act of 2009 (ARRA-HITECH) to the MMIS. This funding generally supports improving health data sharing through investments in the State's Health Information Exchanges (HIEs).

COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES

The Colorado Benefits Management Systems (CBMS), Operating and Contract Expenses line item was created as a result of the Department's FY 2015-16 S-6/BA-6 CBMS Funding Simplification supplemental request to streamline billing processes related to CBMS. The new line item consolidates CBMS funding from line items formerly in the Department's DHS Medicaid-Funded Programs Long Bill group (7), including the former Colorado Benefits Management Systems; HCPF Only Projects; and CBMS SAS-70 Audit line items. This funding was consolidated to allow the Department to reimburse the Governor's Office of Information Technology (OIT) directly, rather than the previous process of reimbursing OIT through transactions with the Department of Human Services (DHS).

The system tracks client data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. There is no specific authorization in statute that specifically mentions CBMS; however, authorization can be inferred from 25.5-5-101, C.R.S. The OIT currently has oversight of daily operations for the CBMS vendor. All OIT funding for CBMS is reappropriated from the Department and DHS. Costs are allocated to the various State and federal programs participating in CBMS through the federally approved cost allocation process, primarily determined through polling results of the county departments of human/social services staff according to a federally approved Random Moment Sampling methodology.

A broad range of components are funded from this appropriation: including vendor payments; Department only projects; computer hardware maintenance and repairs; computer software maintenance and upgrades; non-computer equipment rental; building rental; rental of computers and network equipment; travel expenses; training expenses;

telecommunication services; printing and reproduction of paper documents; legal services; freight and shipping charges; data-processing supplies; office supplies; postage; copy supplies; non-capitalized equipment purchases; dues and memberships; registration fees; capital lease principal payments; and capital lease interest payments.

COLORADO BENEFITS MANAGEMENT SYSTEMS, HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item, previously entitled "CBMS Modernization Project Personal Service, Operating Expenses and Centrally Appropriated Expenses", provides funding for Department and DHS staff with the Health Care and Economic Security Staff Development Center. The Health Care and Economic Security Staff Development Center is the training connection between DHS, the HCPF and OIT to the 64 county departments of Social/Human Services; as well as medical assistance, presumptive eligibility and certified application assistance sites for Medicaid/CHP+ throughout Colorado.

The Staff Development Center works to identify essential training needs and to establish, facilitate, and maintain competency-based training curricula while continually evaluating results, providing a complete training array to staff working with families who are accessing medical and other types of public assistance, such as the Supplemental Nutrition Assistance Program (SNAP), Medicaid, CHP+, and the Temporary Assistance for Needy Families (TANF) program.

OFFICE OF eHEALTH INNOVATIONS OPERATIONS

This line item was created in the FY 2019-20 Long Bill (SB 19-207) from the non-prioritized budget request related to the Governor's Office of eHealth Innovation (OeHI) capital and operating budget requests. Funding is for initiatives outlined in the Colorado Health IT Roadmap. Executive Order B 2015-008 officially created the Governor's Office of eHealth Innovation and the eHealth Commission to provide advice and guidance to the State on advancing Health Information Technology in Colorado. The Department serves as the fiscal agent leveraging the State's procurement, contracting, and accounting established process to manage solicitations, contracts, and payments to vendors and organizations on behalf of the new Office of eHealth Innovation. Beginning in FY 2021-22, the federal funding authority for the work will be through the MMIS as the prior federal funding mechanism (ARRA-HITECH) expired on September 30, 2021.

ALL PAYER CLAIMS DATABASE

This line item pays for Medicaid's share of the All-Payer Claims Database (APCD) and includes $500,000 General Fund for a scholarship program to promote access to the APCD. During the 2020 Legislative Session, the General Assembly eliminated the $500,000 General Fund scholarship program funding and reduced the remaining General Fund

appropriation by 25%. During the 2022 Legislative Session, the General Assembly restored the $500,000 General Fund scholarship program funding and restored the 25% General Fund reduction.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for two Department functions: Disability Determination Services and nursing facility Preadmission Screening and Resident Review (PASRR).

Disability Determination Services

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services (DHS) to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from DHS to the Department.

Preadmission Screening and Resident Review (PASRR) Assessments

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this program is 75%.

All admissions to nursing facilities with Medicaid certified beds, regardless of individual payer source, are subject to preadmission screening, and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, that they remain in the nursing facility for the appropriate amount of time, and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services (DHS) budget through an interagency transfer and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs administered by DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, thereby establishing a direct relationship between the Department and the counties performing these functions.

As part of the Department's fiscal note for SB 06-219, the Department and DHS agreed that the allocation and reimbursement methodology would remain the same as prior to July 1, 2006. This included: 1) using the existing federally-approved random moment sampling model performed by DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 2) continuing to use a cost-sharing allocation; 3) continuing to utilize the County Financial Management System for counties to have one-stop billing; and, 4) utilizing interagency transfers of General Fund between the Department and DHS pursuant to 24-75-106, C.R.S. in order to maximize Medicaid reimbursement to the counties. Subsequent appropriations for County Administration have been made without including a local share; as a result, the State, county and federal share of the appropriation do not follow the traditional 30% General Fund, 20% local share, and 50% federal funds that were historically seen.

The General Assembly appropriated additional funding to this line item in SB 13-200, which authorized Medicaid expansion under the Affordable Care Act. Additionally, to meet the expected high demand for eligibility determination services, the Centers for Medicare and Medicaid Services (CMS) examined its current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and has confirmed that certain eligibility determination-related costs are eligible for 75% federal financial participation (FFP), which has reduced the State and federal share for certain activities that a reimbursed under this line item. Counties can access the enhanced funding through random moment sampling (RMS) or direct coding.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support an incentive payment structure to counties. The incentive payment structure encourages faster and more accurate application processing and other process improvements in order to create a more efficient and effective

eligibility determination process. In the Department's FY 2017-18, S-11, BA-11: "County Administration Financing" the General Assembly approved combining the Hospital Provider Fee County Administration line item into this line item.

At the beginning of the COVID-19 pandemic, the federal government declared a public health emergency (PHE). All Medicaid and most Child Health Plan Plus (CHP+) members were remained enrolled (known as "locked in") and were eligible to receive benefits during the PHE. Continuous coverage of benefits has ended as of May 2023, and the process for member redeterminations and appeals has begun.

During the FY 2021 Legislative Session the General Assembly approved additional funding from the Department's FY 2021-22 BA-10 End PHE Resources budget request, in order to provide the Department and the counties with the resources to review eligibility redeterminations for all locked-in members and process any member appeals at the end of the PHE. With the PHE extended, the Department submitted the FY 2022-23 BA-06 PHE County Administration Resources in order to shift funding from FY 2021-22 to FY 2022-23. Funding was further shifted from FY 2022-23 to FY 2023-24 and FY 2024-25 in BA-06 PHE Funding due to continued extensions of continuous coverage of benefits under the PHE.

During the FY 2022 Legislative Session, the General Assembly approved additional county administration funding from the Department's FY 2022-23 R-08 County Administration Oversight and Accountability budget request to help cover county administration state funding shortfalls and increase the county incentive program budget.

MEDICAL ASSISTANCE SITES

This line item was originally funded through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" and provides funding to Medical Assistance (MA) sites for their Medicaid eligibility determination activities. The sites were renamed to Eligibility Application Partner (EAP) sites in FY 2020-21 contracts, based on federal guidance.

This line item funds EAP sites to conduct Medicaid eligibility determination on location. EAP sites offer additional points of contact for Medicaid eligibility determination and eligibility workers are stationed at places such as schools, clinics and hospitals in order to assist clients. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet and support the Department's aim to have "no wrong door" in determining client eligibility. Previously, EAP sites were unfunded for their eligibility determination activities.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services (CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – Medicaid Funded Programs appropriations.

Funding for administrative case management includes reimbursement for staff and operating costs associated with State supervision and county administration of programs that protect and care for children, including out-of-home placement, subsidized adoptions, child care, and burial reimbursements. Medicaid funding for these costs was identified through a contingency based contract held between the Governor's Office of State Planning and Budgeting and Public Consulting Group, Inc.

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. Also similar to the County Administration appropriation, DHS has agreed to provide additional General Fund spending authority if necessary, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with this funding.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department functions: the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker. Prior to FY 2008-09, each of these functions was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote 22 of the FY 2007-08 Long Bill (SB 07-239), instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result of the FY 2008-09 Long Bill (HB 08-1375), 46 line items were consolidated into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated budget items were the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker, which were combined into one line item entitled "Customer Outreach". The purpose of the funding is described as follows.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

The Department is required to ensure compliance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, including but not limited to outreach and case management services, are provided in a manner consistent with the federal regulations set forth at 42 CFR §§ 441.50-441.61. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services for children. The services include, but are not limited to:

- Initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring EPSDT clients as needed to those agencies and resources.
- Contacting eligible clients to provide in-depth explanation of the program and its importance within 60 days of eligibility being established.
- Offering assistance and information to eligible clients and helping to overcome barriers which might impede access to services.
- Clarifying the role of primary care providers, dentists, and the managed care/prepaid health plans.
- Emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician.
- Maintaining periodic contact with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed.
- Assisting clients with the program and managed care information process; and,
- Referring applicants to the enrollment broker at the time of Medicaid application.

Beginning in FY 2020-21, only the Department's administrative and oversight costs of the EPSDT program are funded by this budget item. All outreach services listed above and previously funded by this budget item are now contracted out to the Regional Accountable Entities (RAEs) and Medicaid Managed Care Organizations (MCOs) and included in their per member, per month rates.

Enrollment Broker

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-005. The vendor contracted to serve as the enrollment broker is charged with providing unbiased choice counseling to assist eligible Health First Colorado and Child Health Plan Plus (CHP+) clients to choose available health plans and a primary care medical provider (PCMP). If a client chooses a health plan or a PCMP, the vendor will enroll the client in the plan or with the PCMP. The enrollment broker also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. The enrollment broker performs this work under the name of Health First Colorado Enrollment. As of January 1, 2013, the enrollment broker vendor provides enrollment services for the CHP+ program.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) based on the recommendation by The Blue Ribbon Commission for Health Care Reform (the "208 Commission") to create a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility and to assist county departments of social services with increased eligibility determination and case maintenance duties arising from HB 09-1293 "Medicaid Hospital Provider Fee" and SB 13-200 "Expand Medicaid Eligibility." The centralized eligibility vendor was re-procured in FY 2015-16 and its role evolved to take on a narrower set of duties in response to county feedback and performance metrics. To reflect this, the General Assembly approved the department's FY 2016-17 R-7 "County Administration Financing" and this line was moved from the Executive Director's Office (C) Information Technology Contracts and Projects Long Bill group into the Executive Director's Office (D) Eligibility Determinations and Client Services in the FY 2016-17 Long Bill (HB 16-1405).

Currently, the centralized eligibility vendor provides a variety of eligibility and enrollment services for Colorado's Medicaid and CHP+ medical assistance programs. These services include eligibility determination and case maintenance for Medicaid Buy-In programs, administering monthly premium payments for Medicaid Buy-In programs and annual enrollment fees for CHP+, managing the appeals and grievances process for eligibility and enrollment disputes, and processing CHP+ manual enrollment and disenrollment. The centralized eligibility vendor also runs the state's central customer service center for Medicaid and CHP+ eligibility and enrollment assistance, which processes over-the-phone medical assistance applications and renewals, assists callers with completing online and paper applications for medical assistance, assists with making premium and enrollment fee payments, provides information on department programs and eligibility requirements, and processes case updates such as address and income changes.

CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

This line item was created in the FY 2016-17 Supplemental Appropriations Bill (SB 17-162) and FY 2017-18 Long Bill (SB 17-254). This funding provides federal funds reimbursement to Connect for Health Colorado for allowable eligibility determination and customer service costs they incur that qualify as certified public expenditures related to the administration of Medical Assistance programs.

ELIGIBILITY OVERFLOW PROCESSING CENTER

This line item was created in the FY 2021-22 Long Bill when the General Assembly approved the Department's FY 2021-22 BA-10: PHE End Resources budget request. This line item provides ongoing funding so the Department can contract with a county or counties to oversee processing of the backlog of Medicaid and CHP+ applications, eligibility determinations, and redeterminations.

RETURNED MAIL PROCESSING

This line item was created in the FY 2020-21 Long Bill (HB 20-1360) from the Department's FY 2019-20 R-6 "Local Administration Transformation" budget request. This line item funds a vendor who processes returned mail generated by the Colorado Benefits Management System (CBMS) for the State. This includes funding for programs managed by the Department and Colorado Department of Human Services.

WORK NUMBER VERIFICATION

This line item was created in the FY 2020-21 Long Bill (HB 20-1360) from the Department's R-15 "Work Number Verification" budget request. This line item provides funding in order to implement a robust income verification process for Medicaid and CHP+ eligibility determinations based on real-time verifications. The Department will set up contract with a vendor to obtain work number verification data and anticipates costs avoided from a reduction in Medicaid caseload.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Acute Care Utilization Review, Long-term Care Utilization Review, External Quality Review, Drug Utilization Review and Mental Health External Quality Review were combined into one line item titled "(E) Utilization and Quality Review Contracts: Professional Services Contracts" within Long Bill group (1) Executive Director's Office.

Acute Care Utilization Review

Acute Care Utilization Review budget item includes the performance of prospective reviews for specified services to ensure that requests for benefits, services and supplies are a covered benefit and that they are medically necessary and appropriate. Reviews are conducted prior to the delivery of services and supplies, and include the following categories: audiology, pediatric behavioral therapy, diagnostic imaging, durable medical equipment (DME), speech therapy, inpatient out-of-state admissions, medical services including transplant and bariatric surgeries, physical and occupational therapy, pediatric long-term home health (LTHH), private duty nursing, certain office administered drugs, and vision.

The Department contracts with an independent contractor to perform these reviews. The reviews ensure that members receive the right services and supports at the right time, for the right amount and duration, and in the right setting. Requiring prior authorization improves the quality of care for members while decreasing services and supplies that are not medically necessary and are duplicative. This results in decreased costs for Department. Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 C.F.R. §433.15 (6)(i), the Department receives enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization as defined under Section 1152 of the Social Security Act.

Long-Term Care Utilization Review

Long-term care utilization reviews include performing prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reevaluation of services.

The Department receives enhanced federal financial participation of 75% for the performance of medical and utilization review activities.

External Quality Review

This budget item provides funding to validate performance improvement projects (PIPs), conduct compliance site reviews, conduct satisfaction surveys, collect and validate Healthcare Effectiveness Data and Information Set (HEDIS) measures and other performance measures for managed-care organizations and fee-for-service providers, and complete other encounter data audits. In addition to creating reports for these activities Health Services Advisory Group, Inc. also creates annual Technical Reports of activities and recommendations that is required by the Centers for Medicare and Medicaid Services (CMS).

The Department is permitted to receive an enhanced federal financial participation (FFP) rate of 75% for funds expended for performance of external quality review or related activities when they are conducted by an external quality review organization as defined in 42 C.F.R. § 438.320. Additional requirements for the enhanced FFP rate can be found in 42 CFR § 438.370, 42 CFR § 438.364, and 42 CFR § 433.15(b)(10).

Drug Utilization Review

This budget item funds the Department's drug utilization review program established pursuant to 42 C.F.R. §456.703. The purpose of the program is to ensure appropriate drug therapy while permitting sufficient professional prerogatives to allow for individualized drug therapy. The program consists of both prospective and retrospective reviews, the application of explicit predetermined standards, and an educational program. Pursuant to 25.5-5-506 (3) (b), C.R.S., the Department submits an annual report to the Health and Human Services Committees of the General Assembly that contains:

- Information on the prospective and retrospective drug review program;
- Steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards;
- Summary of the educational interventions used and an assessment of the effect of these educational efforts on quality of care; and,

- Estimate of the cost savings generated as a result of the drug use review program.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item funds various audit contracts managed by the Department.

Nursing Facility Audits

This budget item funds statutorily required audits of costs reported by Medicaid nursing facilities for rate setting purposes. The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient-related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes.

Hospital and Federally Qualified Health Centers Audits

This budget item funds a Department contract with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers (FQHCs), and rural health centers that participate in the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and participation in meetings with providers to resolve problems. The annual rates of reimbursement are based on the results of these audits and are set to cover the reasonable and necessary costs of an efficiently run hospital, FQHC, and rural health center, per federal and State law.

Single Entry Point Audits

This budget item funds annual audits of single entry point (SEP) agencies provided through a contractor. The scope of work has been limited to reviews of cost reports. To the extent that funds allow, on-site audits are conducted for agencies

that pose the highest risk. In FY 2006-07, the appropriation to this line was increased in order to increase the accuracy of SEP agency billing and potentially increase recovery of improper payments.

Community Mental Health Center Audits

This budget item funds annual audits of the Community Mental Health Centers (CMHC) which are nonprofit or publicly operated clinics that provide mental health services in the community. Specifically, the RAEs contract with the 17 CMHCs to provide mental health services to Medicaid clients in their assigned service area. The Colorado Department of Human Services also contracts with the CMHCs to provide mental health services to indigent persons (i.e., non-Medicaid-eligible individuals).

Regional Center Cost Reporting and Auditing

This funding allows the Department to ensure that Regional Centers receive proper compensation for the services they provide to some of the Department's most acute and vulnerable clients. Additionally, this ensures that the Department would remain in compliance with CMS, as the cost reports would ensure Regional Centers are properly compensated according to their actual costs. This helps to meet one of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" by ensuring the Regional Centers are accurately compensated

Nursing Facility Appraisals

This budget item funds nursing facility appraisals, which occur once every four years. The Department contracts with an independent firm to conduct these appraisals, with the underlying result being the determination of "fair rental value." Fair rental value, or appraised value, means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental (property) value determination is used in the process of rate setting, which is governed by statute at 25.5-6-201, C.R.S. The per-diem rate paid to nursing facilities is based in part on the fair rental value of the facility. Due to the four-year cycle, the Department will complete nursing facility appraisals in FY 2022-23 and will do so again in FY 2025-26.

Disproportionate Share Hospital Audits

This budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of FY 2010-11 DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures". This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements

mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

DSH payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients. These payments assist in securing the hospitals' financial viability and preserving access to care for Medicaid and low-income clients, while reducing the shift in costs to private payers. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

Managed Care Organization Audits

This budget item provides funding for Managed Care Organization Audits as a result of the FY 2015-16 R-15 "Managed Care Organization Audits". This funding is used to hire an auditing firm to perform audits on financial reports and encounter data from physical and behavioral health managed care organizations that contract with the Department. Prior to the passage of this funding, the Department did not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics. This budget item allows for the Department's contractor to:

- Conduct a thorough review of current managed care contract language to identify weaknesses and recommend appropriate changes to specific language;
- Use selected algorithms on claims data of managed care plans to identify outlier populations that could be at risk of overpayment;
- Test identified outlier populations to ensure compliance with regulations for allowable medical expenses;
- Tie financial reports to supporting information to ensure reporting accuracy in accordance with standards established by the American Institute of Certified Public Accountants; and
- Audit of administrative expenses to ensure reported expenses are allowable and accurate.

eConsult Program

During the FY 2021 Legislative Session, the General Assembly approved the Department's FY 2021-22 BA-15 Implement eConsult Program budget request. One component of the approved funding allows the Department to provide quality oversight of eConsults to ensure the program has proper provider training on the effective utilization of eConsults. Funding was approved for the first few years of the program and is scheduled to be implemented in February 2024.

Recovery Audit Contract Program

During the FY 2022 Legislative Session, the General Assembly approved the Department's FY 2022-23 R-13 Compliance FTE budget request. Under CFR § 455 Subpart F, all states are mandated to contract with a vendor to conduct post-payment claim audits on all programs. As a result, one component of the approved funding allows the Department to review projects on an ongoing basis, auditing multiple provider types including medical equipment providers, hospitals, laboratories, and physicians.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, established by HB 91S2-1030 and authorized in 25.5-4-302, C.R.S., is operated by a contractor under supervision of the Department. The contractor pursues recoveries on a contingency fee basis and recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. Since FY 2003-04, the contractor has charged a contingency fee of 10.9%, with the remainder of the recoveries acting as an offset to expenditure in the Medical Services Premiums line.

THIRD PARTY LIABILITY COST AVOIDANCE CONTRACT

This line item was created in the FY 2020-21 Long Bill (HB 20-1360) from the Department's FY 2020-21 R-15 "Medicaid Recovery and Third-Party Liability Modernization" budget request. This line item funds the contractor costs for enhancing the process for cost avoidance of claims by providing information on members with other health coverage.

(H) INDIRECT COST RECOVERIES

INDIRECT COST ASSESSMENT

This line item resulted from the passage of the FY 2013-14 Long Bill (SB 13-230). It was created to separately identify the overhead costs associated with the operation of general government functions. Indirect cost recoveries are intended to offset these overhead costs that otherwise would have been supported by the General Fund, from cash and federally funded sources. Recoveries from cash and federally-funded programs are calculated for statewide overhead costs by the Office of the State Controller.

(2) MEDICAL SERVICES PREMIUMS

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, individuals with disabilities, adults, and children. Medical services are grouped into the following categories, each of which includes several programs: acute care, community-based long-term care, and long-term care. Additional expenditure is incurred for insurance, service management, and financing payments. Through FY 2023-24 BA-7 "Community-based Access to Services", the Department requested and received approval to expand access to certain community-based services. These include expanding access to personal care, homemaker and health maintenance services to members on the state plan, and expanding transition services for members on a community based waivers. For a program-level description of each of these categories of services, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-1, "Request for Medical Services Premiums."

To calculate the funding need for the Medical Services Premiums Line, the Department must forecast Medicaid caseload. The caseload presentation is included in the Department's November 1 Budget Request as a separate exhibit. For a detailed narrative of the caseload forecast, please see the "Medicaid Caseload" Section included in this budget submission.

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health and substance abuse services throughout Colorado through managed-care providers contracted by the Department. The Regional Accountable Entities (RAEs) are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each Regional Accountable Entity for each Medicaid client in each Medicaid eligibility category that is covered by the RAE contract. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's November 1 Budget Request R-2, "Request for Medicaid Behavioral Health Community Program."

BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a Regional Accountable Entity to receive mental health or substance abuse services or enrolled Medicaid clients to receive mental health or substance abuse services not covered by the Regional Accountable Entities. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's November 1 Budget Request R-2, "Request for Medicaid Behavioral Health Community Program."

(4) OFFICE OF COMMUNITY LIVING

In 2012, Governor Hickenlooper issued Executive Order D 2012-027, establishing the Office of Community Living within the Department. The Office is charged with better aligning services and supports so that people with long-term services and supports needs, and their families, do not have to navigate a complicated and fragmented health care system. HB 13-1314, "Transfer Developmental Disabilities to HCPF" transferred funding from the Department of Human Services to the Department, effective March 2014. As a result, this Long Bill group was established with the FY 2014-15 Long Bill (HB 14-1336).

The Office of Community Living Long Bill group of the Department's budget contains the administrative and programmatic funding for services and supports for persons with intellectual and developmental disabilities and their families. Funding extends to FTE, operations support for a standalone case management system, and services and supports for eligible individuals and their families.

(A) DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

(1) ADMINISTRATIVE COSTS

PERSONAL SERVICES

This line item funds the Department's expenditures for FTE and temporary staff who work in support of persons with intellectual and developmental disabilities and their families. It was created as part of HB 13-1314 "Transfer Developmental Disabilities to HCPF", which transferred the administration of long-term services for persons with intellectual and developmental disabilities to the Department. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through the Executive Director's Office, (A) General Administration. POTS appropriations.

OPERATING EXPENSES

In addition to funding telephones, computers, office furniture, and employee supplies for staff working in support of persons with intellectual and developmental disabilities, this line also supports several annual costs such as in- and out-of-state travel, records storage, postage, costs, and subscriptions to federal publications.

COMMUNITY AND CONTRACT MANAGEMENT SYSTEM

This line funds licensing, reporting functions and some limited IT support for the Community and Contract Management System (CCMS), currently known as the DDDWeb, which is used to track client demographics, waiting list information, and bill for services for people with intellectual and developmental disabilities. CCMS is used for the purpose of authorizing and billing for services for the State funded programs, including the Family Support Services Program (FSSP) and State Supported Living Services.

SUPPORT LEVEL ADMINISTRATION

Service providers assisting Home and Community-Based Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services Medicaid Waver (HCBS-DD) clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level evaluations.

(2) MEDICAID PROGRAMS

ADULT COMPREHENSIVE SERVICES

Funding supports the HCBS-DD waiver, which provides services and supports to persons with intellectual and developmental disabilities, allowing them to continue to live in the community, yet within a 24-hour care model. Services provided under this waiver include day habilitation, prevocational, residential habilitation, supported employment, dental, vision, behavioral services, non-medical transportation, and specialized medical equipment and supplies. The DD buy-in service expanded in January of 2023, opting in all eligible members of Medicaid. Through FY 2023-24 BA-7 "Community-based Access to Services", the Department requested and received approval to expand access to certain community-based services. These include expanding access to personal care, homemaker and health maintenance services to members on the state plan and expanding transition services for members on a community-based waivers.

ADULT SUPPORTED LIVING SERVICES

This line provides funding for the HCBS-SLS waiver.

The HCBS-SLS waiver provides supported living in the home or community to persons with intellectual and developmental disabilities. Services include day habilitation, consumer directed attendant support services, homemaker, personal care, respite, supported employment, dental, vision, assistive technology, behavioral services, home accessibility adaptation, mentorship, non-medical transportation, personal emergency response systems, professional therapeutic services, specialized medical equipment and supplies, and vehicle modification. Through FY 2023-24 BA-7 "Community-based Access to Services", the Department requested and received approval to expand access to certain community-based services. These include expanding access to personal care, homemaker and health maintenance services to members on the state plan and expanding transition services for members on a community-based waivers.

CHILDREN'S EXTENSIVE SUPPORT SERVICES

The HCBS-CES waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's intellectual or developmental disability. Services include homemaker, personal care, respite, vision, adapted and therapeutic recreation equipment, assistive technology, community connector, home accessibility adaptation, professional therapeutic services, specialized medical equipment and supplies, vehicle modifications, vision services, and parent education. Through FY 2023-24 BA-7 "Community-based Access to Services", the Department requested and received approval to expand access to certain community-based services. These include expanding access to personal care, homemaker and health maintenance services to members on the state plan, and expanding transition services for members on a community-based waivers.

CHILDREN'S HABILITATION RESIDENTIAL PROGRAMS

In HB 18-1328 "Redesign Residential Child Health Care Waiver," the General Assembly approved the transfer of the Home and Community Based Services Children's Habilitation Residential Program (HCBS-CHRP) administration from the Department of Human Services to the Department of Health Care Policy and Financing. This line item funds HCBS-CHRP, which is a residential service and support program for children and youth from birth to 21 years of age. Services include self-advocacy training, independent living training, cognitive services, communication services, counseling and therapeutic services, personal care services, emergency assistance training, community connection training, travel services, supervision services, and respite services. Through FY 2023-24 BA-7 "Community-based Access to Services", the Department requested and received approval to expand access to certain community-based services. These include expanding access to personal care, homemaker and health maintenance services to members on the state plan, and expanding transition services for members on a community-based waivers.

CASE MANAGEMENT FOR PEOPLE WITH IDD

This line funds 24 Singe Entry Points (SEPs) and 20 Community-Centered Boards (CCBs) to provide targeted case management and administrative case management functions for the HCBS waivers. SEP functions are reimbursed through the SEP contracts and include care planning and case managements services for HCBS Waivers. The Department pays SEPs a case-management fee for each client admitted into a community-based service program. SEPs also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests for work associated with client appeals and for utilization review services related to HCBS and nursing facilities.

CCB administrative case management functions are reimbursed through the CCB contract and include intake and referral, functional needs assessment, quality assurance activities, and supports intensity scale assessment. Targeted Case Management is billed on a Per Member Per Month (PMPM) payment process for ongoing case management and per required monitoring visit. In addition, this line provides reimbursement to Community-Centered Boards (CCBs) for administrative functions, including determination of intellectual and developmental disability, determination of developmental delay, and management of program waiting lists for clients throughout the State. Additionally, this line provides reimbursement to Community-Centered Boards (CCBs) for administrative functions, including determination of intellectual and developmental disability, determination of developmental delay, and management of program waiting lists for clients throughout the State.

(3) STATE-ONLY PROGRAMS

FAMILY SUPPORT SERVICES

The Family Support Services line provides financial support for families who have children, including adult children, with developmental disabilities or delays, with costs that are beyond those normally experienced by other families. The primary purpose of the Family Support Services Program is to keep families together in the family home. In order to qualify, a family must have an eligible child living at home or be interested in facilitating a child's return to the home. Examples of services include medical and dental expenses, additional insurance expenses, respite care and childcare,

special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services.

STATE SUPPORTED LIVING SERVICES

The State Funded Supported Living Services (State-SLS) program is a State Only program designed to provide supports to individuals with demonstrated needs in order to remain in their community. Examples of services include prevocational services, job coaching and development, respite, specialized habilitation, and supported community connections. Ongoing case management activities include intake and referral, assessment service plan development, monitoring, and waiting list management.

STATE SUPPORTED LIVING SERVICES CASE MANAGEMENT

This line funds 20 Community-Centered Boards (CCBs) to provide administrative case management functions for the three State-only programs. Administrative case management functions are reimbursed through the CCB Contract and include intake and referral, developmental disability and delay determination, assessment, service plan development, service monitoring, and waiting list management.

PREVENTIVE DENTAL HYGIENE

This line item supports outreach services to match individuals needing dental care with dentists willing to provide pro-bono dental care. Funding also goes to train clients receiving developmental disability services and staff about preventive dentistry and to educate both populations about how to access dental care.

SUPPORTED EMPLOYMENT PROVIDER AND CERTIFICATION REIMBURSEMENT

This line was created through SB 18-145 “Implement Employment First Recommendations” and provides reimbursement to supported employment providers once their staff obtain a nationally recognized supported employment training certificate or certification. HB 18-145 created new reporting requirements around supported employment services and required that the providers receive a national certification.

(5) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department's budget consists of the Colorado Indigent Care Program, the Primary Care Fund Program, the Children's Basic Health Plan, and other safety net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program is presented below.

COLORADO INDIGENT CARE PROGRAM

History and Background Information

The Colorado Indigent Care Program provides funding to hospitals that have uncompensated costs from treating underinsured or low-income uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. The program consists of three line items: Safety-Net Provider Payments, the Primary Care Fund Program and Pediatric Specialty Hospital. These line items allow providers to receive partial compensation for uncompensated costs due to services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, the Colorado Indigent Care Program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the program increased from 185% to 200% of the federal poverty level effective February 1, 2006 due to the expansion populations created under HB 05-1262. On July 1, 2006, the financial eligibility requirement was further increased to 250% of the federal poverty level per SB 06-044. The program contracts directly with hospitals and community health clinics to provide specific services to eligible individuals. By statute, providers are required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and, 3) any other medical care as financing allows. Providers are required to provide on-site eligibility and co-payment determinations. To determine eligibility, providers assign a rating to applicants based on their total income and assets. Nearly all clients are required to pay a minimal annual co-payment, which varies according to services received and client rating. For all client ratings except the N-rating (0-40% of the federal poverty level), annual co-payments cannot exceed 10% of the family's total income and equity in assets. The annual co-payment for clients with an N-rating cannot exceed $120.

The majority of the program is supported by two sources of federal financial participation: Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limit (UPL). Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for federal matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and cash funds to draw down these federal funds, although the contribution of General Fund dollars to the State match is minimal relative to more innovative sources of State funds. Prior to FY 2009-10, the State utilized certification of public expenditures for all publicly-owned facilities (seen as cash funds in the budget) to draw down matching federal funds. Beginning in FY 2009-10, the use of certification has been replaced with fees assessed on hospital providers. Any provider who participates in the program is qualified to receive funding from the DSH Allotment and the Medicare UPL. See the "Safety-Net Provider Payments" line item for more detail about funding mechanisms.

As required by HB 04-1438, the Department must include in the annual November 1 Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. This information can be found in Exhibit K in the Department's November 1, 2018 FY 2019-20 R-1 Medical Services Premiums Budget Request.

SAFETY NET PROVIDER PAYMENTS

The Safety Net Provider Payments line item was added to the Indigent Care Program Long Bill group following the passage of the FY 2003-04 Long Bill (SB 03-258). The Department's budget request FY 2003-04 DI-6 "Change Methodology for Financing the Indigent Care Program and Disproportionate Share Hospital Through Proposed Safety Net Funding Allocation" requested the consolidation of the following line items into the new Safety Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could more easily be understood by Department staff, the General Assembly, and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved, providing increased overall payments to qualified providers.

Prior to FY 2009-10, the Safety Net Provider Payments line item was composed of four payments: Low-Income, Bad Debt, High-Volume, and Medicaid Shortfall. HB 09-1293 combined the Low-Income, Bad Debt, High Volume, and Medicaid Shortfall payments into two more broadly-based supplemental payments to CICP providers: the CICP Disproportionate Share Hospital (DSH) payment and the CICP Supplemental Medicaid payment. Beginning in FY 2021-22, through the

Department's S-12 Safety Net Provider Payments budget request, the line item was re-aligned to provide spending authority for the DSH payment only. This change further simplifies the line item and allows for easier tracking and more accurate forecasting.

To qualify for the DSH supplemental payment a Colorado hospital must meet either of the following two criteria:

- Be a CICP provider and have at least two obstetricians, or be obstetrician-exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act; or
- Have a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and have at least two obstetricians, or be obstetrician-exempt.

The DSH supplemental payment for qualified hospitals is determined by taking the lesser of either the hospital's DSH limit or each hospital's uninsured costs as a percentage of total uninsured cost of all qualified hospitals multiplied by the DSH allotment. This methodology is used to distribute the remaining allotment among qualified hospitals that have not met their DSH limit.

Under the distribution model, CICP hospital providers are reimbursed up to 100% of uncompensated costs associated with treating indigent clients funded in sum via the DSH separate payment calculations (CICP Disproportionate Share Hospital Payment and CICP Supplemental Inpatient Hospital Medicaid Payment). Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital or Upper Payment Limit for inpatient hospital services funds. Both of these allocation types have limits that restrict the amount of federal match available.

Under the Disproportionate Share Hospital payments, the total federal amount made available is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type.

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005, to provide funding to the State's only pediatric specialty hospital, The Children's Hospital, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital

line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

During the FY 2020 Legislative Session, the General Assembly reduced State-funding to this program by 20.0%.

APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In FY 2004-05, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% should be appropriated to the General Fund.

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers serving indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other Department criteria. The fund was authorized under Section 24-22-117 (2)(b), C.R.S., and distributes funds generated from Amendment 35 (Tobacco Tax), and matching federal funds, to the providers based on the portion of medically indigent or uninsured patients they served relative to the total number of medically indigent or uninsured clients served by all qualified providers. To be a qualified provider, an entity must:

- Accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge;
- Serve a population that lacks adequate health care services;
- Provide cost-effective care;
- Provide comprehensive primary care for all ages;
- Screen and report eligibility for the Medical Assistance Program, Children's Basic Health Plan, and the Indigent Care Program; and,

- Be a federally qualified health center per Section 330 of the federal Public Health Services Act **or** have a patient base that is at least 50% uninsured, medically indigent, a participant in Children's Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

SB 21-212 includes an appropriation of federal funds and directs the Department to seek federal approval to claim matching federal funds for the majority of the payments projected from the line item.

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 185% of the federal poverty level (FPL). The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be a non-entitlement, non- Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. A dental benefit, offered in a capitated managed care environment, was added for children in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes under 185% FPL. All State expenditures for benefits are matched currently with 88% Title XXI federal funds up to the federal allocation available. Based on a memorandum of understanding with the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched at the normal 88% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures

Until FY 2010-11, the Children's Basic Health Plan consisted of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in the FY 2000-01 Supplemental Bill (SB 01-183), the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs. In the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium

Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental Costs.

In November 2004, the voters of Colorado approved Amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The legislation provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% FPL effective July 1, 2005. The legislation also provided funding for cost-effective marketing, which began April 1, 2006. Funding was also provided to remove the Medicaid asset test, which became effective July 1, 2006.

Governor Ritter signed HB 09-1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee to increase eligibility in Medicaid and the Children's Basic Health Plan, as well as increase hospital reimbursement. As part of the Act, eligibility in the Children's Basic Health Plan was increased to 250% FPL on May 1, 2010.[1]

- During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation (FFP) rate for their expenditures. Beginning October 1, 2015, the Department will receive an additional 23 percentage point FFP, which increased the match to 88.00%. Beginning in FFY 2019-20, the federal match rate was reduced by 11.50% and in FFY 2020-21 the federal match rate was reduced to 65.00%.

The Department has received approval from the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

[1] The Hospital Provider Fee program was repealed effective July 1, 2017 and replaced with the Colorado Healthcare Affordability and Sustainability Enterprise in SB 17-267, "Sustainability of Rural Colorado". As such the contracts and programs administered through this line are now paid through the enterprise funding.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients enrolled in the Children's Basic Health Plan. Auxiliary administrative functions are contracted out separately to various vendors for professional services such as actuarial analysis, claims audit, and quality assurance. The actuarial analysis is used to update capitation rates and project claims that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services collect Health Plan Employer Data and Information Set (HEDIS) quality data. Beginning in FY 2012-13, the Department also administers, analyzes, and reports results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as required by the Children's Health Insurance Program Reauthorization Act of 2009.

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

This line item was created during the Department's Supplemental Hearing on January 19, 2011, by the Joint Budget Committee (JBC) as the combination of the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items. The costs of medical and dental services provided to eligible children and medical premiums for prenatal and delivery services for pregnant women enrolled in the Children's Basic Health Plan are funded through this line item beginning in FY 2010-11.

(6) OTHER MEDICAL SERVICES

The Other Medical Services section of the Department's budget contains funding for programs not administered by the Department through the Medicaid or Indigent Care programs. Some of the line items receive federal Medicaid funding but are administered by other departments, Commissions, or hospitals. This Long Bill group also contains funding for the Old Age Pension State Medical Program and the Medicare Modernization Act State Contribution Payment. A description of each program is presented below.

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical and dental care for non-Medicaid-eligible individuals receiving Old Age Pension grants. This program is 100% State funded and is not a federal entitlement. Eligible recipients are over the age of 64 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the State constitution and supplemental General Fund appropriations to ensure adequate funding.

The Old Age Pension program was established in 1936 by an amendment to the State constitution, creating Article XXIV. This article was amended in 1956 to add the Old Age Pension Health and Medical Care Program and Fund in Section 7. Old Age Pension benefits specified in Article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits.

Both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S., was transferred to the Department from the Department of Human Services, effective July 1, 2003. Beginning in FY 2003-04, this line item was placed in the "Other Medical Services" Long Bill group. The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

SENIOR DENTAL PROGRAM

Senate Bill 14-180 created the Colorado Dental Health Care Program for Low-Income Seniors ("Senior Dental Program") within the Department of Health Care Policy and Financing. The purpose of the program is to promote the health and welfare of Colorado's low-income seniors by providing access to dental care to individuals aged 60 and over who are not eligible for dental services under any other dental health care program, such as Health First Colorado (Colorado's Medicaid Program). The Senior Dental Program provides grants to entities throughout the state including local Areas Agencies on Aging, public health agencies, Community Health Centers, private dental practices, and other community-based organizations who meet application criteria developed under the guidance of the Senior Dental Advisory Committee.

The Senior Dental Program is appropriated General Fund dollars as its source of annual funding however additional spending authority may be granted to reallocate recovery funding. The administration of the program includes desk review audits of participating providers which may result in recoveries from providers of a portion of their prior year payments due to audit findings. Recovery funds are also obtained through the efforts of the Office of the Attorney General in relation to an ongoing case involving incorrectly billed dental procedures.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The program is administered by the Advisory Commission on Family Medicine in the Department of Health Care Policy and Financing (SB 13-010). Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education, however, beginning in FY 1994-95, federal regulations allowed a federal financial participation rate of 50%. Since federal Medicaid funds were involved, a line item appropriation to the Department was established. Also, effective July 1, 2013, a privately-owned hospital that receives Family Medicine Residency Training program payments is eligible to receive additional funds for the development and maintenance of family medicine residency training programs in rural areas.

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT

This line item is used to reimburse the federal government for what the federal government determines is the State's obligation of prescription drug costs for Medicaid clients who are also eligible for Medicare. On January 1, 2006, the Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit, replacing

Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the obligation of states to cover prescription drugs for this population, the Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. This is known as the "clawback" payment. For calendar year 2006, states were to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passed, the 90% factor was reduced, or "phased down," by 1.67% each year, until it reached 75% in 2015, where it remains today and ongoing.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

This line item was created with the approval of the Department's S-9, BA-7 "Public School Health Services Administrative Claiming" during the FY 2010-11 budget cycle. The Public School Health Services Program uses Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers.

The line item contains all administrative funding for the program excluding the Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System (MMIS). Funding for this line consists of a transfer of spending authority from the "(6) Other Medical Services; Public School Health Services" line item. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

PUBLIC SCHOOL HEALTH SERVICES

The Public School Health Services program began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of

the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. The Department pays for claims processing, personnel, and contracting costs. The Department of Education provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. The costs incurred by the two departments for administration are deducted from the federal matching funds. Pursuant to 25.5-5-318 (8) (b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT TRAINING GRANT PROGRAM

Pursuant to Section 25.5-5-208, C.R.S., this program grants funding from the Marijuana Tax Cash Fund to organizations to train health professionals on providing services related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. Specifically, the funding is used for the following:

- Training for health professional statewide that is evidence-based and that may be either in person or web based;
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders;
- Outreach, communication, and education of providers and patients;
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

REPRODUCTIVE HEALTH CARE FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICAID

This line item was created by S.B. 21-009: Reproductive Health Care Program and funds a program by which individuals can receive reproductive health care who are not eligible for coverage under Medicaid only because of their citizenship, or immigration status. The program allows individuals to receive the following reproductive health care services which are defined in the bill at no cost: any contraceptive drug, device, or product approved by the federal Food and Drug Administration, services related to the administration and monitoring of these products, including the management of

side effects, counseling services for continued adherence to a prescribed regimen, and any other contraceptive methods and counseling services identified by the federal Department of Health and Human Services or the Women's Preventative Services Guidelines as of December 17, 2019. The Department is required to report on the program to the legislature beginning in FY 2023-24 during its SMART Act hearing.

The Reproductive Health Care Program is appropriated General Fund dollars as its source of annual funding. Because program participants are not eligible for Medicaid, the program service costs are not eligible for federal financial participation (FFP).

PAYMENTS TO DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created during the 2023 Legislative Session through SB 23-138 and provides supplemental funding to the largest safety net hospital in the state. Funding is used to support the financial stability of Denver Health.

RURAL PROVIDER ACCESS AND AFFORDABILITY FUND

This line item was created during the 2023 Legislative Session and is one-time funding for FY 2023-24. The funding is for qualified rural providers based on financial need or the ability to expand health-care access and is intended to improve health-care affordability and access in rural communities.

STATE-ONLY PAYMENTS FOR HOME- AND COMMUNITY-BASED SERVICES

This line item was created during the 2022 Legislative Session through approval of the Department's FY 2022-23 BA-10: ARPA HCBS Spending Plan budget request. This provides the Department with spending authority for the state-only projects approved under the ARPA HCBS Spending Plan, which implements initiatives to enhance, expand, and strengthen home and community-based services over a period of three years. Funding will continue through December 2024, and then this line item will be eliminated in FY 2025-26.

DOULA SCHOLARSHIP PROGRAM

This line item was created during the 2023 Legislative Session through SB 23-288 Coverage for Doula Services. This line item is one-time funding for FY 2023-24 and is used to create a doula scholarship program to provide financial support to eligible individuals to pursue doula training and certification.

HB 22-1289 HEALTH BENEFITS FOR COLORADO CHILDREN AND PREGNANT PERSONS

This line item was created during the 2022 Legislative Session through HB 22-1289 Health Benefits for Colorado Children and Pregnant Persons. Funding for this line item begins in FY 2024-25. The appropriation expands Medicaid and Children's Basic Health Plan (CHP+) coverage to low-income pregnant people and children, regardless of immigration status.

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's budget is for Medicaid funding for services provided or administered by the Department of Human Services (DHS). Programs include services for persons with intellectual and developmental disabilities, high-risk (substance abuse) pregnant women, individuals with mental health needs, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. DHS also receives the Department's share of the costs to support the Colorado Benefits Management System (CBMS) and other information technology support, as well as operations costs separately accounted for but related to the other groups of clients mentioned above. Medicaid funds for these programs are transferred from the Department to DHS as reappropriated funds. Although the funds are considered reappropriated from the perspective of DHS, the funding sources for these transfers from the Department are General Fund, federal funds, and cash funds.

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the Medicaid funding into separate line items to improve expenditure tracking and reconciliation. A description of each of the line items currently within the Department's budget follows.

All funding requests in this Long Bill group originate with DHS. The Department of Health Care Policy and Financing is a financing agency for these appropriations, meaning that the Department must validate the DHS funding request is for a Medicaid-allowable purpose as outlined by the federal Centers for Medicare and Medicaid Services (CMS). This Department also performs general oversight of the Medicaid-funded programs to ensure adherence to federal regulations for use of the Medicaid funds.

During the FY 2022 Legislative Session, the Joint Budget Committee restructured the Department of Human Services Long Bill beginning in FY 2022-23, and thereby HCPF adjusted the names and structure of Section 7 of its Long Bill to match to DHS.

(A) EXECUTIVE DIRECTOR'S OFFICE – MEDICAID FUNDING

The Executive Director's Office is responsible for the overall direction of all departmental activities for the Department of Human Services (DHS) and contains staff and associated resources for implementing policy. This appropriation in the Department's budget includes Medicaid funding for the General Administration section of the DHS budget. Because the Executive Director's Office includes a wide range of elements, the authorizations in the Colorado Revised Statutes are also varied. The main authorization is 24-1-120, C.R.S.

General Administration includes health, life, and dental, salary survey and shift differential of DHS FTE that perform services related to Medicaid, related expenses are reimbursed by the Department.

(B) OFFICE OF CHILDREN, YOUTH, AND FAMILIES – MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located within the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for and protecting their children. The child welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of human/social services.

The Division of Child Welfare has two staff who are responsible for oversight of the county work to enroll the children in the Child Welfare system for Medicaid services and who administer the Children's Habilitation Residential Program (CHRP) waiver. The Medicaid funding in this administration line item pays for the staff salaries related to these workers that provide Medicaid-oversight work.

CHILD WELFARE SERVICES

The Child Welfare Services line item supports funding for counties to deliver Medicaid associated services for children and families. The line item provides Medicaid funding for children in out-of-home placement in Psychiatric Residential Treatment Facilities (PRTF); and therapeutic services for children in Residential Child Care Facilities (RCCF).

By October 1, 2021, all states are required to comply with the federal legislation Families First Preservation Services Act, which creates a new provider type called Qualified Residential Treatment Program (QRTP), which is explicitly a treatment center for youth. At that time, Medicaid will no longer reimburse RCCFs for placements of youth.

DIVISION OF YOUTH SERVICES

The Division of Youth Services is within the Office of Children, Youth, and Families at the Department of Human Services (DHS). The Division of Youth Services provides management and oversight to State-operated and private-contract residential facilities, as well as community-based alternative programs, that serve youth between 10 and 20 years of age who: have demonstrated delinquent behavior; are detained while awaiting adjudication; or are committed to the Division of Youth Services after adjudication. Facilities for youth offenders include intensive secure units, medium care units, staff secure units, and non-secure community residential programs. Only residents in non-secure, community residential programs would qualify for Medicaid. Other youth in secured, locked facilities have their medical care paid entirely through State General Fund.

The Division is currently organized into Administration, Institutional Programs, and Community Programs; Medicaid funding is provided only within the Community Programs section. Within the Community Programs section, the Medicaid funding covers a portion of Personal Services (includes POTS and indirect costs), a portion of Purchase of Contract Placements (mental health services), and a portion for a Managed Care Pilot Project.

(C) OFFICE OF ECONOMIC SECURITY – MEDICAID FUNDING

ADMINISTRATION

The Administration line item was created by SB 22-235 County Administration of Public Assistance Programs. Funding in this line item is for the Department and the Department of Human Services (DHS), in consultation with county departments of human and social services (county departments), to work with a vendor to develop a comprehensive assessment of the best practices related to the administration of public and medical assistance programs and use the results to develop a funding model to fund county administration of public assistance programs.

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's

eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees.

Previously, the Department's share of the funding for SAVE was included in the Department's Medical Services Premiums line item, and costs related to Medical Assistance Sites checking immigration status for clients presenting for medical care at those sites are still charged to Medical Services Premiums.

(D) BEHAVIORAL HEALTH ADMINISTRATION – MEDICAID FUNDING

COMMUNITY BEHAVIORAL HEALTH ADMINISTRATION

This line item funds the Medicaid portion of Personal Services and Operating Expenditures for oversight of the mental health services provided by the Department of Human Services (DHS). Colorado provides mental health care to a larger population than just Medicaid clients, but this line item is prorated from the total State expenditures for mental health care to represent only the Medicaid portion. There is no specific statutory reference for Mental Health Administration, but a reference may be inferred from 24-1-120, C.R.S.

Personal Services for the staff in this administrative line item include salaries and associated expenditures. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

HB 99-1116 created the Child Mental Health Treatment Act to improve the probability that children with significant mental health needs receive treatment. This legislation was passed to help mitigate parents' difficulty in navigating the various governmental systems including child welfare, mental health, law enforcement, juvenile justice, education, and youth corrections in seeking help for their children. Often these situations resulted from a court action of dependency and neglect that caused parents to give up custody of their children to the local departments of human/social services. The Child Mental Health Treatment Act set up a framework for getting mental health treatment for these children without resorting to the dependency and neglect action. However, during the evaluation process for admission to the residential treatment center, if it is determined that the child is a victim of child abuse, the case is referred to child welfare

services. Starting with the FY 2019-20 Long Bill (SB 19-207) the line item name changed from Mental Health Treatment Services for Youth to Children and Youth Mental Health Treatment Act.

(E) OFFICE OF BEHAVIORAL HEALTH – MEDICAID FUNDING

MENTAL HEALTH INSTITUTES

The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 in Denver, and the Colorado Mental Health Institute at Pueblo, established in 1879 in Pueblo. The Institutes provide inpatient psychiatric hospital services to citizens of Colorado having a major illness such that the individual cannot be expected to function and/or be treated in the community. Both locked and unlocked treatment units are provided, with a wide variety of assessment and treatment services offered to patients. Services have included: individual, group, and family therapy; treatment goal-setting; work therapy; community-readiness skills; medication and health education; education programs; pastoral services; substance abuse education and treatment; and, discharge and aftercare planning. The Fort Logan location does not have an inpatient treatment program for substance abuse.

Funding for the Institutes comes from a variety of sources such as disability payments, Medicare, Medicaid, third-party insurers or insurance companies, counties, school districts, and other State Departments (such as the Department of Corrections or the Department of Education). These Institutes also transfer a portion of their revenues to other offices in DHS that provide support for operations of the institutes. Such supporting operations include facilities management and accounting functions in the Office of Operations and computer functions in the Office of Information Technology. The Department pays for the services provided to Medicaid clients at the Institutes as well as the Medicaid portion of the functions in the Office of Operations and Office of Information Technology that relate to Medicaid services at the Institutes.

(F) OFFICE OF ADULTS, AGING, AND DISABILITY SERVICES – MEDICAID FUNDING

ADMINISTRATION

This line item was funded starting in FY 2022-23 (HB 22-1329). It funds the Medicaid portion of personal services and operating expenditures for oversight of the Regional Center services provided by DHS.

Personal services for the staff in this administrative line item include salaries and associated expenditures. Other personal services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally

appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

REGIONAL CENTERS

The State operates three Regional Centers that provide direct support for adults with intellectual and developmental disabilities. These are individuals who have significant needs and for whom adequate services and support are not available in the Community-Centered Board (CCB) system to safely meet their needs. The Regional Centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional centers serve adults in community group homes that provide services for between four and eight people. The majority of Regional Center beds are operated under the same comprehensive Home- and Community-Based waiver program that supports most community-based residential services. The Regional Center campuses also house Intermediate Care Facilities for persons with intellectual and developmental disabilities (ICF/IID).

The Department provides funding for personal services, operating expenses, capital outlay for patient needs, leased space, residential incentive allowance, and the purchase of services. Funding has recently been allocated through the budget process to address staffing, wait-lists, and Medicaid waiver changes.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with Regional Centers of the Department of Human Services (DHS). The line item was added through the FY 2003-04 Supplemental Bill (HB 04-1320) to reflect historic Department practice.

REGIONAL CENTER ELECTRONIC HEALTH RECORD SYSTEM

Currently, the funding in this line item is used to fund the ongoing operational needs of the Electronic Health Record (EHR) System, used at the three State owned Regional Centers. The EHR system provides the Regional Centers with uniform service delivery, documentation, data collection, health record, medication administration record, billing, personal finance, and staff training and scheduling.

COMMUNITY SERVICES FOR THE ELDERLY

This line item was created to support funding of the State Ombudsman program of the Department of Human Services (DHS), which manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. This program provides liaison services between DHS and its clients who are being served by the Division of Aging and Adult Services. The programs provided for the elderly are administered through the county departments of human/social services or through regional Area Agencies on Aging. This program also provides statewide advocacy for residents in long-term care facilities. The advocate can investigate complaints made by or on behalf of residents in the long-term care facilities.

The types of services provided under this program include a nutrition program, a caregiver program, a senior employment program, the long-term care ombudsman program mentioned above, and other supportive services. Because Medicaid pays for services in long-term care facilities to clients who are categorically eligible for Medicaid, the possibility exists that clients in those facilities may need someone to intervene on their behalf when the need arises. Therefore, Medicaid pays a small contribution to the overall costs of the State Ombudsman Program.

In FY 2017-18, funding in this line item increased when the General Assembly approved the Department of Human Services' "FY 2017-18 R-21: Aging and Disabilities Resources for Colorado Medicaid Claiming" budget request, which allows DHS to coordinate with the federal Centers for Medicare and Medicaid Services via the Department to allow for Medicaid Claiming of Aging and Disability Resources Colorado (ADRC) activities. The ADRCs serve as access points for long-term care services and supports for older adults and people with disabilities, and help direct consumers and their families to much needed information, services, and supports. The ADRCs conduct time reporting on the work provided to clients, and identify the amount of time the ADRCs provide services eligible for Medicaid claiming.

(G) OTHER

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS

This line item was created in the FY 2009-10 Long Bill (SB 09-259). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, including common costs, overhead costs, or joint costs.

DEPARTMENT OF HUMAN SERVICES INDIRECT COST ASSESSMENT

This line item was created in the FY 2017-18 Long Bill (SB 17-254). The line item funds the Medicaid share of costs for various Indirect Cost Assessment lines for DHS departmental or statewide overhead costs associated with the operation of general government functions.

II. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2023 that affects Department policies and procedures.

SB 23-002 Medicaid Reimbursement for Community Health Services (Mullica, Simpson, McCluskie, Bradfield)

The bill requires the Department to seek federal approval to pay for services provided by community health workers under Medicaid by July 1, 2024, and to begin implementing this coverage once approval is received. Prior to implementing the new benefit, HCPF must hold four public stakeholder meetings on community health work.

SB 23-138 Appropriation to Department of Health Care Policy and Financing for Denver Health (Zenzinger, Kirkmeyer, Bird, Sirota)

This bill funds a one-time supplemental payment to the Denver Health and Hospital Authority to help offset higher costs and lower than expected revenue reported by Denver Health.

SB 23-172 Protecting Opportunities and Workers' Rights Act (Winter, Rankin, Roberts, Rich)

The bill is anticipated to increase the number of grievances and claims filed and investigated in each state agency's internal human resources department and may increase workload to adjust record keeping requirements, which will require additional human resource staff in each agency. It may also require state agencies to create or modify a harassment training and prevention program as part of a potential affirmative defense.

SB 23-182 Temporary Suspension of Medicaid Requirements (Zenzinger, Kirkmeyer, Bird, Pugliese)

The bill suspends various statutory requirements related to enrollment and cost sharing for Medicaid and other state health programs in line with federal law. These changes are a condition of receiving federal funds under the Families First Coronavirus Response Act, which requires states to maintain continuous coverage for clients and provide certain services during specified wind-down periods following the end of the federal public health emergency.

SB 23-222 Medicaid Pharmacy and Outpatient Services Copayment (Bridges, Kirkmeyer, Bird, Sirota)

This bill removes the requirement that Medicaid recipients pay a copayment for pharmacy and outpatient services.

SB 23-223 Medicaid Provider Rate Review Process (Zenzinger, Kirkmeyer, Bird, Bockenfeld)

This bill changes the date that the Department of Health Care Policy and Financing must submit the first written report to the Joint Budget Committee concerning the review process for Medicaid provider rates to November 1, 2023, instead of November 1, 2025, and makes conforming changes.

SB 23-252 Medical Price Transparency (Van Winkle, Gonzales, Daugherty, Hartsook)

This bill requires hospitals to disclose standard charges for services. The Department of Health Care Policy and Financing must design the disclosure template, monitor hospitals for compliance, and take corrective action. The bill also moves existing hospital transparency reporting requirements from the Department of Public Health and Environment (CDPHE) to HCPF.

SB 23-261 Direct Care Workforce Stabilization Board (Danielson, Exum, Duran, Willford)

This bill establishes a board within the Department of Labor and Employment to review the direct care industry and develop recommendations for (1) minimum employment standards for direct care workers and (2) improving state communications with direct care workers. The bill requires HCPF to provide the relevant data to the board.

SB 23-288 Coverage for Doula Services (Fields, Buckner, English, Joseph)

This bill directs HCPF to create a doula scholarship program to fund attendance at preselected doula training programs.

SB 23-289 Community First Choice Medicaid Benefit (Bridges, Zenzinger, Bird, Sirota)

This bill creates the Community First Choice (CFC) option under the state Medicaid program and moves several services currently provided under the Home- and Community-Based Services (HCBS) waiver programs to the new CFC option. As a result, the Department can expand access to the services and receive an additional federal match of 6.0 percent for these services.

SB 23-298 Allow Public Hospital Collaboration Agreements (Gardner, Roberts, McCormick, Bockenfeld)

The bill exempts hospitals with fewer than 50 beds from select antitrust requirements for the purpose of improving healthcare access in rural or frontier communities. To qualify, hospitals must submit proposals to the HCPF and to the Department of Regulatory Agencies (DORA) if the proposed agreement involves negotiating with health insurance payers.

HB 23-1130 Drug Coverage for Serious Mental Illness (Michaelson Jenet, Rodriguez, Kolker)

This bill requires HCPF to review for coverage new drugs for serious mental illness within 90 days of the FDA approving the drug. This requires a pharmacist FTE at HCPF to monitor FDA approvals, identify which drugs are for serious mental illness, and determine if Colorado Medicaid should cover the drug.

HB 23-1136 Prosthetic Devices for Recreational Activity (Ortiz, Hartsook, Winter, Liston)

This bill requires the Department to provide an alternative prosthetic limb in certain circumstances to members of CHP+. Additionally, Medicaid expansion benefit plan provisions require that all DOI mandatory covered items be covered for Medicaid expansion members. Thus, HCPF must provide an alternative prosthetic limb to Medicaid members that meet the terms of the bill and are part of the Affordable Care Act expansion populations.

HB 23-1183 Prior Authorization for Step-therapy Exception (Jodeh, Sirota, Winter)

The bill requires the Department to review applications to exempt prescriptions for serious or complex medical conditions from any requirement to try an alternative drug (step-therapy requirement) under certain circumstances. Review of additional exemption requests under the bill will increase the cost of this contract by $225,000 annually.

HB 23-1197 Stakeholder Process for Oversight of Host Home Providers (Young, Weinberg, Danielson)

The bill requires the Department to engage in a stakeholder process to review current Home Host standards/processes for individuals on LTSS and determine solutions to address member concerns.

HB 23-1215 Limits on Hospital Facility Fees (Sirota, Mullica, Boesenecker, Cutter)

This bill requires the Department to form a steering committee to produce a report regarding the impact of Facility Fees on the Colorado health care system. This requires multiple contractors to provide data, analysis, and stakeholder engagement. It also requires 0.5 FTE at the Department to work on the report for one year to get it done.

HB 23-1226 Hospital Transparency and Reporting Requirements (Soper, DeGruy Kennedy, Roberts, Will)

The bill adds information to be disclosed by hospitals for the hospital expenditure report and allows the Department of Health Care Policy and Financing to enforce data collection procedures through fines. The bill requires the Department to ensure compliance and incorporate the new data into the report.

HB 23-1228 Nursing Facility Reimbursement Rate Setting (McCluskie, Willford, Zenzinger, Smallwood)

The bill establishes a minimum nursing facility supplemental payment rate and requires HCPF to adjust the rate annually. The bill creates a new supplemental payment for facilities with disproportionately high Medicaid utilization, that are geographically critical to ensuring access to care, and that admit individuals who have been compassionately released from the Department of Corrections.

HB 23-1243 Hospital Community Benefit (Amabile, Moreno)

This bill requires HCPF to promulgate rules related to Hospital community benefit meetings and various requirements, conduct stakeholder outreach regarding hospital community benefit engagement with various populations, and review and report on hospital community benefit reports.

HB 23-1295 Audits of Department of Health Care Policy and Financing Payments to Providers (Bird, Bockenfeld, Zenzinger, Kirkmeyer)

This bill requires the Department to report various audit information on the Department's website including contracts with auditors, conduct audit-related training for providers, hold stakeholder meetings regarding audits, and create a Provider Advisory Group regarding audits.

HB 23-1300 Continuous Eligibility Medical Coverage (Bird, Sirota, Zenzinger, Kirkmeyer)

This bill expands Continuous Eligibility to all kids 0-3; and 1 year of Continuous Eligibility for adults leaving DOC prisons. It also Requires the Department to conduct a feasibility Study to expand continuous eligibility to other groups.