Long Range Financial Plan FY 2023-24

November 1, 2022

Contents

Summary of Long Range Financial Plan

Pursuant to Section 2-3-209, C.R.S. each state agency is required to submit to the General Assembly an annual long-range financial plan. The purpose of the long-range financial plan is to:

A. Have each state agency anticipate and strategically plan for future contingencies that may impact the state agency's ability to meet its performance goals;
B. Assist the state agency as it prepares its annual budget request;
C. Provide additional information to the General Assembly so that it can appropriate money in light of possible future changes; and
D. Provide notice to the public about the potential growth or decline of state government in the future.

To the extent possible, the state agency shall utilize information that is included in the state agency's annual performance report prepared in accordance with Section 2-7-205. Therefore the November 1, 2022 Long Range Financial Plans include:

A. Description of anticipated trends, conditions, or events affecting the agency
B. Description of any programs funded by federal funds or gifts, grants, and donations that may decrease in the future.

The Long Range Financial Plan is supplemented by the annual performance report[1] which includes:

A. Statement of the agency's mission
B. Description of the agency's major functions
C. Description of the agency's performance goals
D. Performance evaluation of the agency's major programs with recommendations to improve performance

The long-range financial plan covers a five-year period and is not a policy document but rather a management tool to support effective planning and resource allocation. As such, it does not reflect the impact of policy proposals. In addition, given the November 1 statutory deadline for the plans, they were developed prior to the finalization of the Governor's FY 2023-24 budget request, and thus may not reflect all technical changes prepared for the budget.

[1] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202022-2023%20Performance%20Plan.pdf

Section 1: Financial Structure

This section complies with the requirements of Section 2-3-209 (2)(e), C.R.S. which states the Long Range Financial Play may include components which discuss the anticipated trends, conditions or events that could impact the department's ability to meet its goals and objectives.

Department Major Budget Drivers

COVID-19 - Changes in Economic Conditions

The novel coronavirus (COVID-19) pandemic that emerged in early 2020 continues to have an unprecedented impact on the health care sector, the economy, and the most vulnerable Coloradans. A large majority of people enrolled in the Medicaid and Children's Health Insurance Program (CHIP)[2] qualify for the programs because their income is below specific thresholds. Colorado expanded eligibility criteria under federal law, and for Medicaid, adults and children must have income below 133% of the federal poverty level to qualify. For CHIP, children and pregnant women must have income below 250% of the federal poverty level to qualify.

The economic downturn associated with the COVID-19 pandemic directly impacted the state budget through significant reductions to state tax income revenue; however, rapid revenue growth has since occurred, exceeding the TABOR cap. Although the economic recovery continues to strengthen, employment lags and employment disparities persist. Given the Department's historic consumption of approximately 26% of the State's General Fund, the economic recovery and reversal of revenue shortfalls are critical to the Department's ongoing service to members. The financial impact to the Department is further magnified by an increased need for health care coverage and benefits caused by the loss of employer-sponsored health coverage. The Department projects that approximately 1.4 million Coloradans will be covered by Medicaid by FY 2023-24 after the public health emergency ends; this estimate represents an increase of 17% over the 1.2 million average in most of FY 2019-20 prior to the start of the pandemic.

During times of recession or other economic contraction, caseload increases. As unemployment rises and people lose their jobs, income, and health insurance, people may apply for coverage through the Department's programs. This drives costs for the State as people enroll in the Department's programs and begin to use services. This creates a double-edged problem for the State: Medicaid and CHIP costs are driven up by the influx of new caseload while the State collects lower General Fund revenues.

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

Compounding the problem is the fact that Medicaid is an entitlement program, which means that the State cannot cap enrollment or turn away new enrollees. Further, federal law prohibits the State from reducing the amount, scope, or duration of services due to a lack of state funding. As a result, there are limited opportunities to reduce Medicaid growth during an economic downturn. In the case of the economic downturn associated with the COVID-19 pandemic, federal legislation helped some employers temporarily maintain their labor force, which likely blunted some of the initial enrollment surge. Federal legislation has also included a continuous coverage requirement, where no current Medicaid members may be disenrolled, which has contributed to overall rising Medicaid caseloads.

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

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

Changes in Colorado's Demographics and Member Populations

The combination of Colorado's increasing population and a greater proportion of adults over 65 will continue to drive costs in the Department's programs. The State Demography Office predicts total population growth of more than 715,000 people (12%) between 2020 and 2030.[3] Growth rates are even higher among older adults, with 19% growth of people between the ages of 65-74, 60% growth of people aged 75-84, and 49% growth for people aged 85 and older. Colorado's population growth rates are expected to exceed national population growth by a significant margin in this time frame. Longer term projections from the State Demography Office's indicates that Colorado's population will reach about 8 million people by the year 2050.The increasing population, and Colorado's rapidly aging population, will undoubtedly affect the Department's spending. As the population grows, caseload in Medicaid and CHIP will also grow. Critically, the growth in adults 65 and older will continue to create significant budgetary pressure. As people age and spend down their resources, they become eligible for Medicaid. Further, people who require assistance with activities of daily living qualify for Medicaid at higher income levels. Older adults have higher per capita costs than adults and children and receive the least amount of federal funding available.

In addition to growth from Colorado's changing population, the Department is working to expand its member population under directives set in HB 22-1289, "Health Benefits for Colorado Children and Pregnant Persons."[4] Beginning in 2025, the Department will offer comprehensive health insurance coverage for low-income children and pregnant persons who would be eligible for Medicaid or CHP+ if not for their immigration status. The expansion of health care access to reduce health disparities will certainly impact the Department's spending. Like with current Medicaid members, the Department has over-expenditure authority for these populations to ensure eligible individuals have appropriate access to care.

Increasing Health Care Costs

The affordability of health care in Colorado continues to be one of the most significant challenges facing the Department, the state, and the nation. With the economic downturn, all payers – self-funded employers and Medicaid alike – benefit from a solid affordability strategy. Specific to the Department, the increased need for HCPF programs and services combined with the state's budget restrictions makes the implementation of effective affordability policy more important than ever. As a trusted health care expert, and in partnership with other health care thought leaders, the Department is focused on research, analytics and reporting that identifies the drivers of rising health care costs and alternatives to address them. Leveraging

[3] https://demography.dola.colorado.gov/assets/html/demodashboard.html
[4] https://leg.colorado.gov/bills/hb22-1289

insights from this effort serves to support not only Medicaid and CHIP members, but all Coloradans.

The Centers for Medicare and Medicaid Services (CMS) predict that national health spending is projected to grow at an average rate of 5.1% per year between 2021 and 2030.[5] Overall, CMS predicts that Medicaid spending will also grow at a rate of 5.6%, which is slightly lower than the projected rate of Medicare growth at 7.2% and private health insurance growth at 5.7%. CMS identifies that key trends involve recovery from the COVID-19 pandemic and growth in input costs such as labor and supplies, leading to a lagged increase in provider service prices.

In addition to this growth in projected health spending, in July 2022, national prices rose 8.5% across the economy from the previous year. Prices for medical care increased by 4.8% over the same period.[6] However, both Medicaid and non-government health care prices are typically set in advance, either administratively or through contracts between providers and insurers. Because of this, the effects of high inflation may take time to permeate through the health care sector, delaying wage increases and other broad increases in health care costs. For Colorado, this will continue to create budgetary pressures. Health care providers will continue to face cost pressures due to the rising cost of wages, capital costs, health insurance, and other factors common to most businesses. Coupled with the ongoing effects of COVID-19, this reality has led to provider consolidation and workforce shortages, which may reduce access to care for Medicaid members. While the Department continues to implement new payment methodologies, condition a portion of reimbursements on outcomes and performance metrics, and implement regulatory structures that prioritize member health, inflationary pressures will continue.

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

- **Prescription drug costs:** The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid, CHIP, and all health plans. In January 2021, the Department prepared a 2nd edition of its report titled "Reducing the Cost of Prescription Drugs."[7] While the Department continues to address key initiatives to help inform prescribers and update payment structures, high prescription drug costs are still a major factor in the affordability of health care. The report lays out a set of comprehensive changes that would favorably impact prescription drug costs and the out-of-pocket costs for families covered by commercial insurance, while achieving a meaningful reduction in the total cost of prescription drugs for Colorado's

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

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

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

Medicaid and CHIP programs. Additionally, because the Department must cover any drug that receives approval from the Federal Drug Administration (FDA) and for which a rebate agreement is in place, the recent action of the FDA to lower the threshold of evidence for conditional drug approval may also increase prescription drug costs for the Department as more members utilize high-cost, conditionally approved drug therapies.

- **Hospital delivery system:** Colorado's hospital prices are some of the highest in the country. The prices for individual procedures, inpatient and outpatient care, vary widely from hospital to hospital. The report[8] documenting COVID 19's impact on the Colorado hospitals' financing published by the Department in August 2021 provided a thorough analysis of the changing price, costs and profits across the hospital industry in Colorado. The Department has continued to leverage the insights from this report, as well as analyzing the emerging insights from new laws on financial transparency and not-for-profit hospital community investments to drive improved hospital affordability policy to the betterment of Coloradans, their employers, the state, and taxpayers. Based on this continued work, the Department published an additional Hospital Insights Report[9] in March 2022 detailing the current financial positions of hospitals across Colorado.
- **Population health and health outcomes:** The Department has developed data capture infrastructure and analytics to better understand care delivery, utilization, health outcomes and costs. The Department is able to leverage these insights to identify populations that would benefit from increased care supports and coordination. Concurrently, the Department has worked with its Regional Accountable Entity (RAE) partners to craft new programs to address these health improvement and affordability opportunities. The state's Behavioral Health Task Force, in which the Department actively participates, has developed a blueprint that includes bold changes that improve patient outcomes, experience, quality and access. The Department continues to be actively involved in these initiatives with the Behavioral Health Authority. The Department recognizes that behavioral health reform will require significant investments of time and resources.
- **RAE Accountability:** The Department is in the process of designing and negotiating the third stage of the Accountable Care Collaborative, known as ACC 3.0, with the Regional Accountable Entities (RAEs). The Department's ability to influence and improve member health care outcomes is dependent on its ability to work with these critical contractors to measure outcomes and implement policy interventions. Because the Department does not directly

[8]https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Cost%20Price%20and%20Profit%20Review%20Full%20Report_withAppendices-0810ac.pdf
https://www.colorado.gov/pacific/hcpf/colorado-cost-shift-analysis
[9]https://hcpf.colorado.gov/sites/hcpf/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20Second%20Edition.pdf

furnish care to members, RAE accountability is a critical strategy to improving health care outcomes and reducing costs.

Federal Policy Changes

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

Changes to Federal Medical Assistance Percentage Funding

There has been discussion on the federal level about both temporary and permanent changes to the federal medical assistance percentage (FMAP) that states receive for Medicaid expenditures. The Families First Coronavirus Response Act, (FFCRA) (Pub. L. 116-127), provided a temporary 6.2 percentage point increase in federal Medicaid matching funds to help states respond to the public health emergency. This did not apply to administrative costs. The estimated impact of the General Funds savings from the enhanced FMAP net the costs of the continuous coverage requirements from additional caseload is approximately $100 million per quarter. States are required to provide continuous enrollment and not reduce benefits for the duration of the declared emergency to qualify for the higher match. The Public Health Emergency (PHE) was most recently renewed through October 15, 2022. The FFCRA provides the temporary FMAP increase until the end of the quarter in which the PHE ends. The temporary nature of the PHE and impending expiration of the FMAP increase, poses the risk of a funding cliff. This could have implications for the state's General Fund.

Similarly, The American Rescue Plan Act (ARPA), includes a provision to increase the federal matching rate (FMAP) for spending on Medicaid Home and Community Based Services (HCBS) by 10 percentage points from April 1, 2021 through March 31, 2022.

Medicaid Waivers and Executive Action

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

The increasing availability of these waivers may provide options for Colorado to reform Medicaid programs beyond what was approved in the past. In addition to waivers, the federal government may change the Medicaid program via new

regulations. This type of Executive Action could have significant effects on the operation and financing of the Medicaid program. Often, the changes that are proposed are extremely technical and complex but will likely have significant implications for provider payment rates and state financing of Medicaid by disrupting current arrangements and restricting the future use of such arrangements.

Enacting a Comprehensive Public Health Care Program, such as Medicare-for-All

A public health care program may have the effect of shifting costs from the State to the federal government. This is not certain; for example, when Congress implemented a drug benefit in Medicare (Part D), they imposed a requirement on states to pay for a portion of the estimated cost of people who were also covered by Medicaid. If enacted federally, a comprehensive public health care program would likely take multiple years to implement and require significant changes in state law to adapt to the new programs.

Scenario Evaluation: Department-specific Contingency

Changes in Colorado's Health Care Landscape

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

Closure of a Rural Hospital

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

Provider Shortages and Consolidation

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

Scenario Evaluation: Economic Downturn

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

When downturns occur, one of the most frequently used ways to reduce Medicaid expenditure is through provider rate reductions. Historically, in order to balance the budget, the Governor has proposed – and the General Assembly has approved – rate reductions to almost all provider groups. From FY 2009-10 to FY 2011-12, rates for most Medicaid providers were reduced by approximately 6.1%. In FY 2020-21, provider rates were reduced by 1 % across the board, along with additional targeted rate reductions during budget balancing.

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

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

Economic Downturns Spur Innovations

Although economic downturns create significant challenges for the State's entitlement programs, they also create opportunities to find efficiencies and spur innovation. The Department's strategy, starting from the beginning of the COVID-19 pandemic, was adjusted to recognize the emerging "new normal in healthcare," with a focus on sustaining and driving positive changes to the system. This includes policies that assure the right care is occurring at the right place, lowering pharmacy costs and hospital efficiency. For example, telemedicine visits have increased, and inappropriate emergency room visits have decreased as Coloradans avoid unnecessary interactions that increase the risk of COVID-19 transmission. By driving a new normal in health care, the Department can also leverage telemedicine services to reduce barriers to care like transportation, childcare, or inclement weather. Telemedicine

can also be used to address traditional care access concerns for people with disabilities, older adults, or rural Coloradans, while also helping to overcome the stigma of accessing behavioral health care by enabling care from the privacy of one's own home. Additionally, the state, vendors and providers may experience benefits due to a broader work base due to employees working remotely which could provide efficiencies in the system.

Capital Construction Funds & Projects

The Department is the fiscal agent of the Office of eHealth Innovation (OeHI). This includes three capital appropriations: CC01, CC02 and CC03.

CC01: Roadmap Refresh, the remaining funds for the Colorado Health IT Roadmap infrastructure will be spent in support of a statewide consent architecture and a unifying architecture for Social Health Information Exchange. Any remaining funds in this category are due to revert 6/30/2023; however, OeHI anticipates spending all funds.

CC02: Rural Connectivity, this funding will be spent to connect the remaining Critical Access Hospitals and Rural Health Centers to the statewide Health Information Exchange infrastructure and to the rural analytics dashboard. Any remaining funds in this category are due to revert 6/30/2024; however, the Office anticipates spending all funds.

CC03: Rural Connectivity This funding will be spent to connect local electronic health records from independent providers to the state's HIE network; onboard those providers to a shared analytics platform between rural providers; and provide technical and workflow support. Any remaining funds in this category are due to revert 6/30/2025; however, OeHI anticipates spending all funds.

The Department submitted the CC-01 Medicaid Enterprise Solutions (MES) Re-Procurement capital request for re-procurement funding of the Department's IT systems. These systems costs include funding to transition the Medicaid Management Information System (MMIS), the Pharmacy Benefits Management System (PBMS) and the Business Intelligence Data Management (BIDM) if a new vendor is selected.

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

Ongoing Debt Obligations

The Department has no ongoing debt obligations.

Section 2: Federal Funds

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

Department State and Federal Stimulus Funding						
	Total Stimulus Funds	*ARPA*	*CARES*	*IIJA*	*Other Federal Stimulus**	*State Stimulus*
FY 2020-21 & FY 2021-22	*$1,650,225,703*	*$406,057,081*	*$5,114,201*	*N/A*	*$1,239,054,421*	*N/A*
FY 2022-23 & FY 2023-24	*$250,168,455*	*$0*	*$0*	*N/A*	*$250,168,455*	*N/A*
FY 2024-25	*$0*	*$0*	*$0*	*N/A*	*$0*	*N/A*
FY 2025-26	*$0*	*$0*	*$0*	*N/A*	*$0*	*N/A*

*Where possible please identify the source of the funds for anything in the "Other Federal Stimulus" column.
*Families First Coronavirus Response Act (FFCRA) funding

Federal Funds Rolloff Planning

American Rescue Plan Act Funds

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

- Additional Support for Medicaid Home and Community-Based Services (HCBS) During COVID-19 Emergency (est. $322M),
- Extension of 100% Federal Medical Assistance Percentage (FMAP) to Urban Indian Health Organizations and National Hawaiian Health Care Systems (est. $100K),

- Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment (est. $10M),
- Special Rule for the Period of a Declared Public Health Emergency (PHE) Related to Coronavirus – Disproportionate Share Hospitals (DSH) provisions (est. $27.1M),
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program ($250K),
- State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services (est. $800K),
- Rural Healthcare Provider Expanded Access ($10M),
- Healthcare Practice Transformation & Integration ($34.8 M),
- ARPA Administration Costs ($100K), and
- Medicaid Member Immunization Effort ($300K).

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

Additional Support for Home and Community-Based Services

The majority of the ARPA stimulus funds are related to support for Home and Community-Based Services (HCBS). Section 9817 of ARPA provides qualifying states with a temporary 10% increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures for HCBS. As part of the requirements in ARPA, the Department must use state funds equivalent to the amount of federal funds attributable to the increased FMAP on HCBS related projects. The Department is required to spend the entirety of their funds by December 31, 2024.

In FY 2020-21 and FY 2021-22 the Department received an additional $322,557,081 in federal funds for HCBS related to ARPA. After reinvesting the savings and drawing down a federal match on eligible expenditures, the Department estimates having $522M to spend across FY 2021-22, FY 2022-23, and FY 2023-24.

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

Funding Type	*Number of Projects*	*Budget Allocated*	*Types of Projects*
One-Time Funding	62	$298,726,475	System Updates, Training, Analyses, Temporary Rate Increases, Surveys, Grant Programs
Projects Continuing - Already Funded	1	$211,757,766	Rate Increases
FTE		$11,727,832	All projects have dedicated FTE hired through ARPA funding

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

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

The Department does not plan to continue the additional FTE supporting the 63 ARPA projects. The deliverables, system updates, and payment methodology recommendations created by the ARPA HCBS projects will be used by ongoing staff on priority projects.

In summary, the total funding for ARPA HCBS projects that will continue after December 31, 2024 equals $211,757,766. This amount is for the HCBS base wage rate increases, which is split between fiscal years with $89,099,125 budgeted for SFY 21-22

and $134,745,128 budgeted for SFY 22-23. The ongoing funding of $160M annually for this project has already been appropriated to the Department.

Extension of 100% Federal Medical Assistance Percentage (FMAP) to Urban Indian Health Organizations and National Hawaiian Health Care Systems

Section 9815 of ARPA extends 100% FMAP to State Medicaid Agencies for services received through Urban Indian Health Organizations for the time period between April 1, 2021 and March 31, 2023.

ARPA does not specify any spending requirements for the savings related to the increased FMAP for Urban Indian Health Organization services. Therefore, this section frees up state funds in the form of savings and has no related fiscal cliff. The Department estimates that between April 1, 2021 and June 30, 2022, a total of $176,375 of State funding has been saved. After March 31, 2023, payments for services at Urban Indian Health Organizations will return to their previous federal match percentages.

HB 22-1190, "Supplemental State Payment To Urban Indian Organizations," appropriated money to the Department to distribute funds to Urban Indian Health Organizations as one-time payments. As of June 30, 2022, the Department has sent $70,285 in payments to Urban Indian Health Organizations. These payments will not continue after the enhanced FMAP ends.

Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment

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

ARPA did not specify any spending requirements for the savings related to the increased FMAP for Covid-19 vaccines and administration and treatment. The Department estimates that between April 1, 2021 and June 30, 2022, a total of $15,893,965 has been freed up from state funds. Once the period of enhanced FMAP ends, the Department accounted for the expiration of the enhanced FMAP in the FY 2023-24 R-1, "Medical Services Premiums."

Special Rule for the Period of a Declared Public Health Emergency (PHE) Related to Coronavirus – Disproportionate Share Hospitals (DSH) provisions

Section 9819 of ARPA recalculates the Disproportionate Share Hospital (DSH) allotment to ensure that total DSH payments going back to January 2020 are adjusted to account for the 6.2 percentage point bump in FMAP associated with the Families First Coronavirus Response Act (FFCRA).

As of June 30, 2022, the Department calculates a total of $33.1M has been returned due to this section of ARPA. This additional funding must be used as General Fund offset per SB 21-213, "Use of Increased Medicaid Match." The Department accounted for the expiration of the enhanced match and resulting impact to the General Fund offset from SB 21-213 in FY 2023-24 R-1, "Medical Services Premiums."

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

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

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

State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services

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

The Department has received a total of $800K through grant funding for this project. Currently, $687K has been encumbered through contracts with $163K encumbered in FY 2021-22 and $524K encumbered in FY 2022-23. No additional funding is required

for the state planning aspect of this section. However, in the future more funding may be necessary to provide community-based mobile crisis intervention services. The Department will assess if these services should be added as a benefit and will request to do so through the normal budget process if so.

Rural Healthcare Provider Expanded Access

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

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

Healthcare Provider Expanded Access

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

A total of $34.8M was appropriated to the Department as a result of this bill. The Department is still in the planning phase for spending. The total Department funds must be expended by December 31, 2024. This section represents one-time funding that does not require future State appropriations.

ARPA Administration Costs

Section 24-75-226 C.R.S. establishes the "American Rescue Plan Act of 2021" cash fund in the state treasury. This section allows for the transfer of money in the fund to another cash fund that is established for the purpose of using the money from the federal coronavirus state fiscal recovery fund. The State transferred $100K in funding to the Department which has been spent as of June 30, 2022. The purpose of this

funding was for FTE costs related to the HCBS spending plan that were incurred prior to receiving spending authority for the initiatives proposed under the plan. This section represents one-time funding that does not require future State appropriations.

Medicaid Member Immunization Effort

Section 24-75-226 C.R.S. establishes the "American Rescue Plan Act of 2021" cash fund in the state treasury. This section allows for the transfer of money in the fund to another cash fund that is established for the purpose of using the money from the federal coronavirus state fiscal recovery fund. The State transferred $300K in funding to the Department for the Medicaid member immunization effort. The Department has hired 2.0 FTE for this project.

CARES Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 provided emergency assistance related to the economic impacts of the COVID-19 outbreak. Colorado received approximately $1,674B from the federal coronavirus relief fund to use for necessary expenditures incurred due to the Covid-19 PHE.

SB 20-212, "Reimbursement for Telehealth Services," expended Medicaid reimbursement for telehealth services to new providers and established requirements related to the delivery of telehealth services. $5.1M was appropriated to the Department for FY 2020-21 from the CARES Act sub fund. The bill provided ongoing appropriations for telehealth services after the $5.1M was expended.

The CARES Act also provided funding that was allocated by the Governor's Office for FTE for the Senior Strike Force. This team is a cross-agency task force created to develop and implement strategies to mitigate the spread of Covid-19 and save lives in residential congregate settings. The total allocated for this project was $45,820. The Department does not have any ongoing costs related to this program.

Families First Coronavirus Response Act (FFCRA)

The Families First Coronavirus Response Act of 2020 was enacted to respond to COVID-19 by providing paid sick leave, tax credits, free COVID-19 testing, expanded food assistance and unemployment benefits, and increased Medicaid funding. The FFCRA created a 6.2% increase in FMAP if state agencies maintained continuous coverage for individuals enrolled for Medicaid or CHIP benefits as of March 18, 2020, or determined

eligible on or after that date. The enhanced FMAP ends at the end of the quarter the PHE ends and the eligibility requirements end at the end of the month the PHE ends.

As of June 30, 2022, the Department has received $623,455,496 in enhanced FMAP for Medicaid services and $18,549,893 in enhanced FMAP for CHIP services. After the end of the PHE, these funds be adjusted through the normal budget process.

H.R. 133 – Consolidated Appropriations Act of 2021

The Consolidated Appropriations Act of 2021 (H.R. 133) provides stimulus relief for the Covid-19 pandemic and contains an omnibus spending bill for the 2021 federal fiscal year. H.R. 133 extended the dates by which state and local governments must make expenditures with CARES Act Coronavirus Relief Fund awards from December 30, 2020 to December 31, 2021. This bill also added a technical correction to the treatment of the 6.2% FMAP rate increase from the FFCRA making it so it applies to the baseline based on the annual average FMAP rate in the state for FY 2019-20 and FY 2020-21.