COLORADO

Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2023-24, FY 2024-25, and FY 2025-26 Budget Request

February 2024

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I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible older adults, people with disabilities, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Medical Services Premiums Budget Narrative describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom-line adjustments. A series of exhibits in this Budget Request supports the narrative.

Further discussion depends on several key points that complicate the projection of this line item. They are summarized as follows:

1. The Department's request identifies, and in some cases amends, the fiscal impact of various State and federal policy changes through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a reduction's fiscal impact can be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.

2. The presence of varying funding mechanisms makes the Department's request more complex. Different Medicaid services have different federal match rates that affect different populations under Medicaid. Certain categories of service have historically been federally matched at different percentages than others. Indian Health Services, described further in this narrative, have historically received a 100% federal medical assistance percentage (FMAP) while Family Planning Services receive a 90% FMAP. Breast and Cervical Cancer Program (BCCP) services are matched at 65% FMAP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the MAGI Adults populations, for instance, a 90.0% FMAP. The former CHP+ population that

transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65%.

3. Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all the recommended services without cost-sharing. The recommended services are those that have been given an A or B rating by the United States Preventive Services Task Force.

4. Following the declaration of a public health emergency by the Secretary of Health and Human Services during the COVID-19 pandemic, CMS notified states that an increased FMAP would be available for each calendar quarter occurring during the public health emergency, including retroactively to January 1, 2020. To be eligible to receive the 6.2 percentage point FMAP increase, states must adhere to a set of requirements which include, but are not limited to, maintaining eligibility standards, methodologies, and procedures; covering medical costs related to the testing, services, and treatment of COVID-19; and not terminating individuals from Medicaid if such individuals were enrolled in the Medicaid program as of the date of the beginning of the emergency period or during the emergency period. The Department is compliant with all requirements and has been drawing the enhanced federal match accordingly. The Consolidated Appropriations Act of 2023 decoupled the continuous coverage requirement and the additional federal match from the public health emergency declaration. The continuous coverage requirement and additional federal match now both end on March 31, 2023. The current 6.2 percent additional match steps down to 5.0 percent from April 2023 through June 2023, 2.5 percent from July through September 2023, and 1.5 percent from October through December 2023, after which there is no more additional match.

5. The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed, and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until December of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously.

II. MEDICAID CASELOAD

The Medicaid caseload analysis is included in the Exhibit B series of this request.

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once the caseload forecast is complete, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts, also called Bottom Line Impacts. Inherent in the per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, pre-existing condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, a categorically eligible low-income child is substantially less costly to serve than a person with disabilities on an annual basis. Because Medicaid caseload is growing and receding at differing rates as measured by individual eligibility categories, it is essential to determine the anticipated cost per capita for all eligibility categories. In broad terms and for most services, the rate of change observed across actual expenditure reference periods is applied to future fiscal years to estimate the premiums needed for current and request years. Adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kind of services, this allows premium calculations to be clustered into several groupings. This improves the reasonableness of the projections and allows service clusters to be examined. To project premiums by individual service category using historic rates, generates a materially higher and less accurate forecast.

The following are the service groupings used in computing the projections or summarizing individual service calculations.

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals

- Outpatient Hospitals
- Lab and X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Other Medical Services
- Acute Home Health

Community Based Long-Term Care:

- Elderly, Blind and Disabled (EBD)
- Community Mental Health Supports (CMHS)
- Children's Home-and Community-Based Services (CHCBS)
- Brain Injury (BI)
- Children with Life Limiting Illness (CLLI)
- Complimentary and Integrative Health (CIH)
- Developmental Disabilities (DD)
- Supported Living Services (SLS)
- Children's Extensive Support (CES)
- Children's Habilitation Residential Program (CHRP+)

Long-Term Care:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Accountable Care Collaborative
- Prepaid Inpatient Health Plan Administration

Financing:

- Healthcare Affordability and Sustainability Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Community Based Long-Term Care, Long-Term Care, Insurance, Service Management and Financing categories, separate forecasts are performed. Only Acute Care is forecasted as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A – CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected current year expenditure in Exhibit A-2. The difference between the two figures is the Department's request.

This calculation is derived by looking at the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected request year expenditure in Exhibit A-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected out year expenditure in Exhibit A. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

Totals for the base request on this page correspond with Columns 2, 4, and 5 on the Schedule 13.

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is approximately 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service (FFIS) each year and is based on a statewide per capita earnings formula that is defined by federal law. For more information about historic FMAP and FMAP changes, see Exhibit R.

Certain populations and services receive different FMAPs than the standard 50.00% as summarized in Exhibit J-5. Members who transitioned from CHP+ to Medicaid under SB 11-008 and SB 11-250 and members in BCCP receive an enhanced FMAP, which is approximately 65%. The State's FMAP for Medicaid services for members receiving the enhanced match is currently 69.34% due to enhancements authorized through the Families First Coronavirus Response Act The expansion

populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 90.00% However, any Community-Based Long-Term Care waiver services for these individuals must be claimed at the standard match as they are not eligible to receive the enhanced FMAP. A sub-group of MAGI Adults, non-newly eligible individuals with disabilities, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25%. The Disabled Buy-In population receives the standard match for expenditure net of patient premiums. A summary of service based FMAPS can be found in Exhibit J-6,

The calculation of expenditure by financing type can be found in Exhibit A series and the calculation of FMAP can be found in Exhibit R.

Calculation of Fund Splits

The Exhibit A series calculates forecasted expenditure and fund source by service group. The FMAP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services (CMS), as reported through the Federal Register or as specified in federal law and/or regulation.

To calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. Most programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. Legislation can impact the fund source for certain services. One key example of this, in FY 2016-17, the General Fund offset from the Old Age Pension Health and Medical Care Fund came entirely from Reappropriated funds based on JBC action. The following programs are paid for using varying funding mechanisms:

- Breast and Cervical Cancer Program: This program typically receives a 65.00% FMAP. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditure. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations.

- Indian Health Services: The federal financial participation rate for this program is 100%. Please see Exhibit F for calculations.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the number of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the State. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. To properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- Affordable Care Act Preventive Services: Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all the recommended services without cost-sharing.

- Non-Emergency Medical Transportation (NEMT): These services receive the administrative federal financial participation (FFP) rate of 50.00% rather than the various service FMAP rates. This entry adjusts the fund splits between federal and state funding to properly account for this service receiving FFP.

- SB 11-008 "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children from ages 6 to 19. Effective January 1, 2013, children under the age of 19 are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). FMAP for these clients remains at the same level as if the clients had enrolled in Children's Basic Health Plan (CHP+) instead of Medicaid at the enhanced match.

- SB 11-250 "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same enhanced FMAP will be available for these clients. The Department received permission from the Centers for Medicare and Medicaid Services (CMS) to

continue receiving a higher match rate for this population, including Section 1205(b) of the Social Security Act, similar to the population under SB 11-008 "Aligning Medicaid Eligibility for Children".

- MAGI Parents/Caretakers 69% to 133% FPL: This population began participation in Medicaid in FY 2009-10 and is funded with a combination of federal funds and HAS Fee. SB 13-200 amended Medicaid eligibility for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line in keeping with Medicaid expansion under the Affordable Care Act, which also ensured that MAGI Parents/Caretakers 69% to 133% of the federal poverty line receive a 100% federal match rate through the end of CY 2016, effective January 1, 2014, with ramp down every year until it reaches 90% effective January 1, 2020. See Exhibit J for additional information and detailed calculations.

- MAGI Adults: This population began participation in Medicaid in FY 2011-12 and was previously labeled Adults without Dependent Children (AwDC). The population is funded with a combination of federal funds and HAS Fee. SB 13-200 amended the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line in accordance with Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the Affordable Care Act provides this population a 100% federal match rate from CY 2014 through CY 2016 with ramp down every year until it reaches 90% effective January 1, 2020. However, waiver services for this population receive the standard FMAP and not the enhanced FMAP per CMS. Calculations and information regarding this population can be found in Exhibit J.

- Continuous Eligibility for Children: HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, beginning March 2014, even if the family experiences an income change during any given year. The Department has the authority to use the HAS Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives the standard federal financial participation rate. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories to better show the impact of continuous eligibility for children. Calculations and information regarding this population can be found in Exhibit J.

- Disabled Buy-In: Funds for this population come from three sources: HAS Fee, premiums paid by clients, and federal funds. While the program receives federal match on the HAS Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculations of fund splits can be found in Exhibit J.

- Non-Newly Eligibles: MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults are funded with a combination of federal funds and HAS Fee. As explained above under those categories, the Affordable Care Act provides both populations with a 100% federal match rate, effective January 1, 2014, though it ramps down over time beginning in CY 2017. A caveat of this enhanced federal match rate is that the expansion population cannot have been eligible for Medicaid services prior to 2009 (or else those individuals are not considered part of the Medicaid expansion population). A subset of the population may have been eligible for Medicaid services prior to 2009 under disability criteria, had the clients chosen to provide asset information when they applied for Medicaid services. For this population, the Department is unable to prove that these clients would not have been eligible for Medicaid services prior to 2009 if they had provided asset information, and therefore cannot claim the full enhanced expansion FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion and receive FMAP determined by a resource proxy with the State portion funded through the HAS Fee, as required by statute. The Department can claim 75% of the expenditure for Non-Newly Eligible clients at the enhanced expansion FMAP and the remaining 25% at standard FMAP. Please refer to Exhibit J for calculations and additional details.

- MAGI Parents/Caretakers 60% to 68% FPL: Parents/Caretakers over 60% FPL are funded with a combination of federal funds and HAS Fee. As explained above, the Affordable Care Act provides MAGI Parents/Caretakers 69% to 133% FPL with a 100% federal match rate, effective January 1, 2014, with a ramp down beginning January 1, 2017. Due to new MAGI conversion rules (please refer to the Caseload Narrative for additional details), the non-expansion eligibility category MAGI Parents/Caretakers to 68% FPL now includes FPL levels over 60%. The MAGI Parents/Caretakers to 68% FPL clients who have FPL levels over 60% are funded with HAS Fee for the State's contribution, rather than General Fund, as required by statute. Please refer to Exhibit J for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 created a limited dental benefit for adults in the Medicaid program, implemented April 1, 2014. To fund the design and implementation of the adult dental benefit, SB 13-242 created the Adult Dental Fund effective July 1, 2013, financed by the Unclaimed Property Trust Fund. Please refer to Exhibit F for calculations and additional details.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive federal financial participation (FFP) and certain individuals with limited resources qualify as a "Qualified Individual", which receives 100% FFP.

- Tobacco Quit Line: The Tobacco Quit Line is administered by the Department of Public Health and Environment (DPHE); the Department pays for the share of costs for the quit line related to serving Medicaid members. The costs are administrative and therefore receive FFP rather than the applicable FMAP by eligibility category.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditure. This is further described in Exhibit K.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in Exhibit L.

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health Federally Qualified Health Centers for the federal share of their actual expenditure in excess of the current reimbursement methodology. Prior to FY 2017-18, these payments were made with certified public expenditure. Going forward, these payments are to be made with General Fund under a Random Moment Time Study (RMTS) methodology.

- Hospital Supplemental Payments: Hospital payments are increased for Medicaid hospital services through a total of five supplemental payments, three of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these payments is to increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL), and to create hospital quality incentive payments that reward hospitals for enhanced quality, health outcomes and cost effectiveness.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Physician Supplemental Payments: Federal funds are drawn to reimburse Denver Health and the Memorial Health Systems in Colorado Springs for physician services provided in excess of the current reimbursement methodology. The Department retains 10% of the federally matched dollars as a General Fund offset.

- Hospital High Volume Payment: Colorado public hospitals that meet the definition of a high-volume Medicaid and Colorado Indigent Care Program (CICP) Hospital qualify to receive an additional supplemental reimbursement for uncompensated inpatient hospital care for Medicaid clients. To meet the definition of a high volume Medicaid and CICP Hospital a hospital must be: licensed as a General Hospital by the Department, classified as a state-owned government or non-state owned government hospital, a High Volume Medicaid and CICP hospital, defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000 and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days, and maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level. Historically, Memorial Health has been the only hospital to qualify for this payment.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund was insolvent and no longer covered the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

- Intergovernmental Transfer for Difficult to Discharge Clients: Privately owned nursing facilities are eligible for receiving supplemental Medicaid reimbursements for costs incurred treating medically complex clients, such that the sum of all Medicaid reimbursement remains below the Upper Payment Limit for privately-owned nursing facilities. To be eligible for these payments, nursing facilities must be privately owned; enter into an agreement with the discharging hospital regarding timelines and initial plans of care for the affected medically complex patients; and provide long-term care services and supports in the least restrictive manner for medically complex clients residing in an inpatient hospital setting for whom no other suitable discharge arrangements are available. The transfer is an annual payment of $1,400,000 total funds, with the State share being transferred through Denver Health & Hospital Authority.

- Denver Health Ambulance Payments: Federal funds are drawn to reimburse Denver Health for ambulance services in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund; the Department retains 10% of the federally matched dollars as a General Fund offset.

- Emergency Transportation Provider Payments: Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. Because these providers receive public funds, the Department has an opportunity to obtain a federal match on expenditures made by public entities. Implementation of a certified public expenditure (CPE) program for public ground EMT providers would allow the Department to make supplemental payments to public (EMT) providers for EMT services to Medicaid clients Pursuant to 42 CFR § 433.51, public funds may be considered as the State's share in claiming federal financial participation when the public funds are certified by the contributing public agency as representing expenditures eligible for federal financial participation. EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider. To be eligible for the reimbursement, the CPE cannot be claimed at any other time to receive federal funds under Medicaid or any other program. The supplemental reimbursement amount is determined by a methodology approved by Centers for Medicare and Medicaid Services (CMS).

- University of Colorado School of Medicine Payment: Originally approved under SB 17-254, the Colorado Legislature approved a transfer from the University of Colorado School of Medicine (UCSOM) to the Department to gain access to federal matching funds. The Department then would reimburse UCSOM through a UPL payment for physician services.

- Public School Health Services: Approved as part of the FY 2019-20 S-7, BA-7 "Public School Health Services Funding Adjustment", this request allowed the Department to use certified public expenditure spent on Public School Health Services (SHS) programs to claim a federal match. Part of the claimed federal funds are applied as a General Fund offset in the Medical Services Premiums line.

- SB 21-213 Use of Increased Medicaid match accounts for the transfer of savings from cash fund financed services to the General Fund as a result of the enhanced federal match was authorized through the Families First Coronavirus Response Act.

See Exhibit A2-A4 for Cash and reappropriated fund financing detail.

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Exhibit B1 contains historical and projected caseload for all eligibility types. Exhibit B-2 provides historical monthly caseload without retroactivity for each of the eligibility types. The Department is forecasting Medicaid caseload to decrease by -18.34% in the current year to 1,404,171 as this will be the first full year without the continuous coverage policy in effect. In the request year FY 2024-25, the trend is projected to continue to decrease by -10.74%, and then increase in the out year by 6.92%.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history through the most recently completed fiscal year and projections are included for historical reference and comparison. The Department provides two separate tables. In Exhibit C-1, the Department provides the per capita cost history based on the cash-based actuals (i.e., the actual expenditure paid in the fiscal year). In Exhibit C2, the Department provides the per capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals. Per capita trends can be affected by changes in caseload, utilization of services, and service costs.

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. The Prenatal State-Only program allows legal immigrants that entered the United States after August 22, 1996 to receive State-funded prenatal care and Emergency only Medicaid benefits for labor and delivery. This expenditure is included in the MAGI Pregnant Adults aid category beginning in FY 2009-10. HB 09-1353 allows legal immigrants that have lived in the United States less than five years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients. Funding for Medicaid pregnant adults was available July 2010. The population that was Prenatal State-Only now represents pregnant adults that are eligible under HB 09-1353. This expenditure is still included in the MAGI Pregnant Adults aid category. Funding for Medicaid children was available July 2015.

EXHIBIT D - CASH FUNDS REPORT

This exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented in Exhibit A. In addition,

current year total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letter note amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses.

EXHIBIT E – SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

This exhibit is a summary of the requests by service group and by eligibility category for the current year, request year, and out-year. It aggregates information from the calculations contained in Exhibits F, G, H, I, and J and caseload information from Exhibit B.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care service expenditure is calculated in a series of steps. Exhibit F1 shows historical expenditure and the annual percent change. The first step of the calculation is to select a per capita percent change rate then to trend the last actual per capita to the next year. Bottom-line adjustments are then made to account for legislation and other impacts not included in historical trends. Total expenditure after bottom-line adjustments is then divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita. The total estimated expenditure for Acute Care is then added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per Capita Percent Change

The per capita percent change is computed for each eligibility category on a per capita cost basis. Exhibit F1provides a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per capita costs is used to modify the request-year and out-year per capita costs, although the Department adjusts the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages considering any policy changes or one-time costs that may skew a one year trend. Per capita trend factors cannot take into account changes in caseload or changes accounted for as bottom-line adjustments. The eligibility categories differ in eligibility requirements, demographics, and utilization, thus different trends are used for each eligibility category.

The trend selections for FY 2023-24, FY 2024-25, and FY 2025-26 are available in Exhibit F9. This includes the selected trend factors for each Medicaid population.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. These impacts are described briefly below:

- FY 2020-21 BA-15 Implement eConsult Program – The Department initiated the policy to save on face-to-face specialty care visits by meeting a portion of patient needs through eConsults. The implementation date is currently set for February 1, 2024.
- Annualization of FY 2018-19 R-10 Drug Cost Containment Initiatives, The Department was appropriated administrative funds to implement a prior authorization system on physician administered drugs and hire a contractor to help with designing an alternative payment methodology for drugs, particularly those that fall under the categories of high-cost and specialty. The Department anticipates prior authorization of physician administered drugs will begin in January 2019 and result in decreased utilization.
- FY 2023 R-10 Non-Emergent Medical Transportation (NEMT) Targeted Rate Increase – The Department restated the impact to rebalancing rates for NEMT services as recommended by the Medicaid Provider Rate Review Committee. The Department's original estimate for this rebalancing was understated and the Department is adding money in order to correct for errors made in the rebalance.
- Annualization of Estimated Impact of Increasing PACE Enrollment accounts for the Department's initiative to increase enrollment of new PACE clients. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care service group to the PACE service category.
- COVID-19 Utilization incorporates the estimated increase in utilization of hospital services and laboratory services associated with COVID-19. The Department estimated the impact using projections of hospitalizations from the Colorado Department of Public Health and Environment for the state, and by estimating the proportion of

hospitalizations that for Medicaid members of the total COVID-19 hospitalizations based on the most recent data on Medicaid members with a hospitalization related to COVID-19.

- R-12 Work Number Verification 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.
- SB 21-009 Reproductive Health Care Program created a state only program to provide reproductive services to non-citizens. The Department expects to see savings in the emergency services populations.
- FY 2021-22 BA-15 Implement eConsult Program authorizes the Department to implement a Medicaid statewide eConsult platform. The adjustment accounts for the net effect of reimbursements to providers and savings from avoided face-to-face specialist visits.
- FY 2020-21 JBC Action 2.5% ATB Rate Increase accounts for the increase in expenditure associated with increasing-rates for all eligible services by 2.5%.
- HB 21-1085 Secure Transportation for Behavioral Health Crisis accounts for a new service within Non Emergency Medical Transportation that provides transportation to members in a behavioral health crisis.
- HB 21-1275 Medicaid Reimbursement for Pharmacists Rendered Services accounts for an increase in services that can be rendered by pharmacists under a collaborative agreement with a physician. This policy change allows pharmacists to render some primary care services as long as they are in collaboration with a physician.
- Estimated Increase in Flu Expenditure accounts for an increase in costs associated with an increase in flu expenditure relative to FY 2020-21.
- Reduction to Blood Clotting Medication accounts for a decrease in rates associated with blood clotting medications.
- Estimated Increase in Respiratory Syncytial Virus (RSV) accounts for expected increases in treating RSV. There were virtually no expenditures associated with treatment of RSV in FY 2020-21 due to increased social distancing during the regular RSV season between October 2020 and March 2021. The Department is already seeing an uptick in reimbursement of these expenditures starting in August 2021.
- The Department included multiple Bottom-Line Adjustments for rate increases that were approved by the JBC. The JBC approved a 2.0% Across the board rate increase, and various targeted rate changes including Durable Medical Equipment, Transportation services, Speech Therapy, and temporary rate increases for certain DME services.
- The Department Included a Bottom-Line Adjustment for new high-cost specialty drugs that are anticipated to become available for use upon approval from the FDA.

- HB 22-1290 Changes to Medicaid For Complex Rehab Technology this bill prohibits the Department from requiring prior authorization for any repair of complex rehabilitation technology (CRT). It also increases Rural CRT reimbursement
- SB 21 - 025 "Family Planning Services for Eligible Individuals" provides family planning services to individuals who are not pregnant and whose incomes do not exceed 250% of the federal poverty level (FPL).
- FY 2022-23 R-06 Value Based Payments establishes alternative payment models which will increases savings in MSP.
- FY 2023-24 R-06 Supporting PCMP Transition with Value Based Payments- Provides funding to train PCMPs to use data tools provided by the FY 2022-23 R-06. Also, a rate increase to PCMPs.
- S-19 BA-19 True Up Funding to Implement Alternative Payment Methodologies- Adjusts the Savings and incentive Payments associated with Pharmacy Prescriber tool based on more accurate data.
- R 08 County Administration, Oversight and Accountability increases funding for pay-for-performance through the County Incentives Program allocation and hire additional staff to provide programmatic oversight
- R-17 Medicaid Benefit Adjustments the Department is requesting a reduction in funding to implement a cap on speech therapy evaluations to only three evaluations per year.
- R-07 Utilization Management Acute Care Impact requests to compensate the Department's Utilization Management vendor for expanding medical necessity reviews for outpatient medical services and physician administered drugs that have been newly identified as having a high risk for fraud and overutilization.
- JBC Action DOC Long Term Care Private Nursing Home: The JBC appropriated funds to the Department to provide nursing home services for Medicaid eligible parolees
- JBC Action Adult Dental Cap: The JBC removed the $1,500 cap on adult dental services.
- The Department approximately $56 million in improper drug rebates. The Department anticipates that FY 2022-23 and FY 2023-24 drug rebate payments from manufacturers will be less to account for the overcollection.
- HB 22-1289 “Health Benefits for Colorado Children and Pregnant Persons” directs the Department to cover all income-eligible pregnant adults on Medicaid/CHP+; create new State-Only CHP+ and Medicaid programs to cover income-eligible children, regardless of immigration status; provide full lactation supports & services to pregnant adults on CHP+/Medicaid; and provide breast pump coverage for all pregnant/postpartum members.
- R-07 Provider Rate Adjustments provides a 3% across the board rate increase to providers that did not receive a targeted rate increase, provides a targeted rate increase for MPPRAC recommendations, and implements a targeted rate increase for rural hospitals. The rate increase also increases base wages of HCBS workers.

- SB 23-222 Medicaid Pharmacy and Outpatient Services Copayment - Removes the requirement for Medicaid patients to pay a copayment for pharmacy and outpatient services.
- Extend Medicaid Coverage for Certain DACA recipients – The Inflation Reduction Act (IRA) expands Medicaid coverage to certain DACA recipients.
- R-10 Children and Youth with Complex and Co-Occuring Needs- provides funding to enhance critical services by increasing benefit navigation and clinical care-coordination for children with complex and co-occurring needs and to add certain Autism Spectrum Disorder (ASD) as a covered diagnosis for mental health and substance use disroder services.
- R-13 Savings from Recoveries accounts for savings from additional program oversight targeted at identifying additional overpayments the Department has made in the past.
- Advancing Birthing Equity – Provides Funding to promote increased health equity outcomes by implementing coverage for birth doulas and human donor milk.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

In 2001, the General Assembly passed SB 01-012, which established a Breast and Cervical Cancer Treatment Program within the Department. In 2019, the General Assembly passed HB 19-1302 which extended the repeal date of the program to 2029. All Breast and Cervical Cancer Program expenditure receives an enhanced federal match rate of approximately 65.00%. Please refer to Exhibit A and Exhibit R for more specific information on the federal match rate for this program.

Beginning January 2017, the age range for clients receiving cervical cancer screening and treatment was expanded to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change did not have an impact of the anticipated magnitude, and the previous caseload adjustment for this policy change has now been removed as the policy change is incorporated into the trend.

Per Capita Cost

With the implementation of the ACA expansion in January 2014 many clients who were eligible through the Breast and Cervical Cancer Program were re-determined as eligible for the MAGI Adult population instead. Per CMS direction, the Department was unable to claim the enhanced ACA FMAP for those clients while they were still actively receiving cancer treatment, and the Department manually moved them from MAGI Adults to the Breast and Cervical Cancer Program

category. Based on analysis of affected clients, the Department determined that the clients included in the manual adjustment were no longer receiving cancer treatment and the Department stopped completing the adjustment as of July 2017. The number of clients in the Breast and Cervical Cancer Program is now much lower, but the per capita costs of clients remaining in the program are higher as they are more likely to use high-cost cancer treatment services.

Fund Splits

The second half of this exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund.

Adult Dental Cash Fund-eligible Per Capita Detail

In 2013, the General Assembly passed SB 13-242, which established the Adult Dental Benefit program along with the Adult Dental Cash Fund, funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the State share of the Adult Dental Benefit program, for expenditure that would otherwise be funded by General Fund for the State share. In 2014, the General Assembly passed HB 14-1336 which provided funding for the addition of full dentures as part of the Adult Dental Benefit. The Department previously covered dental services for adults only in emergencies or in the case of co-occurring conditions that required dental services. The Department does not have a way to systematically distinguish between dental services received in the case of emergency or co-occurring conditions and those covered under the Adult Dental Benefit. Exhibit F2.2 The Adult Dental Cash Fund-Eligible Dental Services reports total Dental expenditure for populations that have the State share of expenditure funded with the Adult Dental Cash Fund and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate the expenditure that will be funded by the Adult Dental Cash Fund.

The Department forecasted expenditure based on the most recent actuals, which were higher than previously forecasted. Therefore, the Department has increased the forecast for FY 2023-24, FY 2024-25, and FY 2025-26.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly moved antipsychotic drugs from the Department of Human Services' portion of the budget to the Medical Services Premiums line item of the Department. This expenditure is now included in the

Acute Care service group within the Prescription Drugs service category. Exhibit F3 Acute Antipsych shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

The Department experienced a large decrease in gross aggregate and per-capita acute antipsychotic pharmaceutical expenditure in FY 2012-13 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly. FY 2014-15 resumed growth due to increases in cost, utilization, and caseload, which continued in FY 2015-16. The Department experienced a slight decrease in FY 2016-17 in gross expenditure. In FY 2017-18, there was another significant decrease in gross aggregate and per-capita expenditure due to the brand name preference of Abilify being removed in April 2017, as well as a large decrease in the unit price of aripiprazole (the generic version of Abilify).

Federal Funds Only Pharmacy Rebates

The Patient Protection and Affordable Care Act (ACA) increased the number of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. To properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental number of rebates that are federal funds only. Estimates are based on most recent actuals. The Department increased costs in FY 2022-23 from previous forecasts based on FY 2021-22data. The Department carried the forecasted growth from FY 2022-23 ongoing.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, to claim the enhanced match, the State must uniquely identify these services. Some family planning services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was also able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on about 95% of the family planning services provided to Medicaid clients. Totals listed on page EF-14 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services (CMS) for enhanced federal funds.

In FY 2016-17, the Department received more rebates attributed to Family Planning than it should have, as the result of a rebate payment error. As such, the Department's total reported expenditures are understated and artificially low in FY 2016-17. The Department has trended forward the FY 2020-21 expenditure by a fraction of previous growth rates to reach FY 2022-23, FY 2023-24, and FY 2024-25 estimates.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are American Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Home- and Community-Based Services (HCBS) Waivers

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I Nursing Facilities relatively consistent.

Clients receiving CBLTC services currently have access to 10 HCBS waivers, each targeted to specific populations. Of the 10 waivers administered by the Department, six are included in the Medical Services Premiums line item and the remaining four fall under the Office of Community Living. The HCBS waivers that are included in the Medical Services Premiums line item are referred to throughout this narrative as HCBS-LTSS waivers. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled (EBD)
- Community Mental Health Supports (CMHS)
- Children's Home-and Community-Based Services (CHCBS)
- Brain Injury (BI)

- Children with Life Limiting Illness (CLLI)
- Complimentary and Integrative Health (CIH)

Calculation of Community-Based Long-Term Care Waiver Expenditure

The CBLTC forecasting methodology forecasts each of the Department's HCBS-LTSS waivers individually. The Department believes this to be an accurate way of forecasting CBLTC because each waiver targets certain populations and provides services targeted at those clients. In CBLTC, each eligibility type has clients receiving services in the HCBS-LTSS waivers. Because each waiver's services vary depending on the target population, any change to a program could impact multiple eligibility types, making it difficult to forecast and identify the root of significant changes in historical trend.

The current methodology includes a forecast for each waiver's enrollment, utilizers, and cost per utilizer. Percentages selected to modify enrollment, utilizer, or per-utilizer costs are calculated to consider policy changes or one-time costs that may skew just one trend year. Trend factors must not account for changes considered bottom-line adjustments. Because each HCBS-LTSS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver.[1]

Since the Department is using an enrollment-based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. This utilization adjustment is determined by taking the ratio of paid claims in each month to the number of PARs in the same month. The Department then used this adjustment factor to estimate the FPE and adjust projected expenditure for each waiver in FY 2023-24, FY 2024-25, and FY 2025-26.

1 The percentages selected to trend expenditures for the waivers are as follows. BLIs are not included in the calculation.

EBD: FY 24 is 5.65%, FY 25 is 5.57%, and FY 26 is 6.63%. **CMHS:** FY 24 is 7.28%, FY 25 is 6.83%, and FY 26 is 6.99%. **CHCBS:** FY 24 is 23.6%, FY 25 is 22.92%, and FY 26 is 22.93%. **BI:** FY 24 is 14.57%, FY 25 is 14.34%, and FY 26 is 15.94%. **CLLI:** FY 24 is 2.22%, FY 25 is 2.18%, and FY 2.12%. **CIH:** FY 24 is 21.34%, FY 25 is 21.29%, and FY 26 is 21.13%.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee trend factors, the Department adds total-dollar bottom-line impacts to the projected enrollment or expenditure. The following impacts have been included in the Request for Community-Based Long-Term Care:

Expenditure

- FY 2024-25 has a 53rd payment period unlike most years where there are 52 weeks of expenditure. An extra week of expenditure has been added to the FY 2024-25 forecast to account for the additional pay period.
- Expenditure for the 53rd payment period is removed in the FY 2025-26 forecast.
- FY 2021-22 Across the Board 2.5% Rate Increase – The Joint Budget Committee approved a 2.5% across-the-board rate increase, effective July 1, 2021.
- FY 2022-23 Across the Board 2.0% Rate Increase – The Joint Budget Committee approved a 2.0% across-the-board rate increase, effective July 1, 2022.
- FY 2023-24 Across the Board 0.5% Rate Increase – The Joint Budget Committee approved a 0.5% ongoing across-the-board rate increase, effective July 1, 2024.
- FY 2023-24 BA-07 Community First Choice – The JBC approved funding for the Department's initiative to provide additional services and information to HCBS waiver members to reduce institutionalization. The initiative is in response to the DOJ's request to improve member access to care and member health outcomes, reducing disparities of care. The information initiative began on July 1, 2023.
- FY 2023-24 BA-07 Transition Coordinator Services – The JBC approved the initiative to provide additional services and information to HCBS waiver members to decrease institutionalization. The initiative is in response to the DOJ's request to improve member access to care and member health outcomes, reducing disparities of care. The waiver transition will be implemented on July 1, 2025.
- Local Minimum Wage: In the 2020 legislative session, the JBC approved an action to increase rates for certain HCBS services in the Denver metro area in response to Denver increasing its minimum wage starting on January 1, 2020 with subsequent increases each January through January 1, 2022. This bottom-line impact includes the expenditure impact of three years of rate increases.

- FY 2021-22 R-6 Remote Supports for HCBS Programs – The Department requested to add a remote support option to existing electronic monitoring services for the EBD, CMHS, BI and SCI waivers. Remote supports are a method of service that joins technology and direct care to support people with disabilities and should reduce the use of in-person services.
- SB 21-038 "Expansion of Complementary and Alternative Medicine" – This bill requires the Department to implement a pilot program that would allow an eligible person with to receive complementary or alternative medicine. The purpose of the pilot program is to expand the choice of therapies available to eligible persons with disabilities and to study the success of complementary and alternative medicine. This bill expanded the pilot program to include persons with specific spinal cord injuries along with the total inability for independent ambulation directly resulting from one of these injuries. This bill expands the pilot program to all eligible individuals in Colorado.
- JBC Authorization of 667 enrollments onto the HCBS - DD waiver –the General Assembly authorized an additional 667 enrollments to be placed onto the HCBS-DD waiver from the waiting list. The Department assumes that if these enrollments were not authorized by the General Assembly, these individuals would have sought alternative care by enrolling on the HCBS Elderly, Blind and Disabled waiver.
- SB 20-212 Telehealth - This bill requires the department of human services to renovate an existing facility at Fort Logan to expand the number of civil beds for people in need of residential behavioral health treatment. Additionally, the bill requires the department of human services to work in partnership with the department of health care policy and financing to add at least 125 additional beds at mental health residential treatment facilities for adults in need of supportive services.
- CDASS Sick Time Provision – Senate Bill 20-205, called the Healthy Families and Workplaces Act (HWFA) was passed by the General Assembly and signed by the Governor on July 14, 2020. The statute requires all employers in the state to provide each of their employees paid sick leave.
- R-09 OCL Program Enhancements - The Department requested funding to increase rates and expand benefits for services offered through the Home and Community-Based Services (HCBS) waivers, increase provider bed capacity, and create additional opportunities for care in the community. Includes adjusted rates for high acuity Brain Injury Waiver Members.
- NPBA-04 Nursing Facility Transitions Costs to HCBS Waivers - The Department expects savings to nursing facilities due to the increase in DOLA housing vouchers by 322. When a member leaves a NF, the Department would accrue savings based on how much that member would have cost if they were still in the NF. DOLA assumed a three-year ramp up to

pass out all housing vouchers beginning in FY 2022-23. The savings are paired with additional costs to HCBS as members transition out of NFs and can begin using community-based living services.

- SB 21-038 (Expansion of Complementary and Alternative Medicine) - This bill expands eligibility from Adamas, Arapahoe, Denver, Douglas, and Jefferson to anywhere in the state. Eligibility is also expanded to include individuals with a primary condition of MS, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability to walk(ambulate) resulting from one of these conditions.
- HB 22-1303 - This bill requires the department of human services to renovate an existing facility at Fort Logan to expand the number of civil beds for people in need of residential behavioral health treatment. Additionally, the bill requires the department of human services to work in partnership with the department of health care policy and financing to add at least 125 additional beds at mental health residential treatment facilities for adults in need of supportive services.
- In the Department's FY 2022-23 R-10 Rate Request, the JBC authorized various rate increases including targeted adjustments to Non-Medical Transportation, Massage Therapy, Changes to the Personal Needs Allowance, and Wage Passthrough Rate Increases that were initially funded through the American Rescue Plan Act.

Hospice

Hospice expenditure for FY 2023-24, FY 2024-25, and FY 2025-26 is forecasted as the sum of two primary categories of services. The first category—Nursing Facility Room and Board expenditure—is for expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity within a nursing facility. The second category of hospice expenditure, referred to throughout the hospice forecast as Hospice Services, contains all hospice expenses other than those accrued as payments to nursing facilities for room and board for hospice clients and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

Hospice Nursing Facility Room and Board total expenditure estimates for a fiscal year are the product of forecasted patient days and forecasted room and board per diem rate.[2] Bottom-line impact adjustments are made for rate changes applied to claims paid that were incurred in the previous fiscal year. To create the patient days forecast, the Department uses claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day

[2] The percentage selected to trend expenditure for HRHC is 47.9% in FY 24, -1.85% in FY 25, and 0.94% in FY 26.

counts. As hospice client per diems are linked to the per diem for Class I Nursing Facility clients, rate reductions are accounted for in the same fashion as they are for nursing facilities; their impact is included in calculations as a bottom-line impact.

The largest component of Hospice Services is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two or three times per week, generally by nurses. Routine Care is aimed at increasing the client's quality of life and comfort as much as possible. and can include pain management, symptom management, assistance with daily tasks, nutritional services, and therapeutic services. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate.

The next-largest component of hospice services expenditure is Hospice General Inpatient Care. This expenditure is incurred for services provided to hospice patients at inpatient facilities under severe circumstances. Inpatient care may be necessary if a patient's symptoms can no longer be managed at home. The purpose of inpatient care is to control severe pain and stabilize symptoms so that the patient can return home, if possible.

The remaining components of Hospice Services expenditure show significant variation in these remaining services by fiscal year.[3]

Payments made to nursing facilities for services provided to hospice clients differ from payments made for Class I Nursing Facility clients in two predominant ways: there is no patient payment component of the per diem rate for hospice services, and the per diem for hospice clients is prescribed at approximately 95% of the per diem rate for Class I Nursing Facility clients. Otherwise, the methodology for forecasting nursing facility room and board expenditure for hospice clients mirrors the Class I Nursing Facility forecast.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the growth cap for nursing facility rates, and nursing facility rate reductions.

[3] The percentage selected to trend expenditure for Hospice Services is 36.46% in FY 24, 7.17% in FY 25, and –11.31% in FY 26.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge similar rates. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. During the FY 2022-23 Legislative Session, PDN services received a 3.0% across the board rate increase which was implemented on July 1, 2023.

Many of the changes in the Private Duty Nursing forecast are due to variations in utilizers and units per utilizer. Registered Nursing has seen the largest growth in expenditure, mainly due to an increase in utilizers in the first half of FY 2023-24. All services have experienced growth in units per utilizer, and thus positive trends have been selected for each category. Additional information on specific trends picked for each service can be found in Exhibit G.

The Department expects rates to remain constant, expenditure forecasts for FY 2023-24, FY 2024-25 and FY 2025-26 are directly from the Department fee schedule for each service.

Private Duty Nursing Utilization Trends and Justification

Registered Nursing (RN)
Although Registered Nursing utilizers had been declining throughout FY 2022-23, they began increasing again in the first half of FY 2023-24. To reflect this growth, the Department chose a 5.51% trend, which is the average growth rate over the first half of the year. The Department expects utilizers to continue growing throughout the rest of the year, and in the following years, though at a slower rate in FY 2024-25 and FY 2025-26.

To align with FY 2023-24 half year actuals, the Department chose a 2.33% trend on units per client. The Department expects units per client to grow in the future based on historical trends and therefore selected positive trends for the request year.

Licensed Practical Nursing (LPN):
LPN average utilizers per month had a more level trend throughout FY 2022-23 but began to grow faster in FY 2023-24. The Department believes that this will continue through FY 2023-24, and the number of clients should continue to grow in the future. The Department chose a 7.14% trend for FY 2023-24 and assumed slight growth in future years

LPN units per client has decreased slightly over the past 6 months, and the Department assumes that this trend will continue. The Department assumed a 0.15% growth rate for the current, with slightly growth in the future.

Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN:
LPN-group, RN-group, and Blended RN/LPN drove 23.81% of total expenditure in FY 2023-24 Side A and represent the smallest number of average utilizers per month. Due to large growth in the Department, the Department assumes a high growth trend that will slow in future years. The Department in FY 2023-24 selected a trend of 9.66% which then decreases in future fiscal years to 3.73% and -1.64%.

Units per client has grown in the past couple of fiscal years; therefore, the Department selected a 3.35% trend for FY 2023-24. The estimated trend decreases to a 3.18% growth rate in FY 2024-25 and 3.12% in the out year. Typically, units per client fluctuates and does not follow a steady pattern of growth.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to projected enrollment or expenditure. The following impacts have been included in the Request for Long-Term Home Health:

<u>Expenditure</u>

- FY 2024-25 53rd Payment Period – In the request year, there are 53 weeks of payments rather than 52. The Department included an extra week of expenditures as a bottom-line impact to account for the additional payment period.
- Expenditures for the 53rd payment period is removed in the FY 2025-26 forecast.
- FY 2023-24 SPA 23-0035 Hospice Rates Increase – In FY 24 and FY 25, Hospice Routine Home Care (HRHC) provider rates are to increase by 3.1%. This is effective October 2, 2023 through September 30, 2025.

- HB23-1228 Nursing Facility Reimbursement Rate Setting – Hospice rates increase by 95% of NF rate increase, implemented July 1, 2023.

Long-Term Home Health

Long-Term Home Health (LTHH) services are deemed necessary by a medical need and are skilled nursing and therapy services that are generally provided in a client's home. LTHH services are either billed hourly or on a per-visit basis with a maximum number of hours. There are nine services under LTHH that are for both children under 21 and adults: clients under 21 that have a medical need can access Physical, Occupational, Speech and Language Therapies (PT, OT, and S/LT respectively), and all clients have access to Registered Nursing/Licensed Practical Nursing (RN/LPN), Home Health Aid Basic and Extended (HHA), Registered Nursing – Brief first visit of day and Brief Second or More Visit of Day, and telehealth. LTHH rates are based on the Department's fee-schedule. During the FY 2022-23 Legislative Session, LTHH services received a 3.0% across the board rate increase effective July 1, 2023.

Similarly to Private Duty Nursing, the LTHH forecast is based on the number of utilizers, and units per utilizer. The most significant change in LTHH is the change in utilizers in the three therapy services (Physical Therapy, Occupational Therapy, and Speech/Language Therapy). Each of the three therapy services have seen a decline in utilizers throughout FY 2023-24 Side A, but are still expected to grow throughout the full year. Some services are still seeing increased growth due to the change in Prior Authorization (PAR) policy, as PARs have not been reactivated. Additional details and specific growth trends can be found in Exhibit G.

All but one of the services in LTHH are forecasted individually using the average monthly service utilizers, the average units per utilizer, and the rate. The rate is assumed to be constant beyond the current year legislative rate increases. Due to low utilization, telehealth is forecasted by total expenditure.

LTHH Trends and Justifications

Home Health Aid Basic and Home Health Aid Extended:
Average utilizers per month for HHA Basic and Extended have steadily increased since FY 2012-13, with large increases in FY 2017-18 and FY 2022-23. HHA Basic experienced slightly lower growth in Quarter 1 and 2 of FY 2023-24, which influenced a slightly lower trend selection. HHA Extended also experienced lower growth in Quarter 1 and 2 of FY 2023-

24, which is reflected in the trend selection. The Department chose 4% growth trends to align with historical data and recent growth.

Both HHAB and HHAE have seen a decrease in utilization over FY 2023-24 Side A. Therefore, the Department selected a -1.00% and a 0.00% trend respectively to align with historical data.

Registered Nursing/Licensed Practical Nurse:
Utilizer numbers were increasing in FY 2020-21 and FY 2021-22; however, utilizer growth has since slowed in FY 2022-23. Therefore, the Department selected a 1.09% trend to align with recent growth. The Department assumes a continued trend of 1.09% in future years.

Utilization has been increasing since FY 2019-20 and continued to grow into FY 2023-24 Side A. The Department selected a 3.95% utilization trend which starts to taper off in future years to align with recent historical data.

RN Brief First of Day and RN Brief Second or more:
Utilizer counts have been growing since FY 2019-20 and continues to grow throughout FY 2023-24 Side A. The Department selected an 8.54% trend and 5.14% trends respectively to align with historical and recent growth.

Utilization for both services has started to increase throughout FY 2022-23 and into FY 2023-24 Side A. Utilization for 2nd visits began to increase throughout FY 2022-23 and continued to increase throughout FY 2023-24 Side A. Therefore, the Department selected a 4.35% trend and 1.37% respectively to align with current utilization patterns.

Physical (PT), Occupational (OT), and Speech/Language Therapy (S/LT):
Growth in all the therapy services has been high over the past few fiscal years. However, the Department has been seeing lower growth rates in all three services for the past 6 months. Due to these recent changes, the Department has lowered the growth trends for PT, OT, and S/LT for FY 2023-24. Growth is expected to continue at a higher rate in FY 2024-25 and FY 2025-26.

The Department believes that the units per client is relatively stable but has increased slightly since Prior Authorization Requests (PARs) were turned off. The Department assumes that units per client will return to its historical levels as PARs are reactivated.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to projected enrollment or expenditure. The following impacts have been included in the Request for Long-Term Home Health:

Expenditure

Telehealth Expenditure Adjustment: Due to small cell sizes that prevent the Telehealth forecast from using the same methodology as the other LTHH services, expenditure for Telehealth is adjusted via bottom line impact.

- FY 2022-23 Across the Board 2.0% Rate Increase – The Join Budget Committee approve a 2.0% across the board rate increase, effective July 1, 2022.
- FY 2024-25 has a 53rd payment period unlike most years where there are 52 weeks of expenditure. Therefore, an extra week of expenditure has been added to the FY 2024-25 forecast to account for the additional pay period.

Enrollment

- N/A

EXHIBIT H - LONG-TERM CARE AND INSURANCE SERVICES

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long-Term Care and Insurance Request

This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities

Class I Nursing Facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict: 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Patient days and expenditure significantly decreased in FY 2020-21 with significant impacts from the Public Health Emergency (PHE). Over the past year, patient days have started to increase again. The Department is closely monitoring this growth.

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

The methodology for the Class I request in Exhibit H is as follows[4]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2022-23.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2022-23. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2023-24 for core components.

[4] For clarity, FY 2021-22 is used as an example. The estimates for FY 2022-23 and FY 2023-24 are based on the estimate for FY 2021-22, and follow the same methodology.

- Using the same data from above, the Department calculates the estimated number of patient days for FY 2023-24.
- The product of the estimated Medicaid per diem reimbursement rate for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2022-23.
- Of the estimated total reimbursement for claims incurred in FY 2023-24, only a portion of those claims will be paid in FY 2022-23. The remainder is assumed to be paid in FY 2023-24. The Department estimates that 93.30% of claims incurred in FY 2023-24 will also be paid during FY 2023-24. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2023-24.
- During FY 2023-24, the Department will also pay for some claims incurred during FY 2022-23 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2022-23 to calculate an estimate of outstanding claims to be paid in FY 2023-24.
- The sum of the current year claims and the prior year claims is the estimated expenditure in FY 2023-24, prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2023-24 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The following impacts have been included in the FY 2023-24, FY 2024-25, and FY 2025-26 calculations for Class I Nursing Facilities:

- Expenditure for the Hospital Backup Program are included as bottom-line adjustments for FY 2023-24 through FY 2025-26. Please refer to Footnote 6 in Exhibit H3 for more detail. The Department increased estimates from the previous forecast to align with recent growth trends.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom-line impact for FY 2023-24, FY 2024-25, and FY 2025-26. Footnote 7 in Exhibit H3 contains additional detail about these recoveries.

- Minimum Wage Increases - In the 2020 legislative session, the JBC approved an action to increase rates for HCBS services, pediatric personal care, and class 1 nursing facility rates in the Denver metro area in response to Denver increasing its minimum wage starting 1/1/2021. Previously under the law, only NFs within a region that increased its minimum wage could receive supplemental payments to fund wage increases. HB22-1333 allows any Colorado NF to receive wage enhancement supplemental payments to increase their minimum wage to at least $15/hour. Costs are offset by savings from eliminating HB 19-1210 Local Minimum Wage Payment requirements.
- In the 2022 legislative session, the JBC allocated funds to provide 10 private nursing facility beds to Medicaid-eligible parolees. The Department of Health Care Policy & Financing is currently working with the Department of Corrections to figure out how to provide beds in private nursing facilities for parolees.
- HB23-1228 was passed during the 2023 legislative session. This bill adjusts the supplemental Medicaid payment rates a nursing facility receives from the Department. This includes changes to the rate setting process, including removing the current statutory limitation on nursing facility per diem rates, and requires the Department to issue additional supplemental payments to nursing facility providers with disproportionately high Medicaid utilization. This bill also mandates that the Department increase the aggregate statewide average of the per diem rate by at least 10%, 3% and 1.5% for FY 2023-24, FY 2024-25, and FY 2025-26.

Incurred-But-Not-Reported Adjustments

As part of the estimates for the allowable per-diem rate, patient payment, and patient days, the Department utilizes the most recent five years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model that examines past claims by month of service and month of payment to estimate the claims that will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. IBNR adjustments analyze the prior pattern of expenditure (the lag between when past claims were incurred and when they were paid) and applies that pattern to the data. This enables the Department to use its most recent data, even where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly Footnotes 4 and 5 in Exhibit H. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2022-23 that will be paid in FY 2023-24 and the percentage of claims incurred in FY 2023-24 that will be paid in FY 2024-25 and subsequent years. The Department applies the same factor to the FY 2024-25 and FY 2025-26 estimates.

The Department uses the IBNR adjustment calculation for the November 2023 Request using paid claims data through April 2020. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor.

The Department observed a decrease in patient days in FY 2021-22 and FY 2022-23 due to residual effects from the COVID-19 pandemic. The Department slightly lowered its assumptions in nursing facility utilization for the patient days forecast. The Department is continuing to expect slow to modest growth in patient days based on a growing elderly population. The Department used fiscal year-to-date actual patient days to inform its forecast for the remainder of the year.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts for cost of living adjustment (COLA). Neither the current period nor the previous period are relevant to this forecast. The only indicators of patient payment are the number of days in the month and the COLA increase for a given year. For this reason, neither a linear nor an autoregressive model was used, as they did not add value to the forecast.

The Department expects patient payments to increase steadily based on recent increases in COLA and updated patient payment information from FY 2022-23 YTD.

FY 2014-15 SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to

$75.00 monthly; this increase was effective as of July 1, 2014. This amount increases by 3.0% annually on January 1st of each year.

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year. Supplemental payments made to Class I Nursing Facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculate total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. Enrollment, utilization, and per-utilizer cost are forecasted using historical actuals.[5]

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The following impacts have been included in the FY 2023-24, FY 2024-25, and FY 2025-26 calculations for the above programs:

- FY 2023-24 HB23-1228 Nursing Facility Reimbursement Rate Setting – Adjustment of supplemental Medicaid payment rates for nursing facilities. Class II Nursing Facility rates increase 10% in FY 2023-24, 3% in FY 2024-25, and 1.5% in FY 2025-26.

[5] The percentage selected to trend expenditure for FY 24, FY 25, and FY 26 is 5.53%. Growth from HB23-1228 is included as a BLI.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-A), Disabled Adults 60-64 (OAP-B), and Disabled individuals to 59 (AND/AB). PACE rates are amended once per year, generally on July 1 of each year.

Exhibit H6 contains two distinct summary measures by fiscal year: average monthly enrollment and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System (MMIS). The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

The Department has added several PACE providers over the last ten years. Senior Community Care of Colorado (Volunteers of America) began serving clients on August 1, 2008, in Montrose and Delta counties. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. InnovAge (formerly Total Long-Term Care), the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility opened in Loveland in November 2015. TRU Community Care opened in February 2017 and serves Boulder and Weld counties. Most recently, Hope West, opened in Spring of 2021 and will serve clients in Mesa county.

Expenditure estimates for PACE in FY 2023-24, FY 2024-25, and FY 2025-26 are the product of two pieces: projected enrollment and cost per enrollee. PACE enrollment was estimated by taking actual enrollment census numbers reported by PACE facilities and applying the average change in monthly enrollment over the last year and applying that trend to FY 2023-24. For enrollment in FY 2024-25 and FY 2025-26, the average change in month-to-month enrollment for PACE facilities in FY 2021-22 was used. The Department assumes that monthly PACE enrollment will begin to return to levels prior to the onset of COVID-19 at some point in FY 2023-24. This method was used to estimate future enrollment on an aggregate-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period because of the way PACE services are provided: that is, clients are not full-time residents of PACE facilities. Systems issues since CY 2013 have resulted in clients who are eligible for Medicaid and receiving PACE services showing up in the

MMIS as not having an enrollment span in the program, causing a delay in monthly capitation payments for these clients. The Department is closely monitoring these systems issues going forward. Actual enrollment in PACE for FY 2022-23 was slightly lower than the enrollment forecasted in the February 2022-23 request, but the Department assumes that enrollment for FY 2023-24 will continue to grow to pre COVID-19 levels. As a result, the enrollment forecast in the February 2023-24 request was decreased in the current year, but increased for request year and out year.

On December 23, 2021, the Department requested that InnovAge Colorado suspend the enrollment of any new Medicaid members for all InnovAge Colorado centers. This request came after an audit was conducted on the operations of all InnovAge Colorado centers. This audit was performed by both the Department and Colorado Department of Public Health (CDPHE). The state identified numerous concerns related to the delivery of services, timeliness of service provision, and appropriate level staffing to meet participant's needs. As an outcome of these results, the Department concluded that InnovAge Colorado failed to provide its participants with medically necessary items and services covered under PACE, which adversely affected or had the substantial likelihood of adversely affecting its participants. On January 23, 2023 the enrollment sanctions for InnovAge Colorado PACE centers were lifted.

Per-enrollee costs for FY 2023-24 are determined by cross-walking the actual FY 2022-23 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2022-23 enrollment projections. Per enrollee costs only represent an estimate to the extent that the exact eligibility type and exact provider distributions for FY 2023-24 are unknown.

SB 19-209 repealed previous statute directing the Department to apply a grade of membership method in determining the upper payment limit methodology. It also requires the Department to meet with PACE organizations to negotiate an appropriate contracted rate for PACE program services for the FY 2023-24 fiscal year.

The Department notes that the table showing the average cost per enrollee represents the total net amount spent in a fiscal year on PACE programs divided by the average number of monthly capitations paid in that specific year. These figures include retroactive capitations and recoupments and do not completely reflect the cost of services received in that fiscal year. For example, the average cost per enrollee in FY 2014-15 factors in approximately $12.9 million in retroactive payments, while the average cost per enrollee in FY 2015-16 encompasses approximately $5.4 million in recoupments.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligible receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligible aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[6] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as "Medicare Qualified Individual (1)." Legislation for the second group, referred to as "Medicare Qualified Individual (2)," comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in Exhibit H7.3.

These premiums reflect the standard Medicare premiums paid by most Medicare recipients or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium.

[6] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40-quarter requirement.

Additionally, some clients pay higher Part B premiums based on higher adjusted gross income; however, the Department is only required to pay the base premium cost.

To forecast growth the Department estimated enrollment growth based on the forecasted growth in the relevant Medicaid populations and used the following projected premiums from the CMS Medicare Trustees Report. Additionally, the Department assumed small amounts of retroactive payments and recoupments for newly added or disenrolled clients based on the most recent actuals.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2013). The Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

The Department estimates expenditure based directly on the contractor's program enrollment estimates to calculate provider and premiums payments for clients enrolled in HIBI.

EXHIBIT I - SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single-Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management

This exhibit summarizes the total requests from the worksheets within Exhibit I.

Single Entry Points

Single entry point agencies (SEPs) were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single-entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to section 25.5-6-105, C.R.S. (2013). A SEP is an agency in a local community through which persons 18 years or older can access needed long-term care services.

The SEP is required to serve clients of publicly funded long-term care programs including nursing facility care, HCBS-LTSS waivers, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of SEPs include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. SEPs also serve as the utilization review coordinator for all community based long-term care services.

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.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and to assure SEP compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

Effective with the July 1, 2020 the Department revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, SEPs were paid through a fixed contract amount for each year. However, the Department has developed and implemented a rates methodology that pays the SEPs for administrative deliverables as well as for Case Management functions.

Effective with the approval of the Department's FY 2021-22 R-14, "Technical Adjustments," funding for SEP agencies and Community Centered Boards (CCBs) has been consolidated into a new line item. Both SEPs and CCBs provide case management and administrative functions for individuals in the Department's HCBS waiver programs. As of FY 2021-22, the Department will report estimates for SEP expenditure in the Department's R-5 Office of Community Living, alongside the forecast for CCB expenditure for services for individuals with intellectual or developmental disabilities (IDD). In effect, starting in FY 2021-22, there will be no fiscal impact of SEPs on R-1 Medical Services Premiums expenditures.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2013)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

Because of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma and clients with diabetes. Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were applied toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2013) (further described in Exhibit A).

The only remaining expenditure in the Disease Management program is for the tobacco quit line, administered by the Department of Public Health and Environment (DPHE). The Department pays for the share of costs for the quit line related to serving Medicaid members. The February 2023 request aligns the Department's projected expenditure with the Reappropriated funds in DPHE's budget that are funded by Medicaid.

Accountable Care Collaborative

In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Accountable Entities (RAEs) that receive service FMAP and that are incorporated in the ACC exhibit.

The ACC is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The cost savings estimated for this program are included in Acute Care; please see Exhibit F for more information on its impact to Acute Care. The monthly management fees are estimated in the Accountable Care Collaborative exhibit.

The Department implemented Phase II of the ACC, which was requested in the FY 2017-18 R-6 "Delivery System and Payment Reforms" request approved in HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives". Phase II of the ACC includes mandatory enrollment of the Medicaid population into the ACC, which would only exclude clients enrolled in a managed care program such as a health maintenance organization or the Program of All-Inclusive Care for the Elderly (PACE) and the Non-Citizens-Emergency Services and Partial Dual Eligibles eligibility categories. The ACC Phase II also combines the RCCOs and Behavioral Health Organizations (BHOs) into a single entity called a Regional Accountable Entity (RAE). RAEs will be responsible for further integrating behavioral and physical health care to achieve improved outcomes and cost reduction. PMPM for the RAEs increased from $15.76 to $15.95 in July 2021, with a portion of the PMPM pushed through from the RAEs to PCMPs. RAEs will receive capitated payments for managed Behavioral Health just as BHOs did.

Legislative Impacts and Bottom-Line Adjustments

The November 2016 request included a bottom-line impact to account for movement of clients from the PMPM-based ACC to the new Kaiser-Access health maintenance organization (HMO), a pilot payment reform initiative under HB 12-1281. This bottom-line impact was removed in the February 2017 forecast with the assumption that the shift of clients to Kaiser-Access was already accounted for in the base FY 2016-17 ACC enrollment trends. On June 30, 2017, the Kaiser-Access HMO ended. The impact of this change is accounted for directly in the forecast of expected ACC enrollment in FY 2017-18, and not as a bottom-line impact.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to

Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Until FY 2009-10, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans. The Department then contracted with three additional prepaid inpatient health plans in FY 2009-10. These included Colorado Access and Kaiser Foundation Health Plan, jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance and Health Independence (CAHI).

Currently, there are no prepaid inpatient health plans, as Rocky Mountain Health Plans ended in November of 2014. The exhibit contains historical information only.

EXHIBIT J - HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for the Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A.

Healthcare Affordability and Sustainability Fee Fund

HB 09-1293 originally established the Hospital Provider Fee Fund to provide for the costs of certain expansion populations on Medicaid, outlined below. SB 17-267 replaced the Hospital Provider Fee Fund with the Healthcare Affordability and Sustainability (HAS) Fee Fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

MAGI Parents/Caretakers 69% to 133% FPL

The Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level. This expansion population receives standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it fell to 94%, then on January 1, 2019, it fell to 93%, and on January 1, 2020 it fell to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

For caseload estimates and methodology, please see the Acute Care and caseload sections of this narrative.

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it fell to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. However, the Public Health Emergency locked several members into this population who are not eligible for the enhanced match because they are over 65 years of age and receiving Medicare benefits. To account for this the Department dampened the assumed FMAP by less than 1%. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver services, this expenditure receives the standard match rate and not the expansion match rate. This incidence can occur for numerous reasons, including clients awaiting disability redeterminations that have caused them to be temporarily moved from their usual eligibility category to this one.

Currently, the Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

Non-Newly Eligibles

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the enhanced expansion federal medical assistance percentage (FMAP) that began January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS Fee Fund. The Department has incorporated the resource proxy in this request.

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State's share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the HAS Fee Fund, effective July 1, 2017, in compliance with statute.

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and has the authority to use the HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department breaks this population out in its respective service categories in Exhibit J to better show the impact of continuous eligibility for children.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditure for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities

This expansion allows for individuals with disabilities with income up to 450% of the federal poverty level to pay premiums to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time. The premiums from the Medicaid Buy-in fund are applied first, and then the remaining expenditure is split at standard medical FMAP as federal funds and HAS Fee Cash Fund. For more information on the funding detail for this population, see Calculation of Fund Splits under Exhibit A. The Department has suspended collecting premiums from this population during the public health emergency.

The Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

Hospital Supplemental Payments

The Department increases hospital payments for Medicaid hospital services through a total of five supplemental payments, three of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

Cash Fund Financing

An offset of $15,700,000 is made from the HAS Fee to offset the loss of federal matching funds due to the decrease in certification of public expenditure for outpatient hospital services resulting from the authorization of the Hospital Provider Fee in HB 09-1293. The HAS Fee replaced the Hospital Provider Fee effective July 1, 2017, under SB 17-267.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit (UPL) financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit using certification of public expenditure.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditure.

The basic calculation for UPL financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the UPL for home health services and nursing facilities are used to offset General Fund expenditure. These offsets started in FY 2001-02. Nursing facilities account for the larger portion of Upper Payment Limit funding. Home health has expenditure that is less by comparison and will experience little impact related to changes in reimbursement rates.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process if it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

In prior fiscal years, the Department could utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department could certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other State funds to draw federal funds to the upper payment limit.

EXHIBIT L - DEPARTMENT RECOVERIES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were used as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue. A new line of recoveries, Credit Balance and Audits, was added in the re-procured contract effective July 1, 2017. Based on the Department's FY 2018-19 R-08 "Assorted Medicaid Savings Initiatives", the Department was appropriated two FTE to increase staffing to review trust compliance issues and identify additional recoveries for the Department.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. The Department's revised forecast for the activity reflects changes to contingency fee paid to the contractor as the contract was re-procured in FY 2017-18. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors. Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 9 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditure by aid category from the estimated final expenditure by service categories. This is a necessary step because expenditure in the Colorado Operations Resource Engine (CORE) is not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System (MMIS). This data provides detailed monthly data by eligibility category and by service category. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditure for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long-term care and insurance pieces separately), and Service Management.

The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed, and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until December of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. The data presented in this request is based on information available as of October 13, 2022.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change of final expenditures in medical services are included in the Budget Request for historical context and comparison. Rates from FY 2008-09 through FY 2022-23 are organized by service group.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2022-23 final actual total expenditure for Medical Services Premiums, including fund splits, the remaining balance of the FY 2022-23 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2022-23 and 2023-24 in the chronological order of the requests/appropriations.

EXHIBIT P - GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditure. The Cash Flow Pattern is one forecasting tool used to estimate final expenditure on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditure.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has adjusted based on knowledge of current program trends.

EXHIBIT Q - TITLE XIX AND TITLE XXI TOTAL COST OF CARE

This exhibit details the total cost of Medicaid services, including lines outside of Medical Services Premiums, such as service expenses for Medicaid Behavioral Health, the Office of Community Living, Medicaid-funded Department of Human Services (DHS) services, and CHP+, separating Title XIX and Title XXI fund sources, to show the total services cost of providing care to clients. This exhibit also includes a total cost of care per capita exhibit for these combined services, including both Title XIX expenditure and Title XXI expenditure, by eligibility category. Effective with the November 2016 Budget Request, the Department added the request amounts for the current, request, and out years to this exhibit.

EXHIBIT R - FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

This exhibit calculates expected FMAP for the current year, the request year, and the out year. CMS calculates FMAP using Bureau of Economic Analysis (BEA) personal income data and population data for the United States and each state. FMAP is calculated using the following formula:

$$FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2 / (\text{Per capita income}_{U.S.})^2 * 0.45)$$

where per capita incomes are based on a rolling three-year average and the FMAP for a given year is taken from the calculation from two years prior.

Estimates are calculated using historic data from the BEA. This calculation only changes if the BEA restates its historical data. However, CMS has informed the Department of the FMAP the Department is eligible for beginning October 1, 2021. Therefore, FMAP for FY 2021-22 and past time periods is not subject to change, as CMS does not restate announced FMAP even in cases where the BEA's updated data results in different calculations. The forecasts for personal income come from the legislative council's most recent forecast for the U.S. and Colorado, and the population forecasts come from the U.S. census for U.S. data and the Department of Local Affair's most recent forecasts for Colorado.

Forecasts throughout this request use these FMAP estimates rather than holding FMAP constant in the request and out years, as was previously done. In cases where a restatement of the BEA's data would result in a different FMAP than was previously anticipated, the Department would submit a supplemental funding request to account for the change in federal funds.