Joint Budget Committee

Staff Figure Setting
FY 2025-26

Health Care Policy and Financing

(All divisions except Behavioral Health Community Programs and the Office of Community Living)

JBC Working Document - Subject to Change

Staff Recommendation Does Not Represent Committee Decision

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How to Use this Document: The Department Overview contains a table summarizing the staff recommended changes. Brief explanations of each change follow the table. Each division description includes a similar table but does not repeat the brief explanations. Sections following the Department Overview and the division summary tables provide more details about the changes.

To find decision items, look at the Decision Items Affecting Multiple Divisions or the most relevant division. This applies to both decision items requested by the department and recommended by the staff. Decision items appear in the requested priority order within sections.

Department Overview

The Department helps pay health and long-term care costs for low-income and vulnerable people. Federal matching funds assist with these costs. In return for the federal funds, the Department must follow federal rules for program eligibility, benefits, and other features. Major programs administered by the Department include:

- **Medicaid** -- serves people with low income and people needing long-term care
- **Children's Basic Health Plan** -- provides low-cost insurance for children and pregnant women with income slightly higher than Medicaid allows
- **Old Age Pension Health and Medical Program** that serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, administering grants such as the Primary Care and Preventive Care Grant Program, and housing the Commission on Family Medicine Residency Training Programs.

Summary of Staff Recommendations

Department of Health Care Policy and Financing

Item	Total Funds	General Funds	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$16,319,607,890	$5,075,664,865	$1,913,641,519	$137,592,164	$9,192,709,342	840.9
Long Bill supplemental	590,734,980	111,446,200	34,654,535	0	444,634,245	0.0
Total	$16,910,342,870	$5,187,111,065	$1,948,296,054	$137,592,164	$9,637,343,587	840.9
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$16,910,342,870	$5,187,111,065	$1,948,296,054	$137,592,164	$9,637,343,587	840.9
Enrollment/utilization trends						
R1 Medical Services Premiums	804,806,948	220,272,801	76,666,621	0	507,867,526	0.0
R1b Health benefits for children lacking access due to immigration	13,779,605	13,779,605	0	0	0	0.0
R2 Behavioral Health	195,378,424	35,590,906	14,355,998	0	145,431,520	0.0
R3 Child Health Plan Plus	31,742,387	8,995,528	2,114,307	0	20,632,552	0.0
R4 Medicare Modernization Act	30,389,662	30,389,662	0	0	0	0.0
R5 Office of Community Living	177,690,388	78,728,954	9,257,033	0	89,704,401	0.0
BA13 Public school health services	-21,188,422	0	-9,978,112	0	-11,210,310	0.0
Aspheric lenses pending rule	-5,526,506	-2,763,253	0	0	-2,763,253	0.0
Update payment rules	-6,594,299	-1,978,290	-461,601	0	-4,154,408	0.0
Subtotal - Enrolment/utilization	*1,220,478,187*	*383,015,913*	*91,954,246*	*0*	*745,508,028*	*0.0*
Eligibility/benefits						
Adult dental annual cap	-8,481,669	0	-2,153,665	0	-6,328,004	0.0
Provider rates						
R9/R15/BA16 Provider rates	-106,064,233	-28,189,914	-15,462,936	0	-62,411,383	0.0
R6 Accountable Care Collaborative	32,665,110	10,226,628	1,635,954	0	20,802,528	0.0

Item	Total Funds	General Funds	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Department of Health Care Policy and Financing						
R7a County escalation unit	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
R7c CBMS development	214,909	-62,623	-29,592	43,582	263,542	0.0
R7d County eligibility administration	0	0	0	0	0	0.0
R8 Claims systems reprocurement	1,419,969	137,661	71,135	0	1,211,173	16.6
R10 HAS Fee admin & refinance	-5,081,811	-2,142,757	-398,148	0	-2,540,906	2.7
R11a CIH waiver	0	0	0	0	0	0.0
R11b Hospital backup unit expansion	-839,287	-478,182	0	0	-361,105	0.0
R11c Alternative Care Facilities rates	-717,626	-358,813	0	0	-358,813	0.0
R11d CHRP respite rate	-176	-88	0	0	-88	0.0
R11e Supported employment IDD	350,000	35,000	0	0	315,000	0.0
R12 BH and primary care integration	1,575,367	368,170	117,691	0	1,089,506	0.0
R13 Contract true up	991,470	356,062	39,673	0	595,735	0.0
R14 Convert contracts to FTE	-509,065	-66,999	-37,018	-186,227	-218,821	8.3
R16 CF transfers & enterprise	0	0	0	0	0	0.0
BA7 HRSN & reentry services	-3,989,322	-810,511	-236,796	0	-2,942,015	0.0
BA8 Technical adjustments	0	3,182,567	0	0	-3,182,567	0.0
BA8b Technical adjustment – DHS indirects	500,000	500,000	0	0	0	0.0
BA9 DOJ Settlement Agreement	1,355,142	710,266	0	0	644,876	10.2
BA10 Youth system of care	-4,095,000	-2,047,500	0	0	-2,047,500	0.0
BA11 ARPA HCBS adjustments	-26,745,543	0	-13,272,348	0	-13,473,195	0.0
BA12 Med transport reviews	-576,505	-172,951	-115,301	0	-288,253	0.0
BA14 All-Payer Claims Database	390,156	-929,943	685,936	0	634,163	0.0
BA17 Personal services reduction	-856,421	-371,429	-56,781	0	-428,211	-10.0
Prepayment claims reviews	-15,939,530	-5,621,260	-685,251	0	-9,633,019	2.0
SBIRT training grants	-1,500,000	-1,500,000	0	0	0	0.0
Remote monitoring tech grants	-500,000	-500,000	0	0	0	0.0
OeHI	2,596,190	0	0	0	2,596,190	0.0
Temporary employees for leave	-5,944	-2,414	-383	-112	-3,035	0.0
NP CU School of Medicine	0	0	20,000,000	-20,000,000	0	0.0
NP Equity Office realignment	74,921	74,921	0	0	0	0.0
Annualize prior year budget actions	61,775,799	30,877,094	-15,872,979	-41,569	46,813,253	-42.5
Community First Choice	0	-49,248,106	0	0	49,248,106	0.0
Centralized appropriations	8,276,609	803,400	2,315,473	-97,745	5,255,481	0.0
Transfers to other state agencies	4,902,874	2,403,616	47,820	0	2,451,438	0.0
Indirect cost adjustment	-178,207	178,207	1,112	-231,098	-126,428	0.0
Total	$18,071,829,234	$5,527,477,080	$2,016,843,896	$117,078,995	$10,410,429,263	828.2
Changes from FY 2024-25	$1,161,486,364	$340,366,015	$68,547,842	-$20,513,169	$773,085,676	-12.7
Percentage Change	6.9%	6.6%	3.5%	-14.9%	8.0%	-0.0
FY 2025-26 Executive Request	$17,445,191,601	$5,419,424,041	$1,962,437,858	$119,331,118	$9,943,998,584	858.7
Staff Rec. Above/-Below Request	$626,637,633	$108,053,039	$54,406,038	-$2,252,123	$466,430,679	-30.5

Decision Items Affecting Multiple Divisions

Enrollment/utilization trends

Requests R1 through R5 and BA13 propose changes to both FY 2024-25 and FY 2025-26 based on a new forecast of caseload and expenditures under current law and policy. They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriations, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

On February 18, 2025, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2024 forecast used for the Governor's request incorporated data through June 2024. The February 2025 forecast incorporates data through December 2024.

The table below shows the incremental difference between the February 2025 forecast and the November 2024 forecast for the forecast requests. This comparison can be useful in understanding how much more or less there is to work with in the overall budget compared to the Governor's request, based on the new information in the February forecast. For this purpose, it is most useful to focus on the cumulative change over both years.

February 2025 Forecast Higher/(Lower) than November 2024 Forecast					
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2024-25					
Medical Services Premiums	$371,869,517	$42,480,360	$23,503,056	$0	$305,886,101
Health Benefits for Children	0	0	0	0	0
Behavioral Health	133,424,241	24,868,750	14,087,260	0	94,468,231
Children's Basic Health Plan	6,039,786	4,842,484	-2,728,559	0	3,925,861
Medicare Modernization Act	657,001	657,001	0	0	0
Office of Community Living	77,139,940	40,122,268	-1,552,298	0	38,569,970
Total - Difference	$589,130,485	$112,970,863	$33,309,459	$0	$442,850,163
% Change from Nov Forecast	*3.9%*	*2.3%*	*2.1%*	*0.0%*	*5.2%*
FY 2025-26					
Medical Services Premiums	$358,447,091	$7,705,210	$47,017,821	$0	$303,724,060
Health Benefits for Children	0	0	0	0	0
Behavioral Health	166,425,873	21,799,912	24,212,693	0	120,413,268

February 2025 Forecast Higher/(Lower) than November 2024 Forecast					
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Children's Basic Health Plan	16,111,303	8,939,992	-3,301,036	0	10,472,347
Medicare Modernization Act	3,911,256	3,911,256	0	0	0
Office of Community Living	82,428,320	40,613,541	-1,957,919	0	43,772,698
Total - Difference	$627,323,843	$82,969,911	$65,971,559	$0	$478,382,373
% Change from Nov Forecast	*3.9%*	*1.6%*	*4.1%*	*0.0%*	*5.2%*
Cumulative over both years					
Medical Services Premiums	730,316,608	50,185,570	70,520,877	0	609,610,161
Health Benefits for Children	0	0	0	0	0
Behavioral Health	299,850,114	46,668,662	38,299,953	0	214,881,499
Children's Basic Health Plan	22,151,089	13,782,476	-6,029,595	0	14,398,208
Medicare Modernization Act	4,568,257	4,568,257	0	0	0
Office of Community Living	159,568,260	80,735,809	-3,510,217	0	82,342,668
Total - Difference	$1,216,454,328	$195,940,774	$99,281,018	$0	$921,232,536
% Change from Nov Forecast	*3.9%*	*2.0%*	*3.1%*	*0.0%*	*5.2%*

Cumulative over the two fiscal years the February 2025 forecast is up $1,216.5 million total funds, including $195.9 million General Fund. This General Fund increase is primarily attributable to:

- Long-term home health utilization trending higher
- Behavioral health capitated rates coming in higher than previously estimated
- Intellectual and developmental disability waiver enrollment and utilization increases

In the January supplemental and budget amendment request, the Governor proposed setting aside $41.3 million General Fund for potential changes in the February forecast.[1] After accounting for the $41.3 million set aside, the remaining variance from the Governor's January budget request is $154.6 million General Fund.

The Office of State Planning and Budgeting sent a letter, dated February 18, 2025, providing balancing proposals to address the shortfall. All of the balancing proposals are in the Department of Health Care Policy and Financing and each will be addressed in the relevant JBC staff figure setting documents.

➔ R1 Medical Services Premiums

Request

The Department requests a change to the Medical Services Premiums appropriation for both FY 2024-25 and FY 2025-26 based on a new forecast of caseload and expenditures under current

[1] See page 5 of the Governor's letter, dated January 2, 2025.

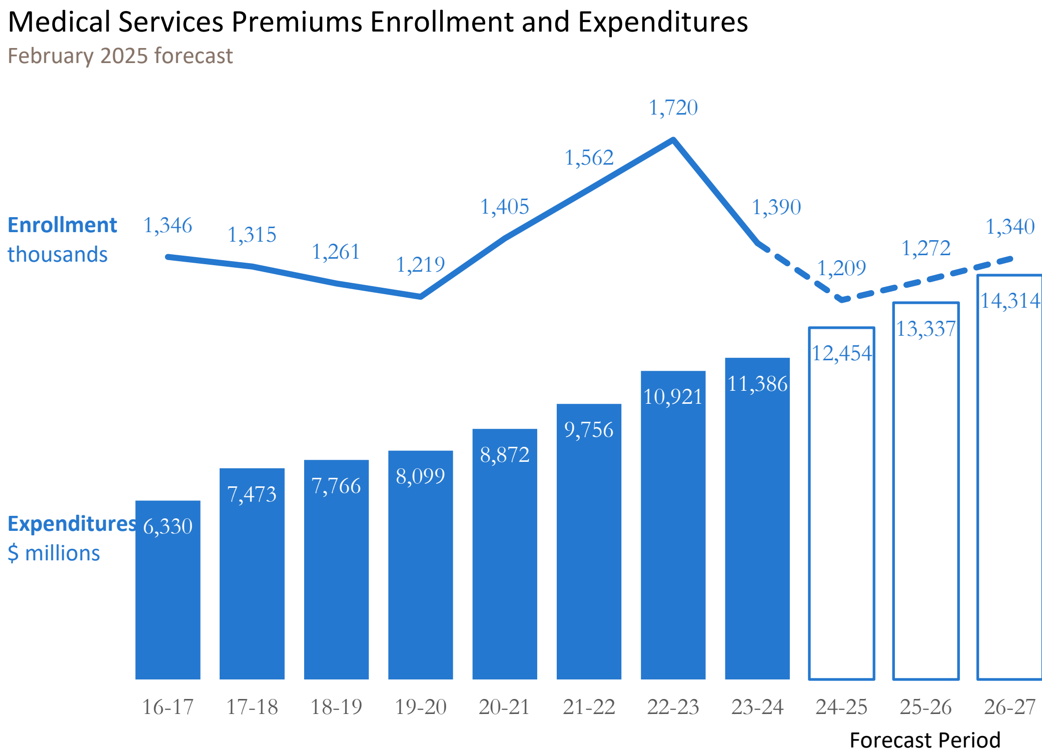
law and policy. Medical Services Premiums pays for physical health and most long-term services and supports for people eligible for Medicaid.

On February 18, 2025, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2025 forecast is higher than the forecast used for the Governor's request by $371.9 million total funds, including $42.5 million General Fund, in FY 2024-25 and $358.4 million total funds, including $7.7 million General Fund, in FY 2025-26. The cumulative General Fund difference over the two years is $50.2 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2025 forecast of enrollment and expenditures to modify both the FY 2024-25 and FY 2025-26 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



FY 2024-25

The table below shows the most significant factors driving the change in the Department's forecast for FY 2024-25. Note that this table displays changes from the appropriation and not

changes from FY 2023-24. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2024-25 Medical Services Premiums Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
FY 2024-25 Appropriation	$12,086,735,818	$3,625,759,766	$1,519,647,523	$6,941,328,529
Acute Care				
Enrollment	-11,777,639	-11,105,700	1,408,561	-2,080,501
Per capita	278,781,583	-2,153,218	54,852,517	226,082,284
Subtotal - Acute Care	*267,003,944*	*-13,258,918*	*56,261,078*	*224,001,783*
Long-term Care Programs				
HCBS waivers	3,112,993	31,429	1,081,870	1,999,694
Long-Term Home Health/PDN/Hospice	90,369,002	45,184,501	0	45,184,501
Nursing homes	28,737,342	14,304,196	138	14,433,008
PACE	10,013,416	5,006,708	0	5,006,708
Subtotal - Long-term Care Programs	*132,232,753*	*64,526,834*	*1,082,008*	*66,623,911*
Medicare & private premiums	-13,169,478	-8,260,066	0	-4,909,412
Service management	-1,227,267	-527,490	-77,650	-622,127
Hospital supplemental payments	-12,970,434	0	-33,762,380	20,791,946
Total	$12,458,605,336	$3,668,240,126	$1,543,150,579	$7,247,214,630
Increase/(Decrease)	$371,869,518	$42,480,360	$23,503,056	$305,886,101
Percentage Change	*3.1%*	*1.2%*	*1.5%*	*4.4%*

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

- Enrollment – The Department slightly decreased the enrollment forecast overall by 6,152 (0.5 percent). The decreases are primarily in parents and pregnant women and children. There are small offsetting increases in the forecasted enrollment of the elderly and people with disabilities, expansion populations, and non-citizens.
- Per capita – The Department increased per capita expenditure estimates for expansion adults, traditional adults, and children, but lowered estimates for the elderly and people with disabilities.

Long-term Care Programs: The long-term care programs include nursing homes, in-home nursing services, and community supports that help people live at home.

- HCBS waivers – Higher enrollment in the Elderly, Blind, and Disabled waiver is offset by lower enrollment in the Children's Home- and Community-Based Services Waiver. Home- and Community-Based Services (HCBS) assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube.
- Long-Term Home Health/PDN/Hospice – Expenditures for home health basic services through the first 6 months of FY 2024-25 are 14 percent higher than projected. Long-term home health (LTHH) and private duty nursing (PDN) are skilled nursing and therapy services

provided in a home setting. People can potentially receive both HCBS and long-term home health or private duty nursing. The difference between long-term home health and private duty nursing is a matter of degree, with private duty nursing the more intensive service and generally limited to people who are machine-dependent and/or require round-the-clock care. In addition to traditional nursing services, home health includes physical therapy, occupational therapy, and speech therapy.

- Nursing homes – After mostly flat enrollment since FY 2021-22, nursing home bed days have been increasing since March 2024.
- PACE – Both rates and enrollment are up moderately relative to the forecast. The Program of All-inclusive Care for the Elderly is a managed care program that includes both acute care and long-term care programs.

Medicare & private premiums: The decrease is due to lower enrollment than forecasted. For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. In a small number of cases the Department also pays private insurance premiums.

Service management: The forecast reflects the change in expected enrollment. Service management is primarily administrative payments to the Regional Accountable Entities for the Accountable Care Collaborative on a per enrollee basis.

Hospital supplemental payments: The Department slightly decreased the projected total supplemental payments to hospitals and adjusted the expected average federal match. To make the hospital supplemental payments, the Department collects money from the hospitals through the Healthcare Affordability and Sustainability Fee, matches the money with federal funds, and then sends the money back to the hospitals in proportion to the indigent clients served. The supplemental payments reduce shortages when Medicaid reimbursements are below costs and when hospitals provide care to patients who are uninsured or underinsured.

FY 2025-26

The Department projects expenditures will increase $883.1 million total funds, including an increase of $207.9 million General Fund, from FY 2024-25 to FY 2025-26. The table below shows the major contributors to the General Fund change.

FY 2025-26 Medical Services Premiums Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
FY 2024-25 Projection	$12,458,605,336	$3,668,240,126	$1,543,150,579	$7,247,214,630
Acute Care				
Enrollment	392,214,500	77,195,924	31,032,220	283,986,356
Per capita	205,137,137	35,898,148	22,477,866	146,761,123
Subtotal - Acute Care	*597,351,637*	*113,094,072*	*53,510,086*	*430,747,479*
Long-term Care Programs				
HCBS waivers	134,681,633	65,826,676	1,926,460	66,928,497
ARPA HCBS	0	13,322,439	-13,322,439	0
Community First Choice	0	-41,251,018	0	41,251,018
Long-Term Home Health/PDN/Hospice	28,696,700	14,348,350	0	14,348,350
Nursing homes	19,880,808	9,959,919	-106,773	10,027,662
PACE	26,517,758	13,258,879	0	13,258,879

FY 2025-26 Medical Services Premiums Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
Subtotal - Long-term Care Programs	*209,776,899*	*75,465,245*	*-11,502,752*	*145,814,406*
Medicare & private premiums	19,344,291	12,844,704	0	6,499,587
Service management	4,842,695	868,730	-634,356	4,608,321
Hospital supplemental payments	34,297,243	0	12,104,955	22,192,288
Nursing supplemental payments	8,655,501	0	4,327,751	4,327,750
EMT supplemental payments	11,207,898	5,179,958	8,495,324	-2,467,384
Other financing	-2,353,634	486,229	1,521,950	-4,361,813
Total	$13,341,727,866	$3,876,179,064	$1,610,973,537	$7,854,575,264
Increase/(Decrease)	$883,122,530	$207,938,938	$67,822,958	$607,360,634
Percentage Change	*7.1%*	*5.7%*	*4.4%*	*8.4%*

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

- Enrollment – The Department projects enrollment will increase 63,507 (5.3 percent) overall. Of the General Fund increase, $42.6 million is for the elderly and people with disabilities, $22.6 million is for children, and $12.0 million is for parents and pregnant women.
- Per capita – The increase includes annualizations of provider rate increases and other policies from prior years and continued growth. Of the General Fund increase, $25.7 million is for the elderly and people with disabilities, $16.8 million is for children, and $13.8 million is for parents and pregnant women. These increases are offset by __.

Long-term Care Programs: The long-term care programs include nursing homes, in-home nursing services, and community supports that help people live at home.

- HCBS waivers – The Department is projecting a 3.3 percent increase in enrollment in the Home- and Community-Based Services (HCBS) waivers and a 5.6 percent increase in costs per utilizer. HCBS assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube.
- ARPA HCBS – The forecast reflects the end of one-time funds through the American Rescue Plan Act that were used to support the state share of provider rate increases.
- Community First Choice – The Department will collect an additional 6 percentage points federal match on services moved from the HCBS waivers to the state plan.
- Long-Term Home Health/PDN/Hospice – The Department projects the precipitous growth in long-term home health to plateau beginning in July 2025 when the Department reinstates Prior Authorization Requirements (PARs). Long-term home health (LTHH) and private duty nursing (PDN) are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS and long-term home health or private duty nursing. The difference between long-term home health and private duty nursing is a matter of degree, with private duty nursing the more intensive service and generally

limited to people who are machine-dependent and/or require round-the-clock care. In addition to traditional nursing services, home health includes physical therapy, occupational therapy, and speech therapy.

- Nursing homes – The Department projects continued increases in bed days and the 1.5 percent statutory increase in provider rates.
- PACE – The Department projects both the managed care rates and enrollment will increase. The Program of All-inclusive Care for the Elderly is a managed care program that includes both acute care and long-term care programs.

Medicare & private premiums: The Department projects increase in enrollment and Medicare premiums. For people eligible for both Medicaid and Medicare the Department pays the Medicare premiums. In a small number of cases the Department also pays private insurance premiums.

Service management: The forecast reflects the change in expected enrollment. Service management is primarily administrative payments to the Regional Accountable Entities for the Accountable Care Collaborative on a per enrollee basis.

Hospital supplemental payments: The Department projects increases in supplemental payments due to increases in the federal upper payment limit. To make the hospital supplemental payments, the Department collects money from the hospitals through the Healthcare Affordability and Sustainability Fee, matches the money with federal funds, and then sends the money back to the hospitals in proportion to the indigent clients served. The supplemental payments reduce shortages when Medicaid reimbursements are below costs and when hospitals provide care to patients who are uninsured or underinsured.

Nursing supplemental payments: The Department projects increase in pay for performance and supplemental payments.

EMT supplemental payments: The Department projects an increase in certified public expenditures by public emergency medical transportation. There are significant lags between service dates and when the funds are certified. In FY 2024-25 some of the service dates earned COVID-related enhanced federal matching funds. The average federal match decreases in FY 2025-26, decreasing the federal funds and increasing the General Fund.

➔ R1b Health benefits for children lacking access due to immigration status

Request

The Department requests an increase for the health benefits for children lacking access due to immigration status based on a new forecast of caseload and expenditures under current law and policy. House Bill 22-1289 required the Department to set up a program with benefits that mirror Medicaid and CHP+. The eligibility criteria include children who would otherwise qualify for Medicaid or CHP+ except for their immigration status. There is no federal match.

On February 18, 2025, the Department submitted an update to the R1 forecast, but it did not change the projection for these services. There is not enough new data for the Department to update the forecast.

The Department projects that the original Fiscal Note significantly understated the cost. The Department increased enrollment projections based on uptake rates for a similar program in Oregon and enrollment trends to date. In advance of the January 2025 implementation, the Department began passively enrolling people who qualified for emergency services under Medicaid within the last year who would not qualify for standard Medicaid or CHP+ due to immigration status. As of January 31, 2025, there were 9,934 children enrolled, compared to 1,344 children assumed in the Fiscal Note. Service costs were $2,732,794 for just January 2025, compared to the estimate in the Fiscal Note of $2,102,664 for the entire fiscal year. The Department decreased the expected per capita costs compared to the Fiscal Note, but not nearly enough to offset the higher projected enrollment.

HB 22-1289 Service Costs for Children		
Item	FY 2024-25	FY 2025-26
Fiscal Note	$2,102,664	$4,360,863
Current Projection	$16,037,803	$32,075,606
Difference	$13,935,139	$27,714,743

Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the Fiscal Note. The program has statutory authority to overexpend the appropriation. This forecast represents what the Department thinks the state will spend for the benefit under current law and policy. Any change to the eligibility or benefits would occur in a bill and the bill would include the savings. The JBC staff has a recommendation for legislation to end the benefit later in this document.

➔ R3 Child Health Plan Plus

Request

The Department requests a change to the Child Health Plan Plus (CHP+) for both FY 2024-25 and FY 2025-26 based on a new forecast of caseload and expenditures under current law and policy. CHP+ pays for physical health services for eligible children and pregnant women and for dental services for children.

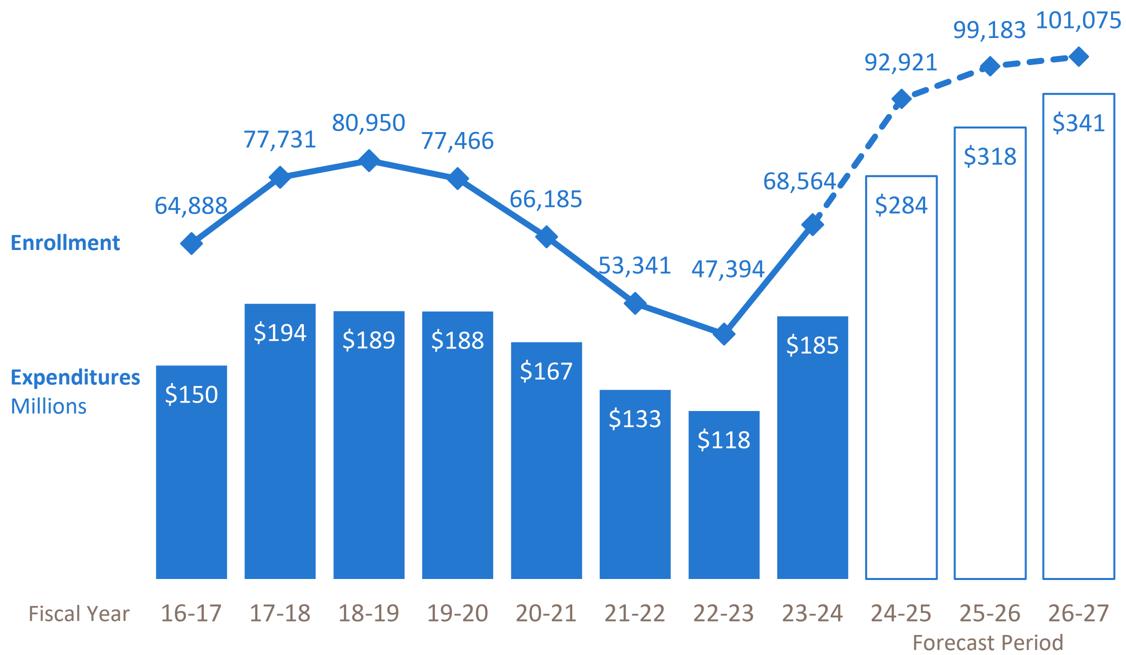
On February 18, 2025, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2025 forecast is higher than the forecast used for the Governor's request by $6.0 million total funds, including $4.8 million General Fund, in FY 2024-25 and $16.1 million total funds, including $8.9 million General Fund,

in FY 2025-26. The cumulative General Fund difference over the two years is $13.8 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2025 forecast of enrollment and expenditures to modify both the FY 2024-25 and FY 2025-26 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



FY 2024-25

The table below shows the most significant factors driving the change in the Department's forecast for FY 2024-25. Note that this table displays changes from the appropriation and not changes from FY 2023-24. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2024-25 CHP+ Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
FY 2024-25 Appropriation	277,481,023	45,117,765	52,065,593	180,297,665
Enrollment	-129,115	2,480,616	-2,525,807	-83,924
Per capita	6,168,901	2,361,868	-202,752	4,009,785
Total	283,520,809	49,960,249	49,337,034	184,223,526

FY 2024-25 CHP+ Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
Difference	6,039,786	4,842,484	-2,728,559	3,925,861
Percent	2.2%	10.7%	-5.2%	2.2%

The Department revised the estimated portion of the population with the state share financed from the General Fund versus the HAS Fee. The Department increased the projected enrollment of children with lower income and the state share financed from the General Fund. The Department increased the projected higher income enrollment with the state share financed from the HAS Fee.

FY 2025-26

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2024-25 to FY 2025-26. The table combines the impact of changes in the forecast and anualizations, which are sometimes separated in other tables within this document.

FY 2025-26 CHP+ Enrollment/Utilization Trends				
Item	Total Funds	General Fund	Other State	Federal Funds
FY 2024-25 Projection	277,481,023	45,117,765	52,065,593	180,297,665
Enrollment	19,793,553	5,588,964	1,338,780	12,865,809
Per capita	14,533,178	4,103,630	982,982	9,446,566
Total	311,807,754	54,810,359	54,387,355	202,610,040
Difference	34,326,731	9,692,594	2,321,762	22,312,375
Percent	12.4%	21.5%	4.5%	12.4%

The Department expects continued churn from Medicaid to CHP+, but at a slower rate than in prior years. The Department projects increased managed care rates to comply with federal regulations.

➔ R4 Medicare Modernization Act

Request

The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act.

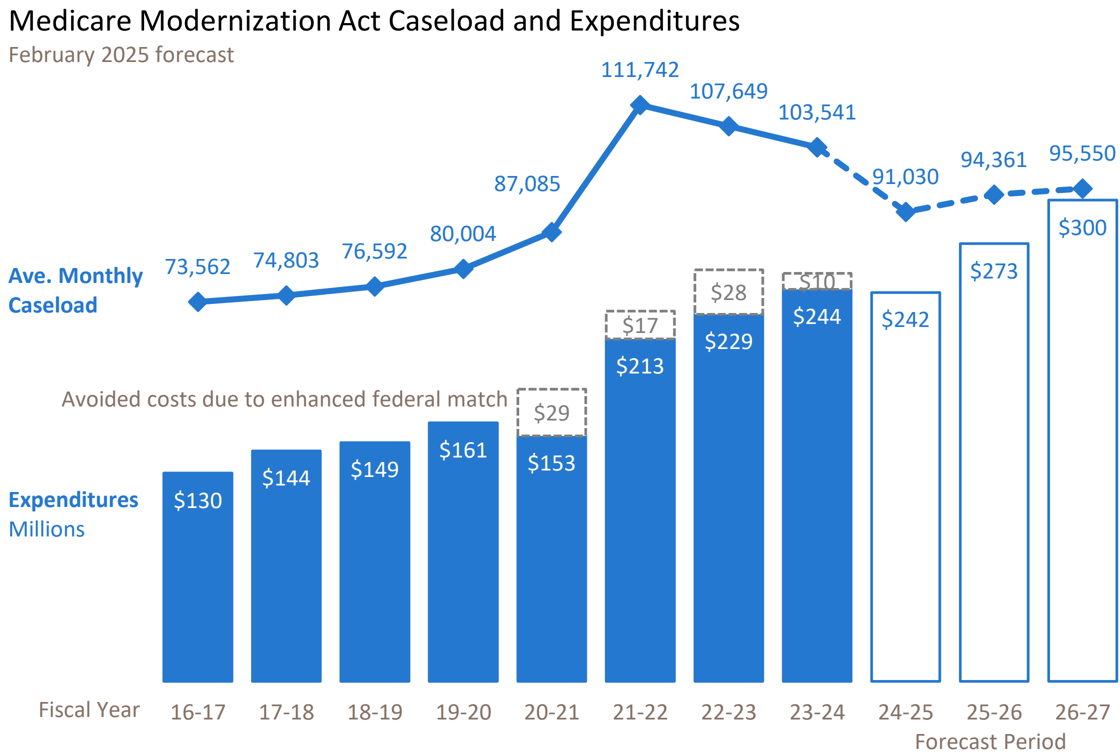
The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This is often referred to colloquially as the “clawback.” The size of the state's obligation under the federal formula is influenced by changes in the population that is dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices. This is a 100 percent state obligation with no matching federal funds.

On February 18, 2025, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2025 forecast is higher than the forecast used for the Governor's request by $657,001 General Fund in FY 2024-25 and $3.9 million General Fund in FY 2025-26. The cumulative General Fund difference over the two years is $4.6 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2025 forecast of enrollment and expenditures to modify both the FY 2024-25 and FY 2025-26 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast. The enhanced federal match through the federal Families First Coronavirus Response Act reduced the state obligation under the Medicare Modernization Act.



➔ BA13 Public school health services

Request

The Department requests a net decrease of $21.2 million total funds for public school health services based on an updated projection of certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

Through the School Health Services Program school districts and BOCES are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs.

Beginning in FY 2020-21 the program expanded, following new federal guidance, to include services outside an IEP or IFSP that are included in other student health plans, such as a 504 disability plan, behavior plan, nursing plan, physician order, or crisis intervention services. Participating school districts and BOCES report their allowable expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds, less administrative expenses, are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services or to expand services for low-income, under or uninsured children and to improve coordination of care between school districts and health providers.

Due to the time required to collect and certify the expenditures, the expenditures significantly lag the date of service. The projected decrease reflects that a smaller portion of payments in FY 2025-26 will be for dates of service that earned an enhanced federal match during the federal public health emergency for COVID.

Recommendation

Staff recommends the request. The expenses for Public School Health Services are driven by an increase in the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The actual amount of certified public expenditures are not in the direct control of the Department. The Department needs the increase in spending authority to distribute the federal funds to the school districts.

➔ Aspheric lenses pending rule

Staff recommends adjusting the Department's forecast to account for a rule the Medical Services Board is considering in April 2025 that would clarify when aspheric eyeglass lenses are considered medically necessary. The recommendation saves $5.5 million total funds, including $2.8 million General Fund. The recommendation is based on feedback from the Department that the Medical Services Board appears likely to approve the rule change.

In making the recommendation, the JBC is not trying to influence the decision of the Medical Services Board. The JBC staff's knowledge of aspheric lenses is limited to Wikipedia. The JBC

staff has no medically informed opinions on when aspheric lenses should be prescribed or covered. Nor is staff asking the JBC members to play doctor and render a judgement on aspheric lenses. The Medical Services Board should make a professional judgement on the proposed rule independent of this budget action.

Instead, the JBC staff is recommending an assumption in the forecast that the Medical Services Board will approve the rule change. If the Medical Services Board makes a different decision, then this will be one assumption the forecast got wrong. It probably won't be the only assumption the forecast missed.

Aspheric lenses improve the focus of glasses for objects that are outside of center. In standard glasses, the stronger the vision correction, the greater the focus distortion away from center. Aspheric lenses solve this problem and are particularly valuable for people with higher vision needs. The new rule would clarify the level of vision needs when Medicaid considers aspheric lenses medically necessary.

The Department projects that approval of the proposed rule will decrease expenditures for aspheric lenses. If needed, the Department may consider prior authorization requirements (PARs) to enforce the rule in future years.

This was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast.

➔ Update payment rules

Staff recommends reducing the projected expenditures for Medical Services Premiums to reflect updated payment rules for multiple related therapy claims on the same day and eyeglasses. The recommendation saves $6.6 million total funds, including $2.0 million General Fund. These updated payment rules are to align with federal guidelines and with the Department's existing rules respectively.

Federal guidelines call for reduced payments for certain therapies by the same provider on the same day for the same client. Under the federal guidelines, the primary service pays at 100 percent and the related services should pay at a lower percent to reflect the providers' economies when delivering multiple services in one visit. This payment rule primarily impacts physical, occupational, and speech therapy services. The Department's current payment systems do not enforce the payment rule.

In June 2023, the Department's vendor for ClaimsXten did an analysis estimating that enforcing this payment rule would save a projected $13.0 million total funds, including $3.9 million General Fund, annually. The enforcement can be done electronically with no increased administrative burden on the provider billing for services. The Department initially anticipated needing additional staff and contract resources to make the necessary changes. Also, the Department did not want to implement new payment rules before knowing whether it would keep ClaimsXten in the reprocurement or move to a different product.

After determining to keep ClaimsXten and working through the logistical requirements and services already covered in the Department's contracts, the Department now believes the

payment rule can be implemented within existing resources as soon as January 2026. The Department is working to put the payment rule in place to align with the federal guidelines. The expected decrease in payments was not captured in the February 2025 forecast.

The Department is looking at other areas where the vendor could help the Department align payment rules with federal and state guidelines. This particular payment rule has a completed and detailed vendor analysis to support a savings projection.

The multiple therapies payment rule was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast. The initiative's title in the Governor's letter was "Review ClaimsXten Cost Savings".

For eyeglasses, the Department covers one pair every two years, but the Department's claims system does not currently enforce the rule. The Department estimates that enforcing the rule will save $113,158 total funds, including $28,290 General Fund, annually. The Department estimates that system updates to enforce the rule can be completed within existing resources by January 2026. The expected decrease in payments was not captured in the February 2025 forecast.

The eyeglasses payment rule was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast. The initiative's title in the Governor's letter was "Coverage Policy Vision Benefits". The Governor's letter contained an error describing the policy change as applying prior authorization requirements (PARs) for more than one pair of eyeglasses annually. This is actually a payment rule change to enforce an existing policy that limits coverage to one pair of eyeglasses every two years.

Update payment rules

Item	Total Funds	General Fund	Cash Funds - HAS Fee	Federal Funds
FY 2025-26				
Multiple therapies	-$6,500,000	-$1,950,000	-$455,000	-$4,095,000
Eyeglasses	-94,299	-28,290	-6,601	-59,408
Total	-$6,594,299	-$1,978,290	-$461,601	-$4,154,408
FY 2026-27				
Multiple therapies	-$13,000,000	-$3,900,000	-$910,000	-$8,190,000
Eyeglasses	-188,597	-56,579	-13,202	-118,816
Total	-$13,188,597	-$3,956,579	-$923,202	-$8,308,816

➔ Medicaid buy-in premiums for people with disabilities

Staff recommends a technical correction to the Department's February 2025 forecast of expenditures for Medical Services Premiums. The recommendation reduces the FY 2024-25 projected expenditures from the HAS Fee and federal funds by $555,063 each and increases the projected expenditures from the Medicaid Buy-in Cash Fund by $1,110,126. The recommendation aligns the appropriation with the requirement that people with disabilities who want to buy in to Medicaid must start paying premiums in April 2025.

Premiums for the disability buy-in programs are deposited in the Medicaid Buy-in Cash Fund. The Department stopped charging the premiums during COVID in compliance with federal guidelines and then kept the premiums turned off during a maintenance of effort period associated with the American Rescue Plan Act's home- and community-based services grant.

Eligibility/benefits

➔ Adult dental annual cap

Staff recommends implementing a $3,000 annual cap on adult dental services. The recommendation saves $1.6 million General Fund by reducing TABOR revenues and thereby reducing the General Fund obligation for a TABOR refund. This change can be implemented through the Long Bill. Colorado previously had annual caps to contain costs of $1,500 and before that $1,000. Dental services for children to age 21 and emergency dental services for adults would still be covered, because these are required benefits.

The adult dental benefit is financed with transfers from the Unclaimed Property Trust Fund (UPTF) to the Adult Dental Fund. The UPTF is exempt from TABOR, but transfers to support the adult dental benefit cross the TABOR boundary.

An annual cap on the dental benefit restrains expenditures but some of the savings come from people spreading costs over multiple years. Deferred dental care reduces overall health and may lead to higher costs for other medical services and emergency dental services.

Federal regulations do not require dental coverage, but any dental coverage offered must meet sufficiency standards. Indiana recently lost a court case with an annual dental cap of $1,000.

The balancing options presented by the JBC staff at the briefing included a $1,500 annual cap that was projected to save $4.4 million General Fund. In the February 18, 2025, letter the Office of State Planning and Budgeting proposed a higher annual cap of $3,000. The higher cap saves less money, but it has less impact on the clients and providers and a lower risk of a legal challenge.

Both an adult dental cap and a reduction in last year's dental rate increases (see the recommendation on R9/R15/BA16 Provider rates) can be implemented with very little overlap. The Department expects reinstating an adult dental cap would primarily impact higher cost remediating procedures. Scaling back the increase in dental rates approved last year would primarily impact lower cost preventive procedures. The two changes mostly impact different billing codes and can be implemented together or independently with no change in the projected savings from either.

Adult Dental Cap	
Total Funds	-$8,481,669
Adult Dental Fund	-1,631,873
HAS Fee	-521,792
Federal Funds	-6,328,004
General Fund obligation for TABOR refund	-$1,631,873

Provider rates

➔ R9/R15/BA16 Provider rates

Request

The Department proposes decreasing rates above 95 percent of Medicare, rates for dental services, and pharmacy rates for drugs with no acquisition cost data. In addition, the Department proposes rebalancing rates for similar home- and community-based services (HCBS) that currently pay differently based on the waiver. The net impact decreases projected expenditures $57.1 million total funds, including $12.9 million General Fund.

The Department withdrew a November 1, 2024 request to reduce rates for pediatric behavioral therapies. The original request would have saved $19.5 million total funds, including $9.7 million General Fund. The Department withdrew the request in BA16.

The request to change pharmacy rates was submitted in R15. This presentation combines the request with other proposed provider rate adjustments

Recommendation

Staff recommended changes to provider rates are summarized in the table below. Each change is described in more detail in the subsections following the table.

R9/R15/BA16 Provider rates				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
Rates above 95% of Medicare	-$21,103,833	-$6,268,202	-$1,016,240	-$13,819,391
Dental services	-34,219,469	-6,248,476	-5,167,140	-22,803,853
Pharmacy pricing	-2,066,234	-470,433	-129,619	-1,466,182
Non-emergent medical transport	-45,749,681	-13,724,904	-9,149,937	-22,874,840
Pediatric behavioral health therapy	-3,181,540	-1,590,770	0	-1,590,770
Community First Choice rebalance	256,524	112,871	0	143,653
Total - FY 2025-26	-$106,064,233	-$28,189,914	-$15,462,936	-$62,411,383
FY 2026-27				
Rates above 95% of Medicare	-$23,022,363	-$6,838,038	-$1,108,625	-$15,075,700
Dental services	-37,330,331	-6,816,519	-5,636,879	-24,876,933
Pharmacy pricing	-2,066,234	-470,433	-129,619	-1,466,182
Non-emergent medical transport	-49,562,155	-14,868,646	-9,912,432	-24,781,077
Pediatric behavioral health therapy	-3,470,770	-1,735,385	0	-1,735,385
Community First Choice rebalance	279,844	123,131	0	156,713
Total - FY 2026-27	-$115,172,009	-$30,605,890	-$16,787,555	-$67,778,564

Rates above 95% of Medicare

Consistent with the request, staff recommends reducing rates above 95 percent of Medicare to 95 percent. The reduction saves $21.1 million total funds, including $6.3 million General Fund. Assuming the state can't afford to match Medicare rates, the recommendation attempts to balance the pain across providers. Medicare sets rates using methods intended to reimburse providers at cost. Not all Medicaid providers start with the same adequacy of rates. The recommendation reduces rates at the high end relative to Medicare with no adjustments to rates at the low end. The impacts are intentionally different by service category.

Over the last few years, the General Assembly has approved several funding adjustments to move Medicaid rates closer to Medicare. Typical adjustments rebalanced the rates to within a band, such as 80 percent to 100 percent of Medicare.

Despite the progress of the General Assembly, not all Medicaid rates are a similar distance from Medicare. Due to budget constraints, the legislature sometimes expanded the band, such as 70 percent to 100 percent, or settled for smaller progress than a full rebalance, as with transportation rates. Also, the Medicare rates are a moving target, so after rebalancing the Medicaid rates can become out of sync with Medicare again.

The recommendation does not set every rate an equal distance from Medicare, but it narrows the band of variance from the Medicare rates. The Medicare rates are not infallible. There are lots of complaints about inadequate Medicare rates that don't accurately capture provider costs. However, Medicare rates are usually the best proxy available for provider costs.

Some of the Medicaid rates were intentionally set above 95 percent of Medicare to encourage "high value" services where increased utilization may decrease costlier emergency services. For example, last year the General Assembly approved the MPRRAC recommendation to increase high value maternity rates to 100 percent of the benchmark. In FY 2023-24, the General Assembly approved the Department's request to exempt high value vaccine and immunization services from reductions to 100 percent of the benchmark. For these services, the request would undo intentional investments by the General Assembly in preventive care.

The recommendation includes reducing anesthesia rates, where the JBC has historically resisted several repeated proposals from the Department to reduce rates.

Technical details about the reduction: The reduction applies only to rates normally reviewed by the Medicaid Provider Rate Review Advisory Committee (MPRRAC) where the selected benchmark is Medicare. It includes rates reviewed in prior years and is not limited to only the rates in this year's MPRRAC review cycle. The reduction is based on the differences between today's Medicare and Medicaid rates and not the Medicare rates at the point in time of the most recent MPRRAC review. If the MPRRAC selected a different benchmark than Medicare, no reduction was proposed. Typically, a different benchmark is only selected when there is no Medicare equivalent. This happens most often with rates for home- and community-based services. The table below summarizes the projected impact on total payments by broad service category, sorted by the largest percentage reductions.

Rate Reduction to 95% of Medicare				
Service Category	Current Projection	With Rate Reduction	Difference	Percent
Physician - Sleep Study	$3,598,376	$2,778,607	-$819,769	-22.8%
Physician - EEG Ambulatory Monitoring	2,521,971	2,067,046	-454,925	-18.0%
Anesthesia	26,869,606	24,639,600	-2,230,006	-8.3%
Behavioral Health Fee For Service	17,500,713	16,174,389	-1,326,324	-7.6%
Maternity	37,612,153	35,543,891	-2,068,262	-5.5%
Durable Medical Equipment	33,234,849	31,641,409	-1,593,440	-4.8%
Laboratory and Pathology Services	74,960,263	71,590,081	-3,370,182	-4.5%
Surgery	110,531,109	107,246,713	-3,284,396	-3.0%
Injections and other Miscellaneous J-Codes	1,366,913	1,334,747	-32,167	-2.4%
Physician	488,618,362	480,841,812	-7,776,549	-1.6%
Dialysis and Nephrology Services	1,243,583	1,238,471	-5,113	-0.4%
Eyeglasses and Vision	25,091,931	25,030,700	-61,231	-0.2%
Total	$823,149,829	$800,127,466	-$23,022,364	-2.8%

Dental services

Consistent with the request, staff recommends scaling back an increase in dental rates approved last year. The total projected General Fund savings is $9.9 million General Fund from the rate reduction and a decrease in the General Fund obligation for a TABOR refund. The rate reduction saves $34.2 million total funds, including $6.2 million General Fund. Also, it reduces transfers from the Unclaimed Property Trust Fund to the Adult Dental Fund by $3.7 million. Transfers from the Unclaimed Property Trust Fund to the Adult Dental Fund count as TABOR revenue. If there is a TABOR refund in FY 2025-26, the reduction to the Adult Dental Fund will increase the General Fund the State can retain. The selected benchmark for dental services was generous compared to the benchmarks for other services and likely not representative of provider costs. With such a large increase last year, there is room for both a meaningful amount of savings from scaling back the increase and preserving a significant rate increase for the dental providers relative to FY 2023-24.

Last year the legislature approved the Department's request to increase 28 dental service rates. Of the 28 rates, 24 were identified by the Colorado Dental Association as critical and recommended in order to have the most immediate impact. The 24 codes represent 44.6 percent of dental utilization. In addition to the 24 codes, the legislature increased another 4 highly used preventive codes that together represent 12 percent of utilization, including 3 codes related to sealants and 1 code for silver diamine fluoride to arrest decay. These preventive services could reduce costlier utilization. Preventive, endodontic, and periodontic codes increased to 100 percent of the benchmark and diagnostic services increased to 70 percent of the benchmark.

The JBC staff raised concerns that the Department's selected benchmark for dental rates included average fees from all payers, including both public and private. The Department's analysis indicated that dental rates paid at 49.8 percent of the benchmark. The selected benchmark was an American Dental Association (ADA) 2020 survey. The Department compares

most rates to Medicare. The Medicare rates attempt to pay at cost and are typically lower than private insurance. When Medicare rates are not available, the Department usually uses other state Medicaid program rates as the benchmark. There are no comparable Medicare rates and the Department decided to use the ADA survey instead of comparing to other states, primarily due to time.

The Department had been scheduled to review dental rates for FY 2025-26, but the MPRRAC requested an out-of-cycle review for FY 2024-25. The Department described the review of dental rates as a partial review to satisfy the MPRRAC's request for an out-of-cycle review. The Department promised a full review of dental rates for FY 2025-26 that would include comparisons to other state Medicaid program rates. However, based on feedback from the Colorado Dental Association, the MPRRAC decided to delay the full review until 2026.

A more recent ADA 2022 survey was available, but the Department's request used the ADA 2020 survey due to a technical error. The legislature approved the Department's request, rather than updating for the 2022 survey, for budget balancing reasons. Using an out-of-date survey dampened some of the impact of selecting a benchmark that included private pay.

In retrospect, the JBC staff views the size of last year's dental services increase as out of proportion to the General Assembly's historic priorities within limited resources for provider rates. Over the last several years, the largest targeted rate increases have gone to Home- and Community-Based Services workers to try to keep pace with increases in the minimum wage. While the Department's analysis indicated a large variance from the benchmark for dental services, the benchmark was more generous than for other services and not a good proxy for provider costs. Last year's increase for dental services was only slightly smaller than the increase for Home- and Community-Based service workers ($78.5 million total funds versus $79 million total funds respectively).

The recommendation would decrease the increase for dental services by 43.6 percent. The recommendation is scalable and the JBC could choose to do more or less. The Governor arrived at the 43.6 percent based on the amount needed to balance the Governor's budget. The amount needed to balance the legislature's budget might be different. The Department notes that dental providers would hold onto a significant remaining increase over the FY 2023-24 rates.

Dental Services					
Item	Total Funds	General Fund	HAS Fee	Adult Dental	Federal Funds
FY 2024-25 Rate increase	$78,485,021	$14,331,366	$3,257,128	$8,594,110	$52,302,417
Reduction percent	43.6%	43.6%	43.6%	43.6%	43.6%
Reduction amount	$34,219,469	$6,248,476	$1,420,108	$3,747,032	$22,803,853

Both a reduction in last year's dental rate increases and an adult dental cap (see *Adult dental annual cap* above) can be implemented with very little overlap. The Department expects reinstating an adult dental cap would primarily impact high cost remediating procedures.

Scaling back the increase in dental rates approved last year would primarily impact lower cost preventive procedures. The two changes mostly impact different billing codes and can be implemented together or independently with no change in the projected savings from either.

Pharmacy pricing

Consistent with the request, staff recommends decreasing the rates paid for drugs with no acquisition cost data. The recommendation saves $2.1 million total funds, including $470,433 General Fund. Federal regulations limit the Department's options to reduce rates for pharmaceuticals. Pharmacy pays at cost while most other Medicaid rates end up a little below cost. When the cost of pharmaceuticals is unknown, the Department uses federally-approved methods to estimate the cost. The Department has some room to modify the estimation procedures.

Most pharmacy rates get indexed to measures of the average acquisition cost. Pharmacies voluntarily participate in quarterly rate surveys that determine average acquisition cost. When there is insufficient data to determine average acquisition cost, maybe because a drug is new and/or low volume, the Department indexes the rates to a measure of wholesale costs but applies a discount. The measure of wholesale costs overstates average acquisition costs but the amount varies by drug. The Department proposes increasing the discount applied to the wholesale costs. The Department anticipates the decreased reimbursement will primarily impact mail order pharmacy providers. The rates for drugs priced this way switch back to using the average acquisition cost if sufficient data becomes available.

Non-emergency medical transportation

Staff recommends reducing the mileage component of rates for non-emergency medical transportation (NEMT) from $6.10 per mile to $3.00 per mile for non-ambulance services. In addition, staff recommends increasing the mileage rate for wheelchair vans from $1.18 per mile to $3.00 per mile to be consistent with the recommendation for other non-ambulance rates. The recommendation saves $45.7 million total funds, including $13.7 million General Fund. The recommendation is based on the following:

- The current rates might attract fraud
- The current rates appear high compared to typical commercial transportation and maximums set by the Public Utilities Commission for large market taxi carriers
- The selected benchmark for the rates is not a comparable service
- The Department believes this size reduction will not impact access to care, wait times, or service safety

In the February 18, 2025, letter the Office of State Planning and Budgeting proposed a smaller reduction to $4.50 per mile as a way to respond to the higher February forecast of Medicaid and CHP+ expenditures. The smaller reduction would save $10.0 million General Fund.

The current rates might be creating an attractive environment for fraud. The fraud problems emerged shortly after the General Assembly approved a significant increase in the mileage reimbursement rate for NEMT in FY 2022-23 from $2.12 per mile to $6.10 per mile. The increase was based on the 2021 MPRRAC review that estimated Medicaid rates were only 37.5

percent of the benchmark. JBC members heard complaints about excessive wait times and unreliable services. The Department requested an increase to 60.8 percent of the benchmark with a long-term goal of 80 percent of the benchmark. The JBC approved an increase to 70 percent of the benchmark. The rate increase occurred in July 2022. The Department saw an increase in providers and utilization. It appeared that the rate increase was achieving the intended impact. However, by August 2023 the Department had evidence suggesting parts of the increases in utilization and providers were attributable to fraud.

Total expenditures for NEMT jumped from $70.5 million in FY 2021-22 to $211.9 million in FY 2022-23 and $303.0 million in FY 2023-24.

The current NEMT rates are high relative to private transportation services. Most NEMT services are paid through a flat pickup rate for each leg of a trip plus mileage, though different methods for determining the reimbursement might apply for different types of trips. The average NEMT urban round trip is 19.5 miles, or slightly longer than the distance from Union Station to Anschutz Medical Center and back. The average rural round trip is 77.5 miles.

The table below compares the maximum rate set by the Public Utilities Commission for large market taxi carriers with what the Department would pay for NEMT for a similar trip. A large market taxi carrier provides indiscriminate passenger transportation for compensation in a taxicab on a call-and-demand basis within and between points in the 10 most populous counties.

Round Trip Union Station to Anschutz			
Item	Max Rate	Units	Total
Large Market Taxi Carrier			
Pickup fee	$3.50	2	$7.00
Per Mile	$2.80	18.8	$52.64
Total			$59.64
Medicaid NEMT			
Pickup fee	$36.40	2	$72.80
Per Mile	$6.41	18.8	$120.51
Total			$193.31
Difference			$133.67
Percent			324.1%

A typical trip to a methadone clinic in the metro area costs Medicaid more than three times what it would cost for the member to take a private taxi. There are differences in business costs between Medicaid providers and taxis, from the complexity of regulations and billing to driver idle time and client no-shows. Some premium for NEMT services might be appropriate. Nevertheless, the size of the difference in payment is notable.

The benchmark selected for the mileage component of the rates might not be comparable. The MPRRAC reviewed NEMT rates again in 2024. The known fraud issues limited the analysis. For example, the Department could not compare total compensation from all components of the provider payments to the benchmark without reliable utilization data. For the mileage component specifically, the Department concluded that the rate is 66.5 percent of the

benchmark. The selected benchmark was Medicare. However, the Department says Medicare mostly pays for ambulance trips (Medicare's coverage of transportation services is very limited compared to Medicaid). The operating costs for an ambulance are very different from a standard vehicle or even a wheelchair van.

The Department believes a reduction in the mileage rate of the magnitude recommended by staff would not negatively impact access to care, wait times, or service safety. Based on the competing private transportation rates, the Department believes it can attract sufficient providers to maintain the current service availability and wait times. Vehicle and driver safety standards will remain the same.

What is the benefit? Medicaid covers non-emergency transportation to medically necessary services from a Medicaid provider for all full beneficiaries. The benefit is federally mandated. The federal match is 50 percent regardless of the eligibility category. The state match comes from the General Fund or the HAS Fee, depending on the eligibility category.

Who provides the services? Medicaid will pay for public transportation when it meets the member's needs. Some taxis with special licensing provide NEMT services. The Department can reimburse family members and friends that provide services. Ride share companies, like Uber and Lyft, do not drug test and certify drivers to the standards specified in statute for the NEMT benefit. Some providers are dedicated NEMT providers.

Who uses the services and for what? The primary users of the benefit include people with disabilities, the elderly, and people with certain conditions, including behavioral health needs and renal disease. Statewide utilization data is skewed by the fraud issues. There is a nine-county metro area that the fraud schemes avoided due to additional scrutiny by a contracted broker that arranges for services. In the nine-county region with brokered services, the top five purposes for trip in December 2024 were:

- 51.35% Methadone clinic
- 10.41% Dialysis
- 8.58% Specialist
- 6.99% Behavioral/mental health
- 4.09% Physical/occupational therapy

How is the program performing? In the brokered region, for December 2024, the average call wait time to schedule services was 15 minutes. The Department is trying to get it down to 5 minutes in the next contract. Members can self-schedule through an internet portal with no wait. The broker asks members to schedule 3 days ahead, but urgent trips with less than 48 hours of advance notice are covered. Ninety-three percent of trips were completed "on-time", but that means the driver was more than 15 minutes late for 7 percent of the trips (for a ride usually scheduled 3 days in advance). The driver didn't show for 0.02 percent of trips (46). The client didn't show for 9.9% of trips (17,822). The broker recorded service complaints on 0.09% (158) of trips. The Department lacks similar performance metrics outside the nine-county broker region.

The broker is paid on a fixed rate contract and the mileage reimbursement rates will have no impact on call wait times. The Department sees big differences in on time trips and driver no

shows by provider and believes performance can be improved by steering services to the better providers. In other words, the Department sees the timeliness and consistency of drivers as primarily a management issue, rather than a function of insufficient rates and a dearth of providers.

Non-emergency medical transportation			
Item	Non-ambulance	Wheelchair van	Total Impact
Miles	15,088,490	1,043,975	
Current rate	$6.41	$1.19	
New rate	$3.00	$3.00	
Rate Change	-$3.41	$1.81	
Total Funds	-$51,451,751	$1,889,595	-$49,562,156
General Fund	-15,435,525	566,879	-14,868,646
HAS Fee	-10,290,350	377,918	-9,912,432
Federal Funds	-25,725,876	944,798	-24,781,078

Pediatric Behavioral Therapy

Staff recommends reducing pediatric behavioral therapy rates to the current average rates for nine of the benchmark comparison states identified by the MPRRAC, excluding Nebraska. The recommendation saves $3.2 million total funds, including $1.6 million General Fund. This is a much smaller reduction than the $19.5 million total funds, including $9.7 million General Fund, that the Department had proposed in November (and then withdrew in January). Since last year's MPRRAC analysis, the comparison states have increased their provider rates. The Department provided additional information supporting that Nebraska's rates remain an outlier. Nebraska has recently taken action to curb utilization and managed care organizations in Nebraska are exploring rate reductions. Colorado's utilization of these services is increasing rapidly.

Comparing Medicaid rates to other states can be a circular process. When one state significantly increases rates, as Colorado did last year, other states take notice. It can contribute to other states increasing rates. The JBC staff does not know if Colorado's rate increase influenced other states.

In December 2024, the Department conducted a time-consuming analysis of available data from all states and found that Nebraska had the highest average rates for pediatric behavioral therapy. Four states did not have comparable publicly available rates due to the structure of their managed care programs. The Department applied adjustments to account for different costs of living. The results were similar to an August 2023 analysis by Indiana that looked at 27 states (26 + Indiana). Nebraska's specific codes ranked highest for three codes, third for one code, and fifth for another code.

Colorado's current rates are right at the 46 state average (99.96 percent) in the Department's analysis. The staff recommendation would decrease Colorado's rates to just below the average (97.88 percent).

In February 2025, Nebraska implemented stricter regulations for these services, noting a 1,200 percent increase in utilization and concerns about federal audits.[2] The new regulations focus on:

- Hours of service
- Provider requirements
- Schools as a place of service
- Parent and caregiver involvement
- Individualized Treatment, Recovery, and Rehabilitation Plan review and update frequency versus Prior authorization frequency
- Recovery
- Supervision requirements
- Crisis
- Scope of practice

A key change is limiting the therapies to 6 hours per day (30 hours per week), except in cases of medical necessity.

In addition, a Nebraska Examiner article reports that Nebraska's managed care organizations are exploring reducing rates for these services by as much as 50 percent. As of the publication of this JBC Staff Figure Setting document, no rate reductions were implemented.

Colorado's expenditures for PBT grew from $94.4 million total funds to $209 million total funds from FY 2020-21 to FY 2023-24, or a compound annual growth rate (CAGR) of 30.3 percent. The utilizers increased from 4,532 to 6,291 (a CAGR of 11.6 percent). The average annual cost per utilizer increased from $20,833 to $33,224 (a CAGR of 16.8 percent). This is all before the rate increase approved in FY 2024-25. These trends raise questions about the sustainability of Colorado's current coverage and rates for PBT.

As a note, the Department did the national comparison on PBT rates in response to the high level of interest from the General Assembly. Based on the time required to do the survey and the checking and adjustments needed to make sure the comparisons are apples to apples, doing national surveys for every rate considered by the MPRRAC is not feasible. The Department plans to continue doing smaller surveys when an alternative benchmark to Medicare is needed.

Community First Choice rebalance

Consistent with the request, staff recommends rebalancing rates for long-term service and supports to implement Community First Choice. The recommendation costs $256,524 total funds, including $112,871 General Fund.

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[2] The new regulations relate to Applied Behavior Analysis (ABA) while Pediatric Behavioral Therapies (PBT) is technically a broader term that can include other services. However, the utilization is so synonymous that HCPF staff use the terms interchangeably.

The General Assembly approved Community First Choice to move selected long-term services and supports from federal waivers that serve defined populations to the State Plan that serves all members. States that implement Community First Choice receive an additional federal match of six percentage points for the services.

Under Community First Choice, the Department must pay the same rates for the same services regardless of the population served. The Department currently pays different rates for different waivers.

The Department selected new rates with the goal of keeping aggregate costs the same. Some rates will increase and some will decrease.

Common policy provider rate adjustment

Staff recommends the targeted rate adjustments described above before a common policy provider rate adjustment. If the legislature needs additional savings from provider rates to balance the budget, a common policy adjustment would be a next logical step to spread the impact.

The JBC staff believes the targeted rate adjustments should be in addition to, rather than in lieu of, any common policy provider rate adjustment adopted by the JBC. The targeted rate decreases above save money by bringing the specific rates more in line with other Medicaid rates. After coming in line with other Medicaid rates, the targeted rates above should share in any common policy adjustment, whether negative or positive.

Using a similar logic, the JBC staff included in the base eligible for a common policy the service management rates (within Medical Services Premiums) and county administration. The Department submitted *R6 Accountable Care Collaborative* and *R7 Eligibility administration* to increase payments for service management and county administration respectively. After the JBC decides whether to approve those funding requests, staff recommends that the adjusted rates share in the impact of any common policy pain or gain.

The table below summarizes the projected eligible base for a common policy provider rate adjustment. The table uses the February 2025 forecast. The base is adjusted to account for the lag between when services are delivered and billed and paid. For a rate adjustment at the beginning of a fiscal year, the Department typically pays an average of 48 weeks at the new rate and the remaining 4 weeks in the next fiscal year. There are a few rates where there is no need for a cash flow adjustment, most notably for county administration.

Common Policy Provider Rate Adjustment				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
Eligible base				
County Administration	113,495,560	18,633,167	26,005,759	68,856,634
Medical Services Premiums	7,076,843,063	2,217,085,718	505,419,249	4,354,338,096
Behavioral Health Fee-for-Service	10,321,359	2,480,011	612,276	7,229,072
Adult Comprehensive Services	857,973,000	427,529,344	1,457,156	428,986,500
Adult Supported Living Services	114,021,163	42,777,677	13,049,819	58,193,667
Children's Extensive Support Services	134,298,161	65,970,439	0	68,327,722
Children's Habitation/Rehabilitation Program	28,718,128	14,357,844	1,220	14,359,064

Common Policy Provider Rate Adjustment				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
Case Management	136,351,717	64,233,422	4,543,302	67,574,993
State Supported Living Services	4,889,902	4,889,902	0	0
State Supported Living Services Case Management	4,765,165	4,765,165	0	0
Family Support Services	10,402,920	10,402,920	0	0
Preventive Dental Hygiene	65,741	65,741	0	0
Total - Eligible base	$8,378,650,319	$2,854,558,183	$525,083,022	$4,999,009,114
Each 1% change	83,786,503	$28,545,582	$5,250,830	$49,990,091

Not all of the Department's providers are eligible for a common policy rate adjustment. A large portion of the Department's providers have rates that are adjusted annually or periodically based on a federal, or occasionally state, statute or regulation. These rates are excluded from the calculation above of the eligible base. For these providers, the Department forecasts the rate adjustments and includes them in the forecast requests (R1-R5).

Detail on the exceptions to a common policy adjustment: The largest exception to the common policy provider rate adjustment is for financing payments, which is mostly the supplemental payments to hospitals and nursing homes that are financed with provider fees. These payments are based on the revenues generated from the provider fees within federal limits, rather than the provider rate common policy. The next major exception to the common policy is for managed care rates. Managed care rates must be adjusted annually pursuant to federal regulation to ensure that they are actuarially sound and reasonably expected to cover provider costs. For nursing facilities there is a formula that sets the General Fund share of the rates at the lesser of actual allowable costs or one percent for FY 2025-26. After FY 2025-26 the nursing rates will be based on appropriations and presumably included in the annual common policy provider rate adjustment. For pharmaceuticals a state formula, approved by the federal government, sets rates at cost. Insurance costs are mostly for when the state pays the Medicare premiums for eligible Medicaid clients and the premium rates for Medicare are set by the federal government. The Medicare Modernization Act is a state reimbursement to the federal government for prescription drug costs for clients who are dually eligible for Medicare and Medicaid and the payment is set by a federal formula that takes into account pharmaceutical inflation. The rates for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are adjusted annually based on a state formula, approved by the federal government, that looks at actual allowable costs. Hospice rates are adjusted annually based on a federal formula.

If the JBC approves a common policy increase, rather than a decrease, some additional Home- and Community-Based Services should be included in the base, rather than excluded. The rates pay for services that help people with disabilities stay in a community setting. The direct service providers make near minimum wage. However, if the JBC approves a common policy decrease, these rates should NOT get included. The Community First Choice option has a maintenance of effort requirement. Colorado would lose the enhanced federal match for these services if it cut the rates.

Rates that should be added for an increase but can't be included for a decrease (due to maintenance of effort requirements)				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
Community First Choice	$1,379,640,851	$659,502,353	$25,441,614	$694,696,884

Administration/other

→ R6 Accountable Care Collaborative

Request

The Department requests a net decrease for Phase III of the Accountable Care Collaborative (ACC). The request saves a net $2.5 million total funds, including $1.3 million General fund. The ACC coordinates care for Medicaid members. The Department requests increased funding for the RAEs and various state-level costs to support the new duties of the RAEs. The Department projects offsetting savings from increased RAE support when members transition out of inpatient and residential settings and from member incentives for behavioral changes linked to better health outcomes.

The Accountable Care Collaborative coordinates care for Medicaid members. Regional Accountable Entities (RAEs):

- develop the provider network
- connect members to services
- conduct outreach for difficult to reach members
- address client and provider complaints
- track outcomes
- promote preventive care
- design interventions and population strategies for high utilizers

Recommendation

The staff recommendation is summarized in the table below. Each component of the staff recommendation is discussed in the subsections following the table.

R6 Accountable Care Collaborative Phase III				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
Increase payments to RAEs for new duties	$29,654,734	$9,548,825	$1,186,189	$18,919,720
Transitions of Care savings				
Adults	0	0	0	0
Children	-471,237	-235,619	0	-235,618
Expand western slope managed care to include children	0	0	0	0
Enrollment mailer	2,100,000	649,635	400,365	1,050,000
Centralize credentialing	650,000	40,950	33,800	575,250

R6 Accountable Care Collaborative Phase III				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
Member incentives	431,613	203,937	0	227,676
Member incentives savings	0	0	0	0
Give RAEs access to Care and Case Management System	300,000	18,900	15,600	265,500
Increase sampling for CAHPS survey	0	0	0	0
Total - FY 2025-26	$32,665,110	$10,226,628	$1,635,954	$20,802,528
FY 2026-27				
Increase payments to RAEs for new duties	$32,717,585	$10,535,063	$1,308,703	$20,873,819
Transitions of Care savings				
Adults	0	0	0	0
Children	-471,237	-235,619	0	-235,618
Expand western slope managed care to include children	3,476,470	1,738,235	0	1,738,235
Enrollment mailer	0	0	0	0
Centralize credentialing	0	0	0	0
Member incentives	431,613	203,937	0	227,676
Member incentives savings	0	0	0	0
Give RAEs access to Care and Case Management System	250,000	15,750	13,000	221,250
Increase sampling for CAHPS survey	0	0	0	0
Total - FY 2026-27	$36,404,431	$12,257,366	$1,321,703	$22,825,362

Increase payments to RAEs for new duties

Staff recommends the requested funding for increasing contractual responsibilities of the RAEs for care coordination. The new or increased requirements in Phase III that are driving costs relate to:

- Transitions of care
- Care coordination and condition management
- Practice transformation supports and monitoring
- Licensing
- Provider communication and complaint resolution
- Social health information exchange reporting

If the RAEs meet their performance targets, this would be a 13.8 percent increase on the projected $214.3 million total funds expenditures projected in FY 2025-26 for the ACC. The rates for the care coordination activities of the RAEs typically get adjusted when the JBC approves a common policy rate adjustment. This is not a catch-up cost-of-living adjustment from the last procurement. This is a proposed increase tied to the new or increased duties.

Increased responsibilities for transitions of care drive most of the additional cost and the projected savings. Among other things, the new contracts will require the following related to transitions of care:

- Require RAEs to provide transitions of care for all members and not just the highest cost or most complex members

- Provide financial rewards when members receive outpatient behavioral health care within 7 days and outpatient physical health care within 30 days of discharge
- Require RAEs to have a documented plan for identifying and intervening with members who overutilize emergency room services

Providers, especially behavioral health providers, tell the JBC staff that they lack timely notifications when clients enter or leave hospital settings. This makes it hard to provide transitions of care. According to the Department, many providers operate on electronic health record systems that are not connected to the Health Information Exchange (HIE) and therefore don't receive data feeds. In Phase III, the RAEs will establish value-based payments with safety net providers to incentivize connection to the HIE. Where providers are unable to connect, the RAEs must establish manual workarounds.

The increased payments for the RAEs are potentially scalable. To model scenarios and the impacts relative to the request, the Department would need to know what kind of money the JBC wants to spend. A decrease in funding would likely impact the Department's projection of the offsetting savings, but staff is not recommending relying on the savings to balance.

Transitions of Care savings

Adults: Staff does not recommend the projected savings associated with the transitions of care. Colorado has already realized some of the savings seen in North Carolina. The Department's assumptions about the timing of the savings don't align with North Carolina's experience. The transitions of care will improve the quality of services to a vulnerable population and it may produce savings. However, the savings themselves, the magnitude of the savings, and the timing of the savings are all too uncertain to assume in balancing the budget.

Savings Assumed in Request				
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Federal Funds
Transitions of Care savings - adults	-$34,009,340	-$10,951,007	-$1,360,374	-$21,697,959

The expanded responsibilities of the RAEs in Phase III will include increased care management during client transitions from an inpatient or residential facility to the community. The additional cost for the care management is included in the "Increase payments to RAEs for new duties" above.

The Department projects a 10 percent decrease in adult hospital readmissions as a result of the Transitions of Care. The savings estimate is based on a study[3] of similar interventions in North Carolina that reduced readmissions by 20 percent.

The study of North Carolina looked at the impact of an entire Transitions of Care program and not at incremental increases to an existing program. Current responsibilities of the RAEs

[3] Transitional Care Cut Hospital Readmissions for North Carolina Medicaid Patients with Complex Chronic Conditions

overlap with the North Carolina program, including data management, care coordination, and local support networks.

Colorado already does most of the things in the North Carolina program to varying degrees, through the ACC and other initiatives. Some of the savings reflected in the North Carolina study are already in Colorado's per capita expenditure trends. The main staples of the North Carolina program include:

- face-to-face patient encounters, with embedded care managers in large-volume hospitals to interact with the hospital team and the patient, and giving specific attention to patients with a high risk for a failed transition;
- timely outpatient follow-up with the primary care provider after discharge, where the care manager also serves as a source of information for the primary care provider;
- medication management to monitor any discrepancies between medication lists, and a source of communication between all involved parties to address any discrepancies;
- patient education and a source of expertise for them to communicate with;
- data and information exchanges;
- and partnerships between agencies and local resources.

The current contracts include a requirement for RAEs to “provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems." The Department argues that while the RAEs have the infrastructure to support members through most of the transitions, the transitions from hospital settings have not been a focus historically.

In addition, we already make performance-based payments through the Hospital Transformation Program to hospitals that decrease readmissions. Hospitals can pursue multiple paths to reduce readmissions, so they might focus on things other than transitions of care. However, if transitions of care services are as cost-effective as the Department asserts, the hospitals already receive financial incentives to provide the service.

The savings in North Carolina took time to accumulate. The changes in readmissions were not statistically significant until a year after patients entered the North Carolina program. The Department projects full savings in the first year. Staff recommends assuming no savings, but if the JBC wants to assume savings, then the Department's projection for FY 2025-26 should be reduced by at least half to account for the slow accumulation of savings over time.

Children: Staff recommends assuming the savings identified in the request associated with transitions of care for children. The Department used a different method and study in projecting the savings for children, based on expanding transitions of care in underserved rural areas.

The Department projects a 25 percent reduction in readmissions for children in RAEs 1, 2, and 4 serving the Western Slope and Eastern Plains. The savings estimate for children is based on an

observational study of Children's Hospitals in Minnesota that found a 31 percent reduction to readmissions within 30 days from similar interventions.[4]

The Department's savings projection considers only readmissions in rural areas with the least amount of existing care coordination. As a result, there is less overlap with existing services than in the projection for transitions of care savings for adults. Most likely, this is new savings that are not captured in the Department's current per capita expenditure trends.

The Minnesota study found savings on readmissions within 30 days. Unlike in the study of adults, these savings appeared quickly, rather than needing time to accumulate.

Finally, the projected savings are children are smaller than for adults, so the consequences of a forecast error are less damaging.

Expand Western Slope managed care to include children

Staff recommends the requested funding to add children to the Western Slope managed care organization that currently covers adults. This will reduce confusion when children and their parents are enrolled in different programs. Managed care rates are higher than fee-for-service rates and include costs for greater care coordination responsibilities, driving an increase in costs.

The change will not occur until FY 2026-27, but to make the necessary changes within existing resources, including eligibility and billing system changes and rate changes, the Department needs policy approval well in advance. Otherwise, the Department would need additional resources to rush these changes.

Enrollment mailer

Staff recommends these requested one-time costs that are necessary to inform members of all the program changes.

Centralize credentialing

Staff recommends the requested one-time system changes to centralize credentialing for behavioral health providers. This would eliminate cumbersome requirements for providers to navigate different credentialing procedures at multiple RAEs.

Member incentives

Staff recommends the requested funding for three programs that provide incentives for pregnant and post-partum members to change behaviors. Medicaid pays for more than 40 percent of births in Colorado. Smoking, substance use, and lack of prenatal care contribute significantly to complications and mortality rates.

[4] Pediatric Inpatient Readmissions in an Accountable Care Organization

- Baby and Me Tobacco Free (BMTF) is a national program that provides diaper vouchers to participants in a tobacco cessation program who test nicotine free. The estimated average cost per member is $781.
- Substance use treatment adherence provides cash for meeting treatment goals as part of an evidence-based behavioral therapy called contingency management. Estimated incentives per member would be $500.
- Prenatal Early-Entry-To-Care provides $50 vouchers to people who engage in the first trimester with education, high-risk screening, or referrals for case management.

The Department provided Colorado-specific research[5] on the BMTF that found a 28.0 percent lower risk of pre-term birth and a 55.0 percent lower risk of admission to a neonatal intensive care unit (NICU).

The JBC staff assistants looked at research on similar programs and found several with homogeneous results of 25 percent lower risks of pre-term birth and 50 percent lower risks of NICU admissions, but also a few studies of programs with no reported improvements in health outcomes.[6] Overall, the research on similar programs seems to align with the research on the BMTF.

The primary caveat with the available research is that the clients self-select into the programs. The programs might be reaching people already inclined for behavior changes that improve health outcomes.

Member incentives savings

Staff does not recommend the projected savings associated with the incentive programs for members. Some Medicaid members are already getting the services through a grant program, so an undetermined amount of the savings to Medicaid are already realized.

The savings projection is based only on the Baby and Me Tobacco Free (BMTF) program, although the Department expects savings from all three programs. The Department of Public Health and Environment currently supports the BMTF through grants using tobacco funding. Medicaid coverage would ensure all Medicaid members have access to the services. Also, Medicaid coverage would allow the public health funding to stretch further. However, some amount of the projected savings to the Medicaid program already occurs when Medicaid members access the grant program.

The table below summarizes the cost for each incentive and the Department's projection of the savings associated with the Baby and Me Tobacco Free program.

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[5] Impact of an Incentive-based Prenatal Smoking Cessation Program for Low-income Women in Colorado

[6] Effectiveness of a Pregnancy Smoking Intervention: The Tennessee Intervention for Pregnant Smokers Program; The effectiveness of a nurse-managed perinatal smoking cessation program implemented in a rural county; The Effects of Smoking Cessation and a Programme Intervention on Birth and Other Perinatal Outcomes Among Rural Pregnant Smokers; Effects of Incentive-Based Smoking Cessation Program for Pregnant Women on Birth Outcomes

Member Incentives				
Item	Clients	Total Funds	General Fund	Federal Funds
Incentives				
Baby and Me Tobacco Free expenditures	273	$213,213	$100,743	$112,470
Substance use treatment adherence	296	148,200	70,024	78,176
Prenatal Early-Entry-To-Care	1,404	70,200	33,170	37,030
Subtotal - Incentives		$431,613	$203,937	$227,676
Savings - Baby and Me Tobacco Free		-$1,121,500	-$529,910	-$591,590
Net Cost - Member Incentives		-$689,887	-$325,973	-$363,914

On balance, the information provided by the Department does not support the projected level of savings. However, the risk of assuming the savings is low. The projected total savings are relatively small. The overlap of the BMTF incentive payments for Medicaid members with the existing grant program is not 100 percent. The other incentives outside of the BMTF may generate savings.

Give RAEs access to Care and Case Management system

Staff recommends the requested funding for licenses and programming costs to give the RAEs access to the Care and Case Management System. This will improve communication and reduce duplication of effort between the RAEs and Case Management Agencies. The activities get favorable federal match rates and some of the work is attributable to the HAS Fee, so the General Fund share of costs is only 6.3 percent.

Increase sampling for CAHPS survey

Staff does not recommend the requested increase in sampling for the for the federally-required Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The Department estimates the increased sampling would cost $549,902 total funds, including $274,951 General Fund. However, due to current budget constraints, the Department proposed that the increased sampling start in FY 2027-28. The JBC staff recommends that the Department submit a new budget request prior to FY 2027-28. There is no need for a budget action in FY 2025-26 to drive this cost in FY 2027-28. That is needlessly complex and suggests an obligation to future General Assemblies.

The CAHPS survey measures consumer satisfaction on topics from the communication skills of providers to the accessibility of services. Response rates hover in the range of 4-7 percent and are typically not sufficient for statistically sound conclusions. The Department hopes additional sampling will produce more responses to inform decision making.

➔ R8 Claims system reprocurement

Request

The Department requests funding for the increased complexity of using modular procurement strategies for information technology systems. The request costs $1.9 million total funds, including $343,562 General Fund, for 18 new positions (16.6 FTE in the first year). Federal regulations require states to use modular information technology systems. Breaking the

information technology into modules theoretically allows upgrades of components when technology changes, or to address problems, without needing to replace everything. It reduces reliance on individual vendors. However, each module still needs careful design and oversight to ensure proper interaction with the other modules. More vendors mean more contracts for the Department to oversee and more responsibilities to coordinate communication and standards between the vendors. The Department is moving from 3 modules and vendors to 16 modules and at least 9 different vendors.

Recommendation

Staff recommends approval of the request with modifications to (1) allocate the costs to fund sources proportional to the enrollment; (2) apply the JBC's common policies regarding new FTE; (3) skip the leased space costs, due to the number of staff at the Department working from home. The recommendation costs $1,419,969 total funds, including $137,661 General Fund, and 16.6 FTE. A change in federal regulations drives the need for the request. The General Fund will pay for only 9.7 percent of the total cost. The benefits of complying with the federal regulation and improving the resilience and adaptability of the Medicaid information technology systems far outweigh the nominal General Fund savings if the JBC denied the request. The request brings more federal funds to Colorado than it spends from the General Fund.

Adding eighteen positions is a large increase, but managing modular technology represents a significant increase in complexity and coordination. There is nothing obvious in the Department's analysis of the workload that suggests this is too many FTE. A small reduction in the FTE would have minimal impact on the General Fund cost, due to the favorable federal match rate.

R8 Claims system reprocurement					
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Federal Funds	FTE
FY 2025-26					
Business Analyst Team					
Analyst IV	$245,674	$16,197	$8,370	$221,107	2.8
Testing Team					
Analyst IV	324,879	21,420	11,068	292,391	3.7
Project Management					
Project manager I	404,084	26,642	13,767	363,675	4.6
Contract management team					
Contract administrator IV	245,674	40,493	20,925	184,256	2.8
Operations support					
Administrator III	133,105	21,939	11,337	99,829	1.8
Analyst III	66,553	10,970	5,668	49,915	0.9
Total	$1,419,969	$137,661	$71,135	$1,211,173	16.6
FY 2026-27					
Business Analyst Team					
Analyst IV	$241,783	$15,940	$8,238	$217,605	3.0
Testing Team					

R8 Claims system reprocurement					
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Federal Funds	FTE
Analyst IV	322,377	21,255	10,983	290,139	4.0
Project Management					
Project manager I	402,972	26,568	13,729	362,675	5.0
Contract management team					
Contract administrator IV	241,783	39,852	20,594	181,337	3.0
Operations support					
Administrator III	133,072	21,934	11,334	99,804	2.0
Analyst III	66,536	10,967	5,667	49,902	1.0
Total	$1,408,523	$136,516	$70,545	$1,201,462	18.0

Business analyst team: The 3.0 positions will evaluate the current business processes and policies, identify potential improvements and enhancements, identify solutions for new federal and state legislation and Department policy changes, and work with the vendors to ensure successful implementation of the changes. The Department currently has 11.0 FTE performing these functions for 3 modules and the request would increase it to 14.0 FTE for 16 modules. These positions get a 90.0 percent federal match based on the type of administrative work.

Testing team: The 4.0 positions will develop and administer tests to validate that changes meet the needs of end users. They will track and monitor defects identified in testing and retest fixes. The Department currently has 6.0 FTE devoted to testing and expects increased complexity to ensure changes work across all modules. These positions get a 90.0 percent federal match based on the type of administrative work.

Project management: The 5.0 positions will help plan the budget, initiate the projects, prioritize the work components, and plan, monitor, and control the enhancements associated with each of the impacted systems. The Department currently has 11.0 project managers. These positions get a 90.0 percent federal match based on the type of administrative work.

Contract management team: The 3.0 positions will manage procurements, draft contract documents, process invoices, manage vendor performance, administer monthly quality assessments and payments, take corrective actions, and attend vendor status meetings. The Department currently had 5.0 FTE performing these functions. These positions get a 75.0 percent federal match based on the type of administrative work.

Operations support: The 3.0 positions will support providers. They will ensure provider communications are drafted and sent out in a timely manner, provider manuals are updated and posted to necessary websites, and the provider call center is prepared for and trained for provider questions about system changes. The team will triage provider complaint escalations, facilitate resolutions, monitor trends in complaints, and coordinate communications. These positions get a 75.0 percent federal match based on the type of administrative work.

➔ R10 HAS Fee admin & refinance

Request

The Department proposes repurposing unused appropriations from the provider fee on hospitals to:

- replace General Fund for administration to better match what drives the workload
- add FTE to address increasing state and federal requirements
- purchase consulting services to help with hospital payment modeling, quality incentives, and discounted care programs

The proposed changes decrease appropriations by $4.3 million total funds, including a decrease of $2.2 million General Fund, and increase the FTE by 6.4. The provider fee is the Healthcare Affordability and Sustainability (HAS) Fee.

The unused HAS Fee is primarily due to ending the Hospital Outstationing program but includes a lower than expected disability determinations contract. The Hospital Outstationing program funded medical assistance sites within hospitals to facilitate eligibility determinations. However, hospitals decided not to participate due to onerous time surveys required by the federal government to determine proper Medicaid reimbursement. The hospitals still help people enroll in Medicaid and CHP+, because the hospitals want to get paid for the services. For the disability determinations contract, the actual cost to procure services came in lower than the appropriation.

According to the Department, current HAS Fee appropriations for administration are not proportionate to the workload driven by the HAS Fee. General Fund makes up the difference. Expansion populations financed by the HAS Fee represent roughly a third of the Medicaid population. The request tries to apply a more consistent method for allocating administrative expenses to the HAS Fee.

Statutes limit the share of HAS Fee for administration to 3.0 percent of expenditures.[7] The administrative costs include:[8]

- Expenses of the enterprise
- Costs to implement and maintain the HAS Fee
- Changes and updates to the Medicaid Management Information System (MMIS) for supplemental and quality incentive payments to hospitals
- Personnel, operating, and consulting related to supplemental payments, disproportionate share hospital payments, and quality incentive payments to hospitals
- Changes and updates to the Colorado Benefits Management System (CBMS) for expansion populations financed with the HAS Fee

[7] Section 25.5-4-402.4 (4)(a)(III), C.R.S.

[8] Section 25.5-4-402.4 (5)(b)(VI), C.R.S.

- Personnel and operating related to the expansion populations, including county administration
- Expanding opportunities to apply for public medical assistance directly at hospitals or through another entity outside the county departments, which includes the Hospital Outstationing

The appropriations for Hospital Outstationing and the disability determination contract were using $3.4 million of the allowable 3.0 percent for administration. The Department proposes applying $2.2 million of the savings toward addressing the disproportionate workload and decreasing the General Fund subsidy.

The Department proposes applying the remaining $1.2 million savings for seven additional staff (6.4 FTE in the first year) and contract services to address increasing state and federal requirements related to the HAS Fee. Changes driving the increased workload include:

- new federal reporting, annual review, and approval processes for determining the upper payment limit
- in-progress audits of major components of the HAS Fee payment methodology
- revised federal policies in 2023 and 2024 on provider fee programs
- increased stakeholder challenges of payment categories and methodologies

The board that sets the HAS Fee and advises on payments and policies related to the HAS Fee requested an independent review of the model and an exploration of alternative fee and payment methods. The board wants to look at the effectiveness of the HAS Fee in meeting the statutory purposes.

If the General Assembly does not approve the request, then the hospitals would pay less in fees. There would be no increase in supplemental payments to the hospitals, because the supplemental payments are already at the federal maximums. The fees are exempt from TABOR as part of an enterprise, so there would be no impact on the General Fund obligation for a TABOR refund. The General Fund would continue to subsidize a disproportionate share of the administrative expenses.

Recommendation

The staff recommendation is summarized in the table below. Each component of the staff recommendation is discussed in the subsections following the table.

R10 HAS Fee Admin & Refinance					
Item	Total Funds	General Fund	HAS Fee	Federal Funds	FTE
Unused HAS Fee					
Hospital outstationing program	-$6,148,800	$0	-$3,074,400	-$3,074,400	0.0
Disability determinations contract	-701,798	0	-350,899	-350,899	0.0
Subtotal - Unused HAS Fee	-$6,850,598	$0	-$3,425,299	-$3,425,299	0.0
True up HAS Fee for administration					
Worker's Compensation	$0	$6,525	-$6,525	$0	0.0
Operating Expenses	0	25,122	-25,122	0	0.0
Legal Services	0	-56,006	56,006	0	0.0

R10 HAS Fee Admin & Refinance					
Item	Total Funds	General Fund	HAS Fee	Federal Funds	FTE
Administrative Law Judge Services	0	-21,300	21,300	0	0.0
Risk Management and Property Funds	0	6,389	-6,389	0	0.0
Leased Space	0	-35,967	35,967	0	0.0
Payments to OIT	0	276,454	-276,454	0	0.0
CORE Operations	0	4,842	-4,842	0	0.0
Medicaid Management Information System	0	-1,264,646	1,264,646	0	0.0
CBMS Operating	0	-119,680	119,680	0	0.0
CBMS Staff Development Center	0	3,896	-3,896	0	0.0
Office For eHealth Innovations	0	-671,985	671,985	0	0.0
Customer Outreach	0	-253,049	253,049	0	0.0
Eligibility Overflow Processing Center	0	28,618	-28,618	0	0.0
Returned Mail Processing	0	-199,928	199,928	0	0.0
Income Verification Programs	0	127,958	-127,958	0	0.0
Subtotal - True up HAS Fee	$0	-$2,142,757	$2,142,757	$0	0.0
CHASE Operations					
Increased federal/stakeholder scrutiny					
Auditor	$79,205	$0	$39,603	$39,602	0.9
Provider fee modeling					
Provider fee analysts	180,930	0	90,465	90,465	1.8
Consulting	450,000	0	225,000	225,000	0.0
Discounted care programs	1,058,652	0	529,326	529,326	0.0
Subtotal - CHASE Operations	$1,768,787	$0	$884,394	$884,393	2.7
Total - FY 2025-26	-$5,081,811	-$2,142,757	-$398,148	-$2,540,906	2.7

The next table summarizes the fiscal impact of the recommendation in FY 2026-27.

FY 2026-27 R10 HAS Fee Admin & Refinance					
Item	Total Funds	General Fund	HAS Fee	Federal Funds	FTE
Unused HAS Fee					
True up HAS Fee for administration	-$6,850,598	$0	-$3,425,299	-$3,425,299	0.0
CHASE Operations FY 2026-27	$0	-$2,142,757	$2,142,757	$0	0.0
Increased federal/stakeholder scrutiny					
Auditor	$80,594	$0	$40,297	$40,297	1.0
Provider fee modeling					
Provider fee analysts	186,211	0	93,106	93,105	2.0
Consulting	350,000	0	175,000	175,000	0.0
Discounted care programs	161,544	0	80,772	80,772	0.0
Subtotal - CHASE Operations	$778,349	$0	$389,175	$389,174	3.0
Total - FY 2026-27	-$6,072,249	-$2,142,757	-$893,367	-$3,036,125	3.0

True up HAS Fee for administration

The JBC staff reexamined the fund sources for every line item in the Executive Director's Office and recommends several small adjustments, both positive and negative. The JBC staff used different methodologies to estimate the HAS Fee share than the Department, so the recommended changes by line item are different from the request. The net result is an increase of $1.8 million from the HAS Fee and an equal decrease in General Fund. For this component,

the Department's request proposed an increase of $2.2 million from the HAS Fee and an equal decrease in General Fund.

This is a rough estimation that will never more than approximate the activities attributable to the HAS fee. For example, the share of enrollment attributable to the HAS Fee is a moving target. Also, there are nuances not captured in the JBC staff method where certain activities in a line item should be attributed to different fund sources.

However, the JBC staff is confident that the methodology is defensible. The next several paragraphs provide a detailed description of the allocation method. Legislators who don't want to get bogged down in the details should skip to the discussion of the CHASE Operations.

Calculation details: The JBC staff's methodology assumes that the proportion of HAS Fee to the total in the Personal Services line item is a reasonable amount. The Department received dedicated FTE when the provider fee was created and the expansion populations were approved. These FTE corresponded to the expected incremental increase in personal services time attributable to the provider fee and expansion populations. The fund sources in the Personal Services line item are not proportional to the enrollment. The Department had to run a Medicaid program before the expansion and would need to run a Medicaid program if the expansion populations went away. For each subsequent incremental change in FTE, the costs have been allocated by fund source based on the specific work of the FTE and the populations supported. The allocation methods by FTE might vary slightly based on the point in time or who was doing the analysis. Also, what drives the workload for staff can change over time from what was originally projected in the appropriation. However, the JBC staff assumes the cumulative results of all the appropriations to date are still reasonable and defensible for the Personal Services line item.

The JBC staff looked at the FY 2024-25 appropriation plus all annualizations in FY 2025-26 of previously approved policies and determined that the HAS Fee represents 6.95 percent of the total base for Personal Services before any new policy actions for FY 2025-26. The information needed for the calculation is in the Department's Schedule 4, for anyone who wants to replicate the analysis. The JBC staff then applied this percentage to line items where the costs should be proportional to the FTE, including worker's compensation, operating expenses, risk management and property funds, leased space, and payments to OIT.

The JBC staff did not adjust any of the line items related to compensation, like Health, Life, and Dental or salary survey. These line items get rebased every year and there is already an established method for allocating the costs by fund source that is based on a snapshot of filled positions and the fund sources that support them. It seems like these costs should be proportional to Personal Services, but there can be small differences based on the point in time of the snap shot, the benefit elections of the individual employees, who gets promotions and step pay increases, etc.

The JBC staff used a different methodology for line items with costs that should be proportional to the enrollment. These line items include things like legal services, the Colorado Benefits Management System, and returned mail processing.

The JBC staff looked at actual FY 2023-24 enrollment and determined that 34.07 percent was attributable to eligibility categories where the state share of costs is financed by the HAS Fee. As previously noted, the percentage of enrollment attributable to the HAS Fee is a moving targeted. The FY 2023-24 percentage of enrollment attributable to the HAS Fee was probably slightly inflated due to lingering effects of the continuous eligibility requirement during COVID, but the percentage was not far off historic averages and within the pre-COVID range.

To arrive at the appropriate HAS Fee for each line item, the JBC staff applied the 34.07 percent to the state share of costs. To arrive at the state share of costs, the JBC staff added together the General Fund and cash funds and removed any non-Medicaid activities, such as cash funds from the CHP+ Trust or the General Fund-only portion of funding for the Office for eHealth Innovations.

The JBC staff will share the detailed calculations on request.

CHASE Operations

Increased federal/stakeholder scrutiny: In response to increased federal scrutiny, audits, and challenges from stakeholders of the fee and payment models, staff recommends 1.0 auditor. The auditor would review internal policies, procedures, and practices to ensure compliance with state and federal requirements and adequate controls. It would audit the fee collections, payments, and model development. The Department requested two auditors, but the JBC staff is only recommending one position. The Department's description of increased federal scrutiny and stakeholder challenges supports a need for one additional position but not two.

Provider fee modeling: To increase the Department's service to stakeholders and ability to analyze the many creative ideas they generate to improve the provider fee, staff recommends 2.0 provider fee analysts and consulting services.

The new positions would analyze methodologies for fee assessments, upper payment limit calculations, and payment methodologies to respond to stakeholder queries and provide more transparency showing the Department's calculations. The Department currently has a team of three staff devoted to the HAS Fee and the two nursing provider fees combined.

The consulting services would bring national experience to help develop alternative models for charging fees, calculating limits on revenues and expenditures, and distributing payments. In addition, the consultant would help prepare informational materials for stakeholders and respond to stakeholder questions.

The Department could use the additional analysts and consulting services regardless of state directed payments. If the General Assembly pursues state directed payments, these resources would be needed to incorporate the reimbursements into managed care rates, calculate rate ceilings, revise fees, submit applications for federal approval, and manage reporting and evaluations. The funding would support new applications for federal approval and responding to federal questions.

If the hospitals don't want to pay this particular increase in administrative costs, then the JBC staff suggests they stop challenging the provider fee and payment models and/or stop

complaining about how long the Department takes to complete various analysis on behalf of the hospitals.

Discounted care programs: Staff recommends contract funding to configure eligibility systems for hospital discounted care programs and then a small amount of on-going funds to update and maintain the systems. These changes are needed with the phase out of the Colorado Indigent Care Program.

Not recommended

Accounting: The JBC staff views this requested position as tied to the additional workload associated with state directed payments and not necessary without federal approval of state directed payments. Therefore, the funding should go in a bill to authorize state directed payments.

The position would process state directed payments, all the associated additional accounting entries, and any reconciliation payments. The position would be responsible for increased federal financial reporting and reporting to the Office of the State Controller, including enterprise status and TABOR reporting.

The request argues that the enterprise requires clear distinction from the Department in fiscal operations and dedicated accounting and reporting services. The state does not hold other enterprises to the standard of dedicated accounting staff that only work for the enterprise.

Auditor: The Department requested two auditors, but the JBC staff is only recommending one position. The Department's description of increased federal scrutiny and stakeholder challenges supports a need for one additional position but not two.

Hospital Transformation Program: The Department requested one position and three years of consulting services to support the Hospital Transformation Program (HTP), but the program has already made it into the fourth of five years without these resources. The HTP distributes some of the hospital supplemental payments based on the achievement of performance and policy goals. The Department is interested in another cycle of the HTP and these resources could help development the performance and policy goals. However, the Department has not described a vision for another round of the HTP. It is not clear to the JBC staff if the General Assembly would want another round of the HTP.

If funded, the position would develop scripts and processes for claims extraction and data analysis to calculate quality metrics by hospital for the HTP. The Department notes that the HTP requires 400 standard data reports and analysis on top of regular hospital payment operations. The position would communicate with program vendors, policy and rates staff, and stakeholders to explain the measured outcomes and identify variances. The position would work with the decision support systems team to design and test changes to the data warehouse.

The consulting services would help develop alternative methods for encouraging continuous improvement of hospital services. The Department's current five-year Hospital Transformation Program is winding down and phase III of the Accountable Care Collaborative (ACC) is ramping up. The Department wants to look at the best ways to make quality incentive payments for

hospitals and integrate those with the ACC. The consultant would help with any related applications for federal approval.

Procurement and contracts specialist: The JBC staff is not convinced the enterprise needs a dedicated procurement specialist. That is not a standard applied for other enterprises. Nor does the JBC staff see how state directed payments would drive enough increased procurement work to justify a new FTE.

The Department argues that the enterprise requires clear distinction in procurement documents from the Department. The Department proposes a dedicated procurement and contracts specialist to perform these functions. Also, the Department says the position would deal with procurements related to the state directed payments.

→ R13 Contract true up

Request

The Department requests funding to update appropriations for contract services. The request costs 1.0 million total funds, including $433,098 General Fund. The request addresses the following issues:

- House Bill 22-1289 provided one-time funding for actuarial analysis to develop rates for the new health benefits for children and pregnant women lacking access due to immigration status, but the Department needs ongoing funding to maintain and update the rates annually.
- The market rates for auditing cost reports used for rate setting and performance tracking for managed care providers have increased.
- Low funding for screenings to ensure nursing residents receive appropriate care is driving performance issues and threatening compliance with federal standards.
- Every four years the Department needs funding for statutorily required nursing facility appraisals that get used in rate setting and the next one is due in FY 2025-26.

Recommendation

Staff recommends approval with the modifications described in the bullets below. These changes save a total of $77,036 General Fund relative to the request.

- Staff removed the costs for actuarial analysis for the new health benefits for children lacking access due to their immigration status, consistent with the staff recommendation to end the benefit, but kept the costs related to pregnant women.
- The staff recommendation corrects a slight technical error in the request that proposed putting the increase for the nursing resident screenings in the General Professional Services and Special Projects line item when it should go in the Contracts for Special Eligibility Determinations line item with the rest of the contract funds.
- Staff allocated 37.04 percent of the state share of costs for auditing the cost reports to the HAS Fee, consistent with the enrollment and the recommendation on R10.

The table below summarizes the staff recommendation. The costs for the nursing facility appraisals are one-time and go away in FY 2026-27 for another four years.

R13 Contract increases				
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Federal Funds
HB 22-1289 Actuarial Analysis	$18,580	$9,290	$0	$9,290
Market rates for auditing cost reports	232,890	76,772	39,673	116,445
Nursing assessments	400,000	100,000	0	300,000
Nursing facility appraisals	340,000	170,000	0	170,000
Total	$991,470	$356,062	$39,673	$595,735

The recommendation is based on the following:

- The lack of funding in H.B. 22-1289 for on-going actuarial analysis for rate setting was an oversight in the Fiscal Note that should be corrected. The Department will incur this cost attributable to the bill.
- The Department needs audits of cost reports to comply with state statutes and federal regulations and has no control over the market rates for the service.
- The current vendor for the nursing preadmission screenings and resident reviews is not completing the evaluations in the federally required 7-9 days and lacks capacity to monitor needs for specialized services, such as behavioral health. The increase will allow for higher contract standards.
- Statutes require the Department to conduct the nursing facility appraisals every four years.

The Department absorbed the cost for the nursing facility appraisals in FY 2021-22, but says it cannot absorb the cost in FY 2025-26 and provided no additional explanation. This is a legitimate cost driven by a statutory requirement, but it is a one-year cost and the JBC could consider telling the Department to absorb it. Also, with changes in the way nursing home rates are set, the JBC could consider legislation to eliminate the statutory requirement for the appraisals every four years. The JBC staff expects the nursing facility appraisals will still be useful in benchmarking nursing home rates, but if the JBC wants to avoid the cost for the appraisals every four years, then a statutory change is an option.

➔ R14 Convert contracts to FTE

Request

The Department proposes reducing contract services and transferring the duties to state FTE. After accounting for impacts on other departments, the proposal saves $85,936 total funds, including $100,352 General Fund, statewide and adds 8.3 FTE. The specific contracts involve: 1) county expenditure reviews to ensure only allowable costs are charged to Medicaid; and 2) user acceptance testing and security analysis for eligibility systems. The Department expects the changes to improve performance in addition to saving money.

For the county expenditure reviews, the Department has had trouble identifying a contractor with the appropriate expertise. The Department received funding in FY 2024-25, through *R8 Eligibility process compliance*, for additional post-expenditure reviews. The funding was

intended to increase the post-expenditure reviews from 2.0 percent to 5.0 percent of county expenditures per year. The Department had multiple failed procurements to identify vendors with relevant experience in local government, human services, and state financial rules. The Department had to default to using an existing contractor without the desired expertise.

In addition, the S.B. 22-235 review of county administration services identified that the Department's post-expenditure reviews are out of alignment with the Department of Human Services, creating extra work for the counties to comply with two different procedures.

To address these problems, the Department proposes converting the funding for contract services to two state positions (1.8 FTE in the first year) and aligning procedures with the Department of Human Services, which also uses state employees for the reviews.

For the technical support and user acceptance testing, the Department anticipates that using state FTE rather than contract services will purchase more hours of service, improve internal knowledge, and avoid disruptions when contracts get reprocured. There are contract funds for technical support and user acceptance testing spread across the Departments of Health Care Policy and Financing, Human Services, Early Childhood, and Public Health and Environment. The Department wants to convert the contract funding to 7.0 state positions (6.5 FTE in the first year). This would include 5.0 user acceptance testers, a scrum master analyst, and a business analyst.

Recommendation

Staff recommends the request with modification to apply the JBC's common policies regarding new FTE, removing the leased space costs, and correcting a technical error in the request. Correcting the technical error slightly changes the fiscal impacts on the other departments. The recommendation is based on the following:

- The changes result in a small savings statewide.
- The changes will improve the Department's expertise and reduce the Department's reliance on contractors for core operations.
- For the county expenditure reviews, using state FTE will allow the Department to align procedures with the Department of Human Services, reducing the workload for counties.
- For the county expenditure reviews, the Department was unable to identify a qualified contractor.

The table below summarizes the staff recommendation by line item.

R14 Convert contracts to FTE							
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Cash Funds-CHP+ Trust	Reapprop. Funds	Federal Funds	FTE
FY 2025-26							
Health Care Policy and Financing							
Personal Services	$539,301	$84,654	$47,155	$986	$163,628	$242,878	8.3
Operating expenses	68,202	10,099	5,545	138	21,293	31,127	0.0
General Professional Services	-249,804	-77,439	-47,463	0	0	-124,902	0.0
Colorado Benefits Management System	-866,764	-84,313	-41,224	-2,155	-371,148	-367,924	0.0
Subtotal - HCPF	-$509,065	-$66,999	-$35,987	-$1,031	-$186,227	-$218,821	8.3

R14 Convert contracts to FTE							
Item	Total Funds	General Fund	Cash Funds-HAS Fee	Cash Funds-CHP+ Trust	Reapprop. Funds	Federal Funds	FTE
Human Services	-$172,388	-$81,501	$0	$0	$0	-$90,887	0.0
Early Childhood	-$10,601	-$6,590	$0	$0	$0	-$4,011	0.0
Public Health & Environment	-$3,238	$0	$0	$0	$0	-$3,238	0.0
Total	-$695,292	-$155,090	-$35,987	-$1,031	-$186,227	-$316,957	8.3
FY 2026-27							
Health Care Policy and Financing							
Personal Services	$683,862	$101,649	$55,977	$1,319	$218,784	$306,133	9.0
Operating expenses	6,615	973	535	14	2,074	3,019	0.0
General Professional Services	-249,804	-77,439	-47,463	0	0	-124,902	0.0
Colorado Benefits Management System	-866,764	-84,313	-41,224	-2,155	-371,148	-367,924	0.0
Subtotal - HCPF	-$426,091	-$59,130	-$32,175	-$822	-$150,290	-$183,674	9.0
Human Services	-$80,372	-$37,806	$0	$0	$0	-$42,566	0.0
Early Childhood	-$5,253	-$3,265	$0	$0	$0	-$1,988	0.0
Public Health & Environment	-$1,605	$0	$0	$0	$0	-$1,605	0.0
Total	-$513,321	-$100,201	-$32,175	-$822	-$150,290	-$229,833	9.0

➔ BA7 HRSN & reentry services [legislation]

Request

The Department requests legislation to implement a newly approved federal waiver that includes allowing Medicaid to pay for housing and related social needs (HRSN) and health related reentry services for people leaving correctional facilities. The request would increase expenditures across multiple departments by $30.4 million total funds, including a decrease of $810,511 General Fund, and an increase of 17.5 FTE. All components of the waiver were previously approved in several pieces or prior legislation. However, to implement the HRSN & reentry services the Department needs a new cash fund, authority to make transfers to the cash fund, and authority to rebalance appropriations between departments based on Medicaid eligible services.

Medicaid payments for HRSN were authorized in H.B. 24-1322. Housing programs in the Department of Local Affairs and for foster children in the Department of Human Services currently serve some Medicaid clients. Those services to Medicaid clients will become eligible for matching federal funds. Specifically, Medicaid will pay for six months of housing vouchers and tenancy support services like lease management, tenancy rights, and utility management.

Medicaid payments for reentry services were authorized in H.B. 24-1045 and S.B. 22-196. The Department of Corrections and Division of Youth Services currently provide reentry services that will become eligible for matching federal funds. Specifically, Medicaid will cover services in a 90-day pre-release period for targeted case management, physical and behavioral health clinical screenings and consultation, and Medication assisted treatment, including medications and accompanying counseling.

The existing HRSN and reentry services are financed with General Fund and there will be General Fund savings when matching federal funds become available. However, the waiver requires that the state reinvest the savings to expand and enhance the same HRSN and reentry services.

The Department proposes a cash fund to capture the savings and account for them to the federal government. The cash fund would be subject to appropriation by the General Assembly for the related administrative costs and service expansions and enhancements. The Department will submit requests in future years for the expansions and enhancements.

Future phases for HRSN will include move-in goods and then nutrition assistance. A future phase for reentry services will include county jails.

The portions of existing HRSN & reentry services that are eligible for matching federal funds will vary annually based on the eligible populations and utilization of services. The departments providing HRSN and reentry services need the same total funds to maintain current levels of service, but the source of funds will change. The Department can forecast the Medicaid-eligible services, but it will never know the exact amount until it happens.

To address uncertainty about the exact expenditures for eligible services, the Department requests budget flexibility to true up differences between the appropriation and the actual eligible expenditures.

The Department's proposal pays the state share of all service costs in HCPF from the newly created cash fund. Then, it includes reappropriated funds in all the departments receiving money from HCPF, in addition to the existing appropriations for those departments, creating lots of double counts of the same money. HCPF proposes a statutory process where the departments receiving money from HCPF would transfer any General Fund savings due to the Medicaid funding into the cash fund, which is paying the state share of the costs. The excess collected in the fund would sit in the fund until the legislature approves appropriations for expanding and enhancing HRSN and reentry services.

Finally, the request includes a technical correction to the annualization of H.B. 24-1045. The Fiscal Note for that bill included projected expenditures in HCPF in FY 2205-26 for reentry services. The Department has a new projection of those costs and now proposes that the state share of the costs will come from the newly created cash fund. Therefore, the annualization of H.B. 24-1045 is no longer needed. HCPF included the annualization in the base budget request and requests removing the annualization in this budget amendment.

Recommendation

Staff recommends a bill to implement HRSN & reentry services. However, the JBC staff dislikes the Department's proposal to double count funds in the departments operating the HRSN and reentry services, because it artificially inflates the costs. For example, the Department's proposal would make it look like the Department of Local Affairs is spending much more on housing services that it actual spends.

Instead, the JBC staff proposes moving General Fund appropriations from the departments operating the HRSN and transition services to HCPF and replacing those General Fund appropriations reappropriated funds transferred from HCPF. The money would still be counted twice (once in HCPF and again in the receiving department), but at least the total funds in the departments operating the HRSN & reentry services would reflect the intended budget.

The JBC staff is still trying to figure out the best way to provide reasonable budget flexibility for the departments to true up appropriations with actual eligible expenditures while preserving the most control for the General Assembly. The JBC staff needs more time to work with the Office of Legislative Legal Services on the details. The final solution may impact the structure of the appropriations, so the recommended amounts by department and line item are pending.

Staff recommends including the appropriations associated with implementing the HRSN and reentry services in the bill. The Long Bill can't make appropriations to or from a cash fund that does not yet exist.

Also, the JBC staff does not want to presume what LCS will say about the necessary administrative costs by department in the Fiscal Note. Instead, the JBC staff proposes coordinating with LCS on the fiscal impact once a bill draft has been prepared.

The administrative costs will be paid for from the General Fund savings, so there will be no impact on General Fund balancing associated with the administrative costs. However, anything spent on administration will diminish the amount of savings that can be reinvested in service expansions and enhancements in future years.

Finally, the JBC staff recommends the requested technical correction to the annualization of H.B. 24-1045. This can be done in the Long Bill. This is the sole source of the General Fund impact associated with this request.

→ BA8 Technical adjustments

Request

The Department requests the second year impact of a supplemental approved by the General Assembly. The supplemental corrected three technical errors in the FY 2024-25 appropriation and those corrections carry forward to FY 2025-26. There is no net change to the FY 2025-26 budget, but there is some movement of money between line items. One of the technical error corrections increased the funding for salary survey in FY 2024-25. In FY 2025-26, the salary survey money is allocated to the Personal Services line item.

Recommendation

Staff recommends approval of the request, consistent with the General Assembly's action on the supplemental.

Below is an excerpt from the JBC staff supplemental recommendations, if the JBC wants a reminder on the nature of the technical corrections:

S8 Technical adjustments					
	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Salary Survey double reduction	$834,248	$358,393	$49,721	$3,921	$422,213
Payments to OIT mismatch	2,032,901	265,906	142,820	412,271	1,211,904
Human Services indirect cost assessment	0	-3,182,567	0	0	3,182,567
Total	$2,867,149	-$2,558,268	$192,541	$416,192	$4,816,684

Salary Survey double reduction: The JBC staff erroneously reduced the Salary Survey line item twice to implement a JBC policy. The JBC moved some of the Salary Survey to a new Step Pay line item to improve transparency. The JBC staff initially moved the correct amount to the Step Pay line item, but then reduced the Salary Survey line item a second time by the same amount (with no corresponding increase in the Step Pay line item). Other unrelated changes in the same line item masked the error and neither the JBC staff nor the Department discovered the problem until after the Long Bill was signed. To correct the error and implement the JBC's original intent, the salary survey appropriation needs to be increased by $834,248 total funds, including $358,393 General Fund. This would treat the Department consistent with other departments and correctly implement the JBC's compensation common policies.

Potentially, the Department could absorb the shortfall by holding positions vacant. The Department's FY 2024-25 appropriations include $78.0 million total funds, including $29.0 million General Fund, for personal services line items. The request is slightly more than 1 percent of the base personal services. However, JBC staff recommends making personal services reductions based on policy rather than technical errors. If the JBC wants to reduce personal services, it should adjust the common policy or target a specific program in the Department. The Department used all of the General Fund appropriated for personal services in FY 2023-24. Forcing the Department to hold positions vacant would impede carrying out programs approved by the General Assembly.

Payments to OIT mismatch: The appropriations for the Department to pay the Office of Information Technology (OIT) do not match the amounts approved by the JBC. In FY 2023-24, OIT began calculating the Department's share of expenses in two parts. One part relates to the Department's share of OIT services and the second part represents the share of expenses for the Colorado Benefits Management System (CBMS). The Department serves as the fiscal agent for CBMS. In FY 2023-24, a miscommunication caused the department to request funding for the Department's share of three new OIT initiatives but not the CBMS share. Unrelated delays in CBMS contracts allowed the Department to cover the bill from OIT in FY 2023-24. CBMS program staff did not alert the Department budget staff that there was a problem. That problem then carried forward to FY 2024-25.

Without the requested funding, the Department will not have money to pay OIT. The CBMS share of the OIT initiatives is significant, ranging from 4.0 percent to 21.1 percent of the appropriations for the relevant OIT line items. The three OIT

initiatives, approved by the General Assembly, relate to expanded use of the MyColorado mobile app, increasing needs of the IT asset management program that tracks and manages IT assets, and improvements to data management that include creating a state data catalog, reducing security risks, and creating efficiencies.

Human Services indirect cost assessment: Based on historic and year-to-date expenditures, the fund sources to pay indirect cost assessments for the Department of Human Services need truing up. The adjustment decreases General Fund by $3.2 million and increases federal funds by the same amount. Without the adjustment, the Department projects it will revert the General Fund at the end of the fiscal year.

➔ BA11 ARPA HCBS adjustments

Request

The Department requests the second year impact of a supplemental approved by the General Assembly. The supplemental used unspent money from the American Rescue Plan Act (ARPA) Home- and Community-Based Services (HCBS) for provider rate bonuses so that the Department could spend the money by the federal deadline of March 31, 2025. In addition, the supplemental made small true ups to appropriations to reflect actual expenditures by project. In FY 2026-27, all of the one-time money comes out of the appropriations.

Recommendation

Staff recommends approval of the request, consistent with the General Assembly's action on the supplemental.

➔ BA12 Med transport reviews

Request

The Department requests the second year impact of a supplemental approved by the General Assembly. The supplemental provided more money to review non-emergent medical transportation (NEMT) claims. In FY 2025-26 the cost to address the claims review backlog decreases, because the Department will be caught up and only reviewing new claims. However, there are some offsetting additional costs for policy consultation and transition support to the new broker for NEMT services.

Recommendation

Staff recommends approval of the request, consistent with the General Assembly's action on the supplemental.

Below is an excerpt from the JBC staff supplemental recommendations, if the JBC wants a reminder about what was approved in the supplemental:

S12 Med transport reviews				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2024-25				
Claims review backlog	$1,961,155	$588,346	$392,231	$980,578
Policy consultation	275,000	82,500	55,000	137,500
Transition support for new broker	0	0	0	0
Total - FY 2024-25	$2,236,155	$670,846	$447,231	$1,118,078
FY 2025-26				
Claims review backlog	$644,650	$193,395	$128,930	$322,325
Policy consultation	660,000	198,000	132,000	330,000
Transition support for new broker	355,000	106,500	71,000	177,500
Total - FY 2025-26	$1,659,650	$497,895	$331,930	$829,825
2-year total	$3,895,805	$1,168,741	$779,161	$1,947,903

Claims review backlog: The request would reduce a backlog of claims waiting review. The Department started prepayment reviews for NEMT in FY 2023-24 due to concerns about fraud. The actual claims needing review are more than assumed in the appropriation. Also, the Department wants to continue reviewing claims through FY 2025-26. The current funding runs out in FY 2024-25. The request assumes 19,969 claims reviews in FY 2024-25, including the backlog, and 6,564 claims reviews in FY 2025-26. The funding would allow prepayment reviews within 30 days of new claims.

Without the funding, providers will need to wait longer to get paid and/or the Department will need to reduce the claims reviewed, increasing the potential for fraud.

The need for prepayment reviews will phase out when the Department procures a statewide broker for NEMT. The prepayment reviews are on claims outside of a nine county metro region where the Department has a regional broker for NEMT. In the nine county region, the broker verifies the medical necessity of each trip, verifies the driver and vehicle assigned, and verifies that the claim matches the mileage. Also, the broker conducts post-service satisfaction surveys. The statewide broker will perform these same functions for the rest of the state. These are parts of the broker's responsibilities for coordinating services and developing the provider network.

The General Assembly approved using broker services to cover the entire state in FY 2019-20. The Department hired a statewide broker in 2020 by amending the contract with the nine county broker, rather than issuing a Request for Proposals (RFP). The broker was not able to deliver the services. Several large local providers refused to contract with the broker. There were gaps in service and problems with wait times. The Department had to terminate the contract and then the pandemic hit. Based on the stresses to the healthcare delivery system and the Department's resources, the Department decided to delay reprocuring a statewide broker.

Arguably, had the Department successfully procured broker services statewide six years ago, the current fraud schemes the Department is battling would not have worked.

The Department believes expanding from a nine county broker to a statewide broker will not cost any additional funds. Funding for the statewide broker was originally included in the Medical Services Premiums line item. After the Department terminated the statewide broker contract, the Department didn't spend the money, because there was no statewide broker. The Department stopped building the funding into the forecast for Medical Services Premiums. There is no appropriation in FY 2024-25 for a statewide broker. However, there is funding for the nine county broker. Based on initial feedback from potential bidders, the Department believes the current roughly $4 million per year the Department spends on the nine county broker will be sufficient to procure a statewide broker. The Department is working on provider incentives within existing funding and procedure changes to avoid a repeat of providers refusing to contract with the broker. The Department is planning for the statewide broker to begin in January 2026.

Policy consultation: In addition, the Department wants more advice on ways to improve the NEMT benefit. The prepayment review vendor found many quick fixes to reduce risk and speed payment reviews. For example, the vendor helped the Department:

- populate audit workbooks with relevant rules automatically, eliminating the need to cross reference multiple documents
- design standardized trip logs with information needed to ensure rule compliance and nothing extraneous that would burden providers
- develop a rule that limits multiple transports in one trip to protect the privacy and safety of clients but still allow family members and caregivers to share rides
- identify providers with the highest performance risks

Regarding the last bullet, new information from the vendor caused the Department to cancel a round of bidding for the nine county broker. The vendor identified that a bidder had ownership shares across several states in multiple companies with performance concerns. The Department decided to redesign the bid to get better information on the applicants.

With more consulting time, the Department expects the vendor to perform further risk assessments on providers, help design additional rules, recommend more automations, and document best practices.

Transition support for new broker: Finally, the Department wants the vendor to work with the new statewide broker for NEMT on risk mitigation. The Department intends the consulting services to help the statewide broker implement sufficient and efficient procedures to ensure client safety and proper billing.

➔ BA14 All-Payer Claims Database

Request

In January, the Department submitted a supplemental request and an associated budget amendment to improve security of the All Payer Claims Database (APCD). The original request cost $7.2 million total funds, including $2.4 million General Fund, in FY 2025-26. The Joint Budget Committee rejected the supplemental request. In the February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast, the Governor included a reduction of $500,000 General Fund from the APCD for ending a scholarship program that helps researchers access the data. The Governor did not withdraw the request for security funding.

The APCD collects information from insurers and makes it available to researchers and public agencies to improve health care, improve health, and reduce costs. Each claim contains information on what services were provided and why, who received and who provided services, when and where services were provided, and how much was charged and paid. Examples of data from the APCD informing policy making can be found in the annual APCD reports.

There are limitations to the data. For example, the APCD can show that a diagnostic test was ordered, but the APCD does not show the results of the test. Despite the name, the APCD lacks information on about 30 percent of insured lives in Colorado. Federal rulings limit the APCD's ability to require self-insured entities under the Employee Retirement Income Security Act (ERISA) to submit data. Some ERISA entities submit data voluntarily. The APCD reports that changes in federal policy to create a standardized data format for collecting medical, pharmacy, and dental claims, as well as eligibility and provider files, may provide a path for collecting data from more insurers in the future. The APCD lacks information from some federal health insurance programs, including Veterans Administration, TRICARE, Federal Employees Health Benefits, and Indian Health Services. The APCD does not include information on services to uninsured Coloradoans.

A security audit by the Office of Information Technology (OIT) in June 2024 recommended updating the 2016 infrastructure for the APCD to keep pace with security threats. The Department indicates that newer technology would improve processing times, expand analysis options, and create opportunities for integrating the data with other technology, such as the Social Health Information Exchange being developed by the Office eHealth Innovation, as well as address the security concerns.

The OIT audit also recommended network security and compliance improvements. To implement these changes, the contractor operating the APCD proposes hiring additional staff, including a network security officer, regulatory compliance officer, documentation specialist, and compliance audit specialist.

In addition to refreshing the APCD infrastructure and improving network security and compliance procedures, the request proposes truing up the federal funds to reflect expected revenue. The Centers for Medicare and Medicaid Services (CMS) allows federal matching funds for the share of APCD activities that benefit the Medicaid program. The appropriation includes

funding for both activities that do and do not receive a federal match. In recent years, the share of activities receiving a federal match has exceeded the assumptions in the appropriation. Also, the Department received approval for enhanced federal matching funds for certain activities of the APCD of 90 percent for technology development and 75 percent for technology maintenance. As a result, the current appropriation understates the actual federal funds earned by the APCD by $3.8 million.

State and federal funding represents approximately 90 percent of the APCD operating budget. The APCD receives small private grants and charges researchers for accessing the data. Typical costs for a data set range from $15,000 to $50,000. Analytics for custom reports are priced by the hour and can range from less than $7,500 to more than $60,000, depending on the amount of work to design the query, scrub the output to protect personal health information, and provide professional analysis to interpret the data.

Recommendation

The staff recommendation is summarized in the table below. Components of the staff recommendation are discussed in more detail in the subsections following the table.

The recommendation is lower than the request by $3.4 million General Fund and a 20 percent General Fund reduction from the FY 2024-25 appropriation. This is the lowest level of funding the JBC staff feels comfortable recommending, based on the information provided from the Department and the contractor and the security concerns identified in the OIT audit. If the JBC does not want to fund the APCD at this level, then the JBC should choose the budget balancing option described below to eliminate the APCD.

BA14 All-Payer Claims Database				
Item	Total Funds	General Fund	CF-HAS Fee	Federal Funds
FY 2024-25 Appropriation	$5,435,778	$4,471,011	$0	$964,767
Supplemental true up for actual federal funds earned	3,793,095	0	0	3,793,095
FY 2024-25 Appropriation	$9,228,873	$4,471,011	$0	$4,757,862
Base reductions				
Eliminate scholarship funds	-500,000	-500,000	0	0
Eliminate non-critical reports	-300,000	-300,000	0	0
Qualify additional data mart activities for Medicaid match	0	-300,000	0	300,000
Allocate Medicaid state share to HAS Fee based on enrollment	0	-665,976	665,976	0
Subtotal - Base reductions	-$800,000	-$1,765,976	$665,976	$300,000
Security improvements				
Data management system reprocurement	800,000	553,406	8,994	237,600
Network security and compliance	390,156	282,627	10,966	96,563
Subtotal - Security improvements	$1,190,156	$836,033	$19,960	$334,163
FY 2025-26 Recommendation	$9,619,029	$3,541,068	$685,936	$5,392,025
Change from FY 2024-25	$390,156	-929,943	685,936	634,163
Percent Change	4.2%	-20.8%	n/a	13.3%
Governor's Request	$12,642,781	$6,901,743	$0	$5,741,038

BA14 All-Payer Claims Database				
Item	Total Funds	General Fund	CF-HAS Fee	Federal Funds
Staff Rec. Above/-Below Request	-$3,023,752	-$3,360,675	$685,936	-$349,013

Supplemental true up for actual federal funds earned

The State Controller already approved additional federal funds spending authority for the APCD for FY 2024-25, but a supplemental true up of the federal funds to match expected earnings makes it easier to see the total public support for the APCD, improves transparency, and makes it easier to follow the recommended policy changes for FY 2025-26. The increase in federal funds is not a policy change. It just aligns the Long Bill appropriations with what the APCD is already earning.

Base reductions

In light of the statewide budget challenges, the Department and the contractor came up with a potential "skinny" budget for the APCD that eliminates all non-essential activities and tries to maximize alternative fund sources.

The "skinny" budget proposes eliminating the $500,000 General Fund scholarship program that helps researchers access the APCD. The APCD may get some of the lost revenue back, if researchers come up with the funds to replace the scholarships money. This might be an area where philanthropic groups step up.

The APCD could reduce $300,000 in costs by eliminating all non-critical reports. No statutory changes would be needed.

The Department thinks they can qualify an additional $400,000 of the current General Fund costs as Medicaid expenses for a data mart. If successful, the Department would draw a 75 percent federal match, reducing the General Fund cost by $300,000. This change is dependent on federal approval, but it fits the description of a data mart expense in the Department's Advanced Planning Document, so the Department thinks it would qualify for reimbursement.

In addition to the "skinny" budget changes proposed by the Department and the contractor, the JBC staff recommends allocating a portion of the APCD activities that are eligible for Medicaid to the HAS Fee. The staff recommendation allocates 34.07 percent of the state share of the Medicaid eligible expenses to the HAS Fee, consistent with the FY 2024-25 share of Medicaid enrollment attributable the HAS Fee and the staff recommended approach in R10.

Security improvements

Staff recommends an increase in funding to address the security concerns raised by the OIT audit. The APCD collects a large volume of sensitive personal health data. High federal standards protect the privacy of the data and impose penalties for improper handling. It would be risky and arguably irresponsible to fund the APCD without resources to keep the data secure. However, the JBC staff reduced the recommended funding for security improvements from the Department's request.

First, for the data management and system reprocurement, staff recommends $800,000 total funds for the development, based on actual bids received. The original request estimated this would cost $2.8 million total funds. The estimated on-going maintenance remains unchanged at $1.0 million total funds per year. The recommendation allocates a portion of the state share of the Medicaid-eligible expenses to the HAS Fee, using the same method described above.

Second, staff recommends only two of the four security positions requested by the Department. The staff recommendation includes a network security officer and regulatory compliance officer. The contractor identified these two positions as the most critical to shore up the data. Staff does not recommend the documentation specialist and compliance audit specialist. These positions would document the data use and release expectations and audit compliance with those expectations respectively. Without the positions, users may not be clear about the expectations and the data could get used inappropriately or inaccurately. While such errors could be problematic, they carry marginally lower security concerns and arguably the users share in some of the responsibility. The recommendation allocates a portion of the state share of the Medicaid-eligible expenses to the HAS Fee, using the same method described above.

Budget balancing alternative – Eliminate the APCD

Eliminating the APCD was one of the budget balancing options provided by the JBC staff at the briefing. The APCD collects data for research and analysis, rather than providing direct services. While APCD analysis has informed several policy decisions and improved cost estimates, it is rare for APCD information to be the only, or even primary, reason for a policy decision. Only about half of the states (22) have an APCD. Colorado could manage without the APCD.

Eliminating the APCD can be done through the budget. Statutes direct the Department to destroy the data if the funding is insufficient. However, there are statutes that direct a few state programs to use data from the APCD. Those state programs would need to identify alternative sources of data or make policy decisions without the availability of data from the APCD. Conforming statutory changes would be needed.

➔ BA17 Personal services reduction

Request

The Department requests a reduction in personal services to help address the budget shortfall. The request saves $856,421 total funds, including $371,429 General Fund, and 10.0 FTE. The positions are currently vacant. While there are still business cases to support these positions, the Department believes it can manage the workload without them.

Recommendation

Staff recommends approval of the request based on the statewide budget needs.

The Department did not provide much explanation for why the positions are not needed or how the Department will manage the workload without the positions. The request raises mild

questions about equity that this Department offered administrative reductions when not every department followed suit.

The proposed reduction to the personal services line item is a hair under one percent of the FY 2024-25 General Fund appropriation for personal services. The Department did not withdraw any of the requested increases in FTE for FY 2025-26. The cumulative impact of all the changes the Department requested would still increase appropriations and FTE for the Executive Director's Office.

➔ Prepayment claims reviews

Staff recommends additional resources for prepayment reviews to net savings of $15.9 million total funds, including $5.6 million General Fund. Additional resources for prepayment reviews would likely reduce expenditures by preventing improper billing and fraud.

The savings are not guaranteed. The estimated savings in the table below are based on prepayment reviews of transportation services. There were large known fraud issues with transportation services. There might be fewer improper billing issues in other service areas, reducing the potential savings. On the other hand, the Department says this savings estimate is lower than the return on investment described by the federal Centers for Medicare and Medicaid Services (CMS) based on similar programs in other states.

This approach may reject some legitimate payments for nit-pickey technical errors, driving increased workload for providers to correct errors, or decisions by providers to accept losses. However, there would be no contingency fees creating perverse incentives for the contractor.

Prepayment Review

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Prepayment review contract	$3,500,000	$1,517,950	$232,050	$1,750,000	0.0
Compliance FTE	160,470	69,596	10,639	80,235	2.0
Potential savings	-19,600,000	-7,208,806	-927,940	-11,463,254	0.0
Total	-$15,939,530	-$5,621,260	-$685,251	-$9,633,019	2.0

This balancing option originally appeared in the JBC staff briefing and got included in the Governor's January 2, 2025, proposal for balancing. The net savings are slightly revised to reflect the JBC's common policies regarding new FTE.

➔ SBIRT training grants

Staff recommends eliminating grants that train providers in screening, brief intervention, and referral to treatment (SBIRT) for substance use and redirecting the money to pay for SBIRT services. The recommendation saves $1.5 million General Fund. This is a grant program and it supports training, rather than direct services. There is no federal match. Medicaid would continue to reimburse services for Medicaid clients.

SBIRT training grants

Item	Total Funds	General Fund	Marijuana Tax Cash Fund
SBIRT training grants	-$1,500,000	$0	-$1,500,000

SBIRT training grants			
Item	Total Funds	General Fund	Marijuana Tax Cash Fund
Medical Services Premiums	0	-1,500,000	1,500,000
Total	-$1,500,000	-$1,500,000	$0

Pursuant to Section 25.5-5-208, C.R.S., the Department grants $1.5 million annually from the Marijuana Tax Cash Fund to organizations that provide training and technical assistance for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. Historically, the grantees primarily provide training, but the grants can also support outreach, communication, coordination between professionals, and public awareness campaigns.

The change can be done through the Long Bill. The statute requires $1.5 million in grants on or after July 1, 2018, but it does not require annual grants. The legislature has already satisfied the minimum statutory requirement. However, the legislature has continued to appropriate money annually with a footnote clarifying that the purpose of the money is to continue the grants in Section 25.5-5-208, C.R.S. In FY 2020-21, the General Assembly reduced funding for the SBIRT grants through the Long Bill. No separate legislation was needed.

To achieve General Fund savings, the staff recommendation redirects the Marijuana Tax Cash Fund to pay for SBIRT services in the Medical Services Premiums line item. One of the allowable statutory purposes of appropriations from the Marijuana Tax Cash Fund is to treat and provide related services to people with any type of substance use or mental health disorder. The Department already covers the SBIRT services using General Fund as the state match. Rather than the staff recommendation to offset General Fund, the JBC could consider using a cut to the SBIRT training grants to help balance the Marijuana Tax Cash Fund.

These are grants for provider training. SBIRT is still a covered benefit for Medicaid clients. Providers are required to have training to deliver services, but the training does not need to be through this program. The trainees do not work exclusively with Medicaid clients and there are no means tests on the people they serve. Providers can pay for their own professional development.

The Department recently changed some of the grant parameters, so prior year data is not entirely representative of FY 2024-25 activities. The FY 2024-25 grants will support 150 statewide trainings. As of January 31, 2025, 83 trainings were complete with 491 individual providers. Assuming a similar number of participating providers per training, 150 trainings will reach approximately 885 providers. The Department estimates the grant funding supports approximately 11 technical assistance interactions for per month with school districts, local public health agencies, primary care clinics, and behavioral health providers.

A lack of funding may result in a decrease in the supply of providers offering services. In the long run, a lack of training grants may impact access to care for both Medicaid and private pay clients and lead to lower health outcomes. However, many other factors may also impact the supply of providers, such as reimbursement rates or training standards in the various impacted professions.

This was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast.

➔ Remote monitoring technology grants

Staff recommends no funding for rural grants for remote monitoring technology. The recommendation saves $500,000 General Fund. There is no federal match. The grants were authorized by S.B. 24-168 and compliment new reimbursements for remote patient monitoring. The grants have not yet started. The Department expects to begin making five grants of $100,000 each in July 2025.

The bill authorized related new reimbursements for remote patient monitoring (described above) but the legislature could choose to stop one without stopping the other. Ending the new reimbursements for remote patient monitoring requires a bill, but ending the grant program can be done through the budget.

Without this funding, the supply of providers offering remote patient monitoring might grow more slowly.

This balancing option originally appeared in the JBC staff briefing and got included in the Governor's January 2, 2025, proposal for balancing.

➔ OeHI

The JBC staff recommends a reduction to the Office of eHealth Innovations (OeHI) of $250,000 General Fund in FY 2024-25 that would continue into FY 2025-26. Also, staff recommends an increase of $2.6 million federal funds in FY 2025-26 based on the projected Medicaid-eligible activities and federal match rates.

Since OeHI was created in FY 2019-20 by executive order, the office has consistently reverted a significant portion of the General Fund appropriation. The only year OeHI reverted less than 20 percent of the General Fund was FY 2023-24, when it reverted 15 percent.

OeHI Reversions

Item	Total Funds	General Fund	Federal Funds
Appropriation			
FY 2019-20	1,958,154	961,017	997,137
FY 2020-21	1,958,154	961,017	997,137
FY 2021-22	6,465,845	3,372,367	3,093,478
FY 2022-23	6,465,845	3,372,367	3,093,478
FY 2023-24	6,465,845	3,372,367	3,093,478
Actual Expenditure			
FY 2019-20	1,937,375	530,213	1,407,162
FY 2020-21	6,556,066	660,675	5,895,391
FY 2021-22	4,385,240	2,296,332	2,088,908
FY 2022-23	5,096,812	2,621,444	2,475,368
FY 2023-24	5,366,705	2,869,668	2,497,038
Reversion/-Overexpenditure			
FY 2019-20	20,779	430,804	-410,025

OeHI Reversions			
Item	Total Funds	General Fund	Federal Funds
FY 2020-21	-4,597,912	300,342	-4,898,254
FY 2021-22	2,080,605	1,076,035	1,004,570
FY 2022-23	1,369,033	750,923	618,110
FY 2023-24	1,099,140	502,699	596,440
Percent Reversion/-Overexpenditure			
FY 2019-20	1.1%	44.8%	-41.1%
FY 2020-21	-234.8%	31.3%	-491.2%
FY 2021-22	32.2%	31.9%	32.5%
FY 2022-23	21.2%	22.3%	20.0%
FY 2023-24	17.0%	14.9%	19.3%

The JBC staff is generally reluctant to recommend reductions based on reversions. Departments intentionally hold reserves and take measures to curb expenditures to avoid spending more than the appropriation. This is good fiscal management. Taking the reversions does not necessarily decrease the likelihood of more reversions. Consistently taking the reversions can put a program in what one former JBC director colorfully described as a "death spiral". In the "death spiral" each corrective action leads to progressively less spending on the program without ever correcting the under expenditure. Often reversions are the result of unexpected circumstances. Programs go through cycles of reversions and tight budgets.

However, in this case the percentage reversion has been large and sustained over multiple years. When OeHI was created there was uncertainty about how much of the activity would be eligible for federal matching funds. Since OeHI was created, the federal government has expanded the information technology activities eligible for an enhanced match and the Department has become more sophisticated at qualifying activities for an enhanced federal match. The appropriation for OeHI has never been adjusted to reflect the changed conditions.

OeHI's own spending plan suggests that it can absorb a reduction of $250,000 General Fund in FY 2024-25.

FY 2024-25 OeHI Spending Plan				
Activities	Total Funds	General Fund	Federal Funds	Federal Match
Health Equity	$2,350,138	$239,231	$2,110,907	90.0%
SHIE	1,259,070	123,157	1,135,913	90.0%
Rural	42,174	4,217	37,957	90.0%
Labor	535,439	267,719	267,720	50.0%
Non-Medicaid	2,491,687	2,491,687	0	0.0%
Total	$6,678,508	$3,126,011	$3,552,497	
FY 2024-25 Appropriation	$6,465,845	$3,372,367	$3,093,478	
Spend plan higher/-lower than approp.	$212,663	-$246,356	$459,019	

In addition, OeHI says it received an unexpected refund from the Office of Information Technology of $172,401 General Fund in FY 2024-25 that was not incorporated in the budget. OeHI offered the refund for reallocation.

For FY 2025-26, OeHI expects to spend all of the appropriation, in large part due to the Rural Connectivity Extension capital construction project moving into a maintenance and operations phase. The Department expects operating expenditures for the project to increase from $42,174 in FY 2024-25 to $2,765,875 in FY 2025-26. Also, the federal match shifts from 90 percent for information technology development to 75 percent for maintenance.

FY 2025-26 OeHI Spending Plan				
Activities	Total Funds	General Fund	Federal Funds	Federal Match
Health Equity	$1,887,471	$188,747	$1,698,724	90.0%
SHIE	1,072,771	107,277	965,494	90.0%
Rural	2,765,875	691,469	2,074,406	75.0%
HIE	1,400,000	700,000	700,000	50.0%
Consent	223,828	111,914	111,914	50.0%
Labor	278,260	139,130	139,130	50.0%
Non-Medicaid	1,400,000	1,400,000	0	0.0%
Total	$9,028,205	$3,338,537	$5,689,668	

The staff recommendation would require OeHI to reductions from the its current spending plan for FY 2025-26. However, given the scalable nature of these initiatives and OeHI's reversion history, the JBC staff believes OeHI could absorb the reduction.

The staff recommendation assumes the reduction would come mostly from OeHI's non-Medicaid activities. Therefore, the recommendation to refinance some of OeHI's Medicaid activities with HAS Fee remains unchanged (see *R10 HAS Fee admin & financing* above).

OeHI Staff Recommendation				
Item	Total Funds	General Fund	CF-HAS Fee	Federal Funds
FY 2024-25				
Current Appropriation	6,465,845	3,372,367	0	3,093,478
Long Bill Supplemental	-250,000	-250,000	0	0
Total	$6,215,845	$3,122,367	$0	$3,093,478
FY 2025-26				
R10 HAS Fee admin & refinance	0	-671,985	671,985	0
Federal funds true up	2,596,190	0	0	2,596,190
Total	$8,812,035	$2,450,382	$671,985	$5,689,668

The Department's request assumed some of the common policy funding for payments to the Office of Information Technology would be appropriated in OeHI. The staff recommendation keeps the money in the Payments to OIT line item.

➔ Assessments for nursing services

Staff recommends removing funding from FY 2024-25 for assessments for skilled nursing services provided in the home or a community setting, due to a federally-driven delay in implementing the assessments. The recommendation saves $1,938,600 total funds, including $484,650 General Fund. The Department expected to implement the assessments for nursing services in January 2025, but a federal extension of time to spend American Rescue Plan Act

(ARPA) funds for home- and community-based services extended an associated maintenance of effort requirement. As a result, the Department will not be able to implement the assessments until FY 2025-26, and so the FY 2024-25 appropriation is no longer needed.

The General Assembly provided the funding in response to the FY 2024-25 *R10 Assessment for skilled nursing*.

➔ NEMT broker fund source true up

Staff recommends an adjustment to the fund sources for the NEMT broker in FY 2024-25. The recommendation reduces the FY 2024-25 General Fund by $790,013 and increases the cash funds from the HAS Fee by the same amount. In the supplemental bill, the JBC approved moving the cost for the NEMT broker from the Medical Services Premiums to a new line item in the Executive Director's Office. The JBC staff moved the correct total, but not the correct amounts by fund source. The fund sources for Medical Services Premiums are trued up in the Department's February forecast, but a separate action is needed to true up the fund sources in the new line item for the NEMT broker. The fund source allocation is based on who uses the benefit. The federal match is 50 percent regardless of the population served, but the source of the state match varies based on whether the utilizers are financed from the General Fund or HAS Fee. This looks like a decrease in General Fund and an increase in HAS Fee, but the changes are offset by equal and opposite changes in the Medical Services Premiums line item that are part of the February forecast. The changes to the FY 2024-25 fund sources carry forward to FY 2025-26.

➔ Temporary employees related to authorized leave

Staff recommends eliminating the line item. The recommendation saves $5,978 total funds, including $2,348 General Fund. The line item pays for temporary employees when permanent employees are on leave for family and medical reasons. It was added by amendment to the FY 2022-23 Long Bill. The funding coincided with the passage of H.B. 22-1266 that made changes to the state compensation philosophy and expanded leave policies. The funding has remained constant since then. This is not a standard line in every department, but it appears in some departments. Staff believes the Department can absorb the costs within the appropriation for Personal Services. In FY 2024-25 the line item was 0.008 percent of the appropriation for Personal Services and an even smaller percent of all the Department's compensation-related line items.

TABOR revenue changes

The table below summarizes recommendations that impact revenues subject to the limitations in Article X, Section 20 of the State Constitution (TABOR). Reducing revenues subject to TABOR could reduce the General Fund obligation for a TABOR refund.

These budget balancing strategies makes additional General Fund available only to the extent there is a TABOR surplus. The December 2024 forecasts from Legislative Council Staff and the

Office of State Planning and Budgeting projected TABOR surpluses in FY 2025-26 of $844.1 million and $553.1 million respectively. Small percentage decreases in the forecasts, or the accumulation of other policies that decrease TABOR revenues, could reduce or eliminate the budget balancing utility of these strategies.

These strategies primarily involve legal changes to the way the state treats revenue, rather than reductions in services. The tradeoff for associated with adopting these strategies is reduced TABOR refunds to the citizens of Colorado.

The table below summarizes the strategies. The table includes changes in TABOR revenues associated with the proposed reduction to dental services provider rates and the adult dental cap that are described above and can be implemented through the budget. The other changes require legislation and are each described below the summary table. The table lists changes requested by the Department first, followed by changes recommended by the JBC staff in order of size.

TABOR revenue changes		
Item	FY 2024-25	FY 2025-26
R16b Disability buy-in	-$1,110,127	-$6,660,761
Include nursing provider fees in enterprise	-10,140,370	-65,202,711
Dental services provider rates	0	-3,747,032
Adult dental cap	$0	-1,631,873
Total	-$11,250,497	-$71,863,472

→ R16b Disability buy-in premiums to enterprise [legislation]

Request

The Department requests legislation to move into an enterprise the premiums that people with disabilities pay to buy-in to Medicaid. The Department estimates the change will reduce the General Fund obligation for a TABOR refund by $6.7 million.

The Medicaid Buy-in Cash Fund receives premiums from people with disabilities who elect to buy in to Medicaid. The Department suspended the premiums during the pandemic. The Department expects to begin collecting premiums again in April 2025.

There are two buy-in programs for people with disabilities. One allows working adults with disabilities to buy in with income up to 450 percent of the federal poverty guidelines. The other lets children with disabilities buy in with family income up to 300 percent of the federal poverty guidelines. Both programs charge premiums on a sliding scale based on income. The premiums from both programs get deposited in the Medicaid Buy-in Cash Fund. The Medicaid Buy-in Cash Fund offsets the costs of the program, reducing both the state and federal shares of the total cost.

The Healthcare Affordability and Sustainability Fee (HAS Fee) pays the state share of costs for the disability buy-in programs. The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) collects the HAS Fee. The Department sees a connection between the existing support CHASE provides for the disability buy-in program and collecting the premiums.

Recommendation

Staff recommends the requested legislation with modification to ensure it takes effect in FY 2024-25. Aligning the shift in responsibility for collecting the premiums with when the Department expects the premiums to restart is cleaner and provides some budget balancing benefit in FY 2024-25.

Having the enterprise collect the premium revenue will reduce the projected General Fund obligation for a TABOR refund by the amount of premium revenue collected. The table below summarizes the projected premium revenue by fiscal year.

Premium Revenue	
Fiscal Year	Revenue
FY 2024-25	$1,110,127
FY 2025-26	$6,660,761

The JBC staff anticipates this could be done in a larger bill amending the responsibilities of CHASE to include collecting the nursing provider fees, using the HAS Fee to offset General Fund, and/or authorizing a state directed payment program, or it could stand alone.

➔ Include nursing provider fees in enterprise [legislation]

Staff recommends legislation to expand the business purposes of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to include the provider fees[9] on nursing homes. The recommendation saves $10.1 million General Fund in FY 2024-25 and $65.2 million General Fund in FY 2025-26 by reducing TABOR revenues and thereby reducing the General Fund obligation for a TABOR refund. The same arguments used to make the Healthcare Affordability and Sustainability Fee (HAS Fee) an enterprise apply to the nursing provider fees.

Include nursing provider fees in enterprise			
Item	Cite	FY 2024-25	FY 2025-26
Projected nursing fee revenues			
Medicaid Nursing Facility Cash Fund	25.5-6-203 (2)(a)	$58,691,389	$63,044,597
Service Fee Fund	25.5-6-204 (1)(C)(II)	2,150,828	2,158,114
Subtotal		$60,842,217	$65,202,711
Revenue to enterprise (effective May-2025)		$10,140,370	$65,202,711
General Fund obligation for a TABOR refund		-$10,140,370	-$65,202,711

The business purpose of the nursing provider fees is the same as the primary business purpose of the HAS Fee. The nursing provider fees match federal funds to increase reimbursement rates for providing care under Medicaid. Who pays and benefits from the nursing provider fees differs from the HAS Fee. There are some additional statutory purposes of the HAS Fee that are not part of the nursing provider fees, most notably for expansion populations. If the HAS Fee is

[9] Plural because there are two separate nursing provider fees, with one for traditional nursing homes and one for those serving people with intellectual and developmental disabilities.

part of a government owned business providing business services to hospitals, then the nursing provider fees could be part of a government owned business providing business services to nursing homes.

The State would not need to adjust the TABOR spending limit. TABOR requires an adjustment to the spending limit for qualifications or disqualifications as an enterprise. However, the legislature determined that abolishing the hospital provider fee and creating a new HAS Fee enterprise to replace it did not trigger an adjustment to the spending limit.[10]

This would not qualify or create a new enterprise. Statute requires that a state enterprise qualified or created after January 1, 2021, not receive more than $100 million in revenue over five years unless approved by election.[11] The recommendation would modify the business purposes of an existing enterprise created prior to January 1, 2021.

If nursing fees grow slower than the TABOR growth rate, then keeping the nursing fees in the TABOR base allows the state to retain more General Fund. Conversely, if nursing fees grow faster than the TABOR growth rate, then they crowd out General Fund.

The Department expects nursing rates will grow faster than TABOR but with low confidence due to changing consumer habits. State statute calculates the primary nursing fee by multiplying non-Medicare bed days by a per diem that increases annually by a federal nursing home inflation metric. This is similar, but not exactly the same, as the inflation metric used for TABOR. The other part of both the TABOR and nursing fee equations is population. From 2016 to 2020 the nursing population grew roughly 0 percent. In 2021 the patient population decreased 18.5 percent due to COVID. The patient population has grown slightly more than 1 percent per year since 2021. Looking forward, the State Demographer projects the population age 75+ will increase 5 percent per year, or 4-5 times faster than Colorado's overall population. However, the Department continues to see consumers choosing community-based services over nursing homes.

Converting the nursing fees to an enterprise could be done in state statute and would not require any new federal approval.

In addition to saving General Fund in the near term, converting the nursing fees to an enterprise could allow the state to maximize the fees and draw an additional $28.5 million federal funds to support nursing homes. That may decrease the need for General Fund increases for nursing homes in the future. Under current law and revenue projections, increasing nursing fees to the federal maximum would increase the General Fund obligation for a TABOR refund. In an enterprise, the fees could be increased to the maximum with no TABOR impact. Federal law limits the nursing fees to 6.0 percent of net patient revenues. The current fees are 3.9 percent of net patient revenues.

Staff recommends not assuming any increase in the nursing provider fees to help balance the budget until FY 2026-27. Increasing the fees to the maximum would likely require six to twelve

[10] Section 25.5-4-402.4 (3)(c)(I), C.R.S.

[11] Section 24-77-108 (1), C.R.S.

months for federal approval, plus whatever time the Department needs to redesign the fees and supplemental payments. Federal approval is not guaranteed. The Department anticipates increased federal scrutiny of provider fees under the current administration. Maximizing the federal funds would require removing a state statutory exemption for nursing providers with the Continuing Care Retirement Community designation. Also, the legislature would likely want to adjust the fee structure to mitigate the impacts on non-Medicaid providers who do not receive the benefits. The current supplemental payments prioritize behavioral health supports and quality incentives. If the legislature wants to change those priorities with an increase in supplemental payments, then that might add implementation time.

In addition to the complexities noted above, current law requires nursing home rates to increase for FY 2025-26 by the lesser of 1.5 percent or the actual increase in allowable costs. This is the last phase in a multi-year step down of the statutory requirements around nursing home provider rate increases. In FY 2026-27 there will be no statutory requirement for a nursing home provider rate increase. Eliminating the statutory requirement for a 1.5 percent increase is a budget balancing option that would save $5.3 General Fund. The impact could be mitigated by an increase in the nursing provider fee. But, this balancing option would be inconsistent with the negotiated multi-year step down in nursing rates. For this reason, and the assumption that the Department could not increase nursing provider fees until FY 2026-27, the JBC staff recommendation does not include eliminating the 1.5 percent statutory increase for the nursing homes in FY 2025-26.

Expanding the business purposes of CHASE to include collecting nursing provider fees was in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast.

Legislation – Revenue Changes

This section discusses recommended legislation that would provide budget relief by increasing revenue. Both of these strategies provide short duration savings, although the General Assembly could decide to make a HAS Fee offset of the General Fund on-going. One-time savings are still beneficial when addressing long-term budget shortfalls, because they buy time for other policy options to emerge or take effect.

The table below lists changes requested by the Department first, followed by changes recommended by the JBC staff in order of size. The table does not include the expenditure impact of using the HAS Fee to offset General Fund. That $25.0 million General Fund savings is shown in the section titled "Legislation – Appropriation Changes".

Recommended Legislation - Revenue Changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2024-25				
R16a Cash fund repeals	$0	$698,757	-$698,757	$0
HAS Fee offset General Fund	25,000,000	0	25,000,000	0
Total	$25,000,000	$698,757	$24,301,243	$0

Recommended Legislation - Revenue Changes				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
R16a Cash fund repeals	$0	$0	$0	$0
HAS Fee offset General Fund	25,000,000	0	25,000,000	0
Total	$25,000,000	$0	$25,000,000	$0
FY 2026-27				
R16a Cash fund repeals	$0	$0	$0	$0
HAS Fee offset General Fund	0	0	0	0
Total	$0	$0	$0	$0

➔ R16a Cash fund repeals and transfers [legislation]

Request

The Department requests eliminating obsolete cash funds and using the balances to offset General Fund. Using the cash fund balances to offset General Fund saves $698,757 General Fund.

The Department identified three cash funds that are no longer needed. Each received gifts, transfers, or appropriations for a short period of time and then the revenues stopped. All of the funds are subject to appropriation. The Department spent the money from the funds as appropriated and instructed in statute. Small amounts remain in the funds.

Cash Fund Repeals and Transfers				
Fund	Cite	Purpose	Source	Balance
Pediatric Hospice Care Cash Fund	25.5-5-305 (6)	Admin costs to seek fed approval for pediatric hospice benefit	Gift from Children's Hospital	$431
Colorado Health Care Services Cash Fund	25.5-3-112 (1)	Distributions to Denver Health, community health clinics, and primary care clinics	General Fund from FY 2025-26 through FY 2011-12	$674,317
Primary Care Provider Sustainability Fund	25.5-5-418	Primary care office visits, immunization administration, health screening services, and newborn care	Children's Basic Health Plan Trust	$24,009
Total				$698,757

Recommendation

Staff recommends legislation to repeal the obsolete funds identified by the Department and transfer the balances to the General Fund in FY 2024-25. The budget balancing benefit of transferring the money to the General Fund is the same as using the balances in the cash funds to offset General Fund appropriations.

The JBC staff anticipates the changes can be implemented in the cash fund transfer bill that the JBC has approved.

➔ HAS Fee offset General Fund [legislation]

Staff recommends legislation to temporarily use the Healthcare Affordability and Sustainability Fee (HAS Fee) to offset General Fund for Medical Services Premiums. The recommendation saves $50.0 million General Fund, including $25.0 million in FY 2024-25 and $25.0 million in FY 2025-26. The recommendation would require the hospitals to pay more into the HAS Fee, but there would be no decrease in expenditures for any other purpose of the HAS Fee, including expansion populations and supplemental payments to the hospitals. The General Assembly implemented similar one-time financing in the last two budget shortfalls, using $150 million in FY 2010-11 and $161 million in FY 2020-21 from the HAS Fee to offset General Fund.

The HAS Fee is an assessment on hospitals. The revenue from the HAS Fee matches federal funds and gets used for: supplemental payments to increase hospital reimbursements; eligibility expansions; and associated administrative expenses.

The Department recently changed the way it calculates the supplemental payments to hospitals, resulting in an on-going increased net benefit to the hospitals. Previously, the Department calculated the payments to reimburse hospitals to 97 percent of the federal upper payment limit. The policy, approved by the board and negotiated with the federal government, took into account uncertainty in the forecast and attempted to avoid potential clawbacks. The new policy reimburses at 99.25 percent of the upper payment limit. Federal policy allowed the Department to make the change retroactive for 2 years. That generated a one-time net benefit to the hospitals of $54 million. Going forward, the policy change is expected to increase the net benefit to hospitals by approximately $19 million every year.

The Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast suggested using $22.0 million in FY 2024-25 and $25.1 million in FY 2025-26 from the HAS Fee to offset General Fund. The $22.0 million in FY 2024-25 was based on using half of the $54 million one-time net benefit to hospitals from switching to reimbursements at 99.25 percent of the upper payment limit. The $25.1 million in FY 2025-26 was based on the remaining amount needed to offset the increased cost of the Medicaid forecast after all the other balancing options the Governor was willing to put forward in the February 18, 2025, letter.

The General Assembly could pair this budget balancing strategy with a directed payment program to generate a net increase for hospitals. A directed payment program could expand the allowable HAS Fee financing for hospitals. Federal limits constrain the current supplemental payments to hospitals. The UPL calculation is based on Medicare and does not include managed care. Colorado has managed care contracts with Denver Health and Rocky Mountain Prime and for behavioral health services. States can implement a directed payment program for managed care. The federal government limits directed payment programs, too, but the limits align with average commercial pay, rather than the lower Medicare pay. A directed payment program would increase the amount Colorado could pay hospitals. The second constraint limits collections from provider fees to six percent of net patient revenue. A directed payment program would add hospital services delivered through managed care to the net patient revenue, increasing the amount of HAS Fee that could be collected. In addition, advocates

argue that Denver Health could make an intergovernmental transfer that would not count against the six percent limit. If an intergovernmental transfer can go to the enterprise that manages the HAS Fee, it may not count against the TABOR limit.

Advocates argue a directed payment program could increase the federal funds available for hospitals by around $200 million. The JBC staff needs more information on the specifics of a directed payment program to confirm the estimate. If the State implemented a directed payment program in FY 2025-26, it would occur in a year when the Governor is proposing either no increases or decreases in payments for other providers.

Implementation of a directed payment program requires federal approval. Advocates argue that counting on federal approval in the current political environment is risky. An increase in federal funds from a directed payment program may not materialize to counterbalance the staff recommendation for higher HAS Fees.

Advocates indicate that implementing a directed payment program will require some conforming amendments in statute. The JBC staff has not seen the specific proposed changes.

Are the amounts scalable?

The amounts are scalable, but trying to use over $25 million of the HAS Fee in FY 2024-25 or FY 2025-26 may impact other uses of the HAS Fee. There is a gap between federal limits on what we can pay hospitals and what we can collect from hospitals. Right now, the federal upper payment limit (UPL) caps the supplemental payments we can make to hospitals. However, there is room to collect more HAS Fee revenue from the hospitals up to the federal limit of six percent of net patient revenues. We could not use additional revenue from the HAS Fee to increase payments to hospitals, but we could use it to offset General Fund. If the legislature tried to use more HAS Fee than the recommendation to offset General Fund, then that might crowd out other uses of the HAS Fee.

The Department is confident that using $25 million from the HAS Fee for General Fund relief in FY 2024-25 and FY 2025-26 will not impact other expenditures from the HAS Fee. The Department's confidence decreases above that threshold. There is significant uncertainty about both the expansion population costs and hospital net patient revenues.

If there are insufficient revenues for all of the allowable purposes of the HAS Fee, the statues currently direct the Department to scale back the eligibility expansions. Through a statutory change, the legislature could instead direct the Department to scale back the supplemental payments to the hospitals. A decrease in supplemental payments to the hospitals would result in less federal matching funds and lower reimbursement to the hospitals.

Could the change be ongoing?

The staff recommendation is for one-time offsets of General Fund from the HAS Fee, but the legislature could make the offsets on-going. The JBC could make that part of the authorizing legislation or revisit the issue in a future year.

The reasons for the staff recommendation of one-time financing include:

- The two previous increases in the amount of HAS Fee that offsets General Fund were both one-time.
- There is uncertainty whether an on-going General Fund offset might impact other existing uses of the HAS Fee, due to potential forecast errors in projecting expansion population costs and hospital net patient revenues.

Making General Fund offsets from the HAS Fee on-going might marginally weaken the political and legal arguments that the HAS Fee is an enterprise. Using the HAS Fee to offset General Fund does not provide an obvious direct business benefit to the hospitals. However, it arguably provides many indirect business benefits to the hospitals, such as reducing the need for other cuts that would impact hospitals or building good will with the legislature. Businesses routinely spend money to garner indirect benefits. Also, there is already a long-standing precedent for some of the HAS Fee to offset General Fund. The creation of the Hospital Provider Fee, which was the predecessor to the HAS Fee, would have decreased some prior financing from certified public expenditures that was offsetting $15.7 million in General Fund costs. To avoid an increase in General Fund costs, the statute[12] directed that the Hospital Provider Fee cover this cost. The practice was continued when the HAS Fee replaced the Hospital Provider Fee and the HAS Fee became an enterprise. To this day, the HAS Fee offsets $15.7 million General Fund every year. The General Fund offset is treated as part of the enterprise activities and it does not impact TABOR revenues. Nor does it impact the ability of the entity to qualify as an enterprise under TABOR.

Legislation – Appropriation Changes

This section discusses legislation that would change appropriations. The table lists ideas requested by the Department first. It includes a placeholder for BA7 HRSN & reentry services, discussed above, but the amounts are pending. It includes the expenditure impact of the recommendation to use the HAS Fee to offset General Fund that is discussed in the previous section. The remaining staff-initiated recommendations are then grouped into ideas that stop benefits not yet implemented versus ideas that stop existing benefits. Within each of those categories, the ideas are listed in descending size.

[12] Section 25.5-4-402.4 (5)(b)(VII), C.R.S.

Recommended Legislation - Appropriation Changes					
Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2025-26					
BA7 HRSN & reentry services	Amounts pending				
HAS Fee offset General Fund	0	-25,000,000	25,000,000	0	0.0
Stop benefits not yet implemented					
Continuous eligibility expansions	-5,971,609	-5,613,171	-358,438	-7,632,894	0.0
Community health workers	-3,492,522	-2,807,023	-685,499	-8,233,986	-1.0
Continuous glucose monitoring	-326,757	-278,683	-48,074	-711,554	0.0
Remote patient monitoring	-283,957	-260,732	-23,225	-299,597	0.0
Stop existing benefits					
Health benefits for children lacking access due to immigration status	-19,195,209	-19,195,209	0	0	0.0
Equine services	-198,014	-198,014	0	-198,014	0.0
Total	-$29,468,068	-$28,352,832	-$1,115,236	-$17,076,045	-1.0
FY 2026-27					
BA7 HRSN & reentry services	Amounts pending				
HAS Fee offset General Fund	0	-25,000,000	25,000,000	0	0.0
Stop benefits not yet implemented					
Continuous eligibility expansions	-$11,943,220	-$11,226,343	-$716,877	-$15,265,790	0.0
Community health workers	-4,077,883	-3,274,870	-803,013	-9,607,485	-1.0
Continuous glucose monitoring	-980,223	-836,008	-144,215	-2,134,562	0.0
Remote patient monitoring	-366,249	-336,293	-29,956	-386,421	0.0
Stop existing benefits					
Health benefits for children lacking access due to immigration status	-32,075,606	-32,075,606	0	0	0.0
Equine services	-198,014	-198,014	0	-198,014	0.0
Total	-$49,641,195	-$47,947,134	-$1,694,061	-$27,592,272	-1.0

➔ Continuous eligibility expansions [legislation]

Staff recommends legislation to stop the Department from implementing continuous eligibility for children to age 3 and people to 1 year after incarceration. The recommendation would save $12.1 million total funds, including $5.6 million General Fund. House Bill 23-1300, sponsored by the JBC, authorized the eligibility expansions. During continuous eligibility clients do not need to reapply for services. They remain eligible even with a change in income or family status. The recommendation is based on the following:

- This eligibility expansion has not yet been implemented, so stopping it would not take away existing benefits. The Department expects to implement it in January 2026.
- The projected service costs double in FY 2026-27, so the ongoing savings are in the range of $11.2 million General Fund annually.
- People who qualify for Medicaid or CHP+ could still get services. They would just need to complete the application.
- People not qualifying for Medicaid or CHP+ would have higher income. They may have access to insurance through an employer. People with income up to 400 percent of the

federal poverty guidelines could get tax credits to purchase insurance through the exchange.
- Children already receive continuous eligibility for one year.

Eligibility interruptions may disrupt preventive care or reduce adherence to treatment, leading to lower health outcomes. For example, children might miss immunizations or developmental screenings. Adults after incarceration might skip treatments for behavioral health or for chronic conditions. Continuous eligibility after incarceration may impact recidivism. Reducing churn reduces eligibility determination workloads at counties.

House Bill 23-1300 included funding for staff, but their workload is primarily driven by other components of the bill and the associated federal waiver, rather than these specific eligibility expansions. The staff recommendation assumes no decrease in administration. Staff assumes the Department can absorb programming costs to prevent eligibility and claims system changes associated with the expansion from turning on in January 2026.

Stop continuous eligibility expansions				
Item	Total Funds	General Fund	Cash Funds - HAS Fee	Federal Funds
FY 2025-26				
Children 0-3	-$11,791,862	-$5,469,302	-$205,959	-$6,116,601
Adults leaving carceral settings	-1,812,641	-143,869	-152,479	-1,516,293
Total	-$13,604,503	-$5,613,171	-$358,438	-$7,632,894
FY 2026-27				
Children 0-3	-$23,583,725	-$10,938,604	-$411,918	-$12,233,203
Adults leaving carceral settings	-3,625,285	-287,739	-304,959	-3,032,587
Total	-$27,209,010	-$11,226,343	-$716,877	-$15,265,790

The Department strongly prefers to pause the continuous eligibility expansions until budget conditions improve. These expansions are part of a larger federal waiver with several initiatives that will increase federal funds and improve care. The waiver has already been approved. Work done to date would be lost. Ending the continuous eligibility expansions would require reopening the waiver and the Department is concerned that might result in different approval decisions under the current administration.

Some key parts of the waiver the Department worries could be at risk include:

- Additional federal funds for housing and related social needs (HRSN)
- Additional federal funds for reentry services for people leaving correctional settings
- Increasing the 15-day reimbursement limit on stays in institutions for mental diseases
- Presumptive eligibility for people seeking home- and community-based services

The Department's arguments do not change the staff recommendation. First, the JBC staff has tried to avoid making recommendations in this document based on speculation about changes in federal policy. If the JBC wants to go down that road, then the budget resolution passed by the House suggests a need for far more severe eligibility and benefit reductions than stopping these eligibility expansions that have not yet been implemented. Second, if the federal government wants to revisit previously approved waivers, it can do that with or without the

excuse that Colorado wants to stop these narrow eligibility expansions that draw a federal match. Finally, the JBC staff does not understand why the Department thinks budget conditions will improve if the General Assembly is only pausing programs, rather than ending them.

If the JBC finds the Department's arguments compelling, the JBC could pause the eligibility expansions, rather than ending them. The JBC staff would recommend pausing them for four years, but not because the federal administration will change. Rather, four years is the longest possible pause before the Department needs to implement all the provisions included in the federal waiver. Maybe by then budget conditions will improve.

The JBC staff believes the best option for Colorado is to end the expansion. Therefore, the recommendation is to ask federal permission for the thing that is best for Colorado. The state has no control over whether the federal government wants to undo previous agreements. If that is going to happen, it could happen with or without a request to stop these eligibility expansions.

➔ Community health workers [legislation]

Staff recommends legislation to stop the Department from implementing reimbursement of community health workers. The recommendation saves $11.8 million total funds, including $2.8 million General Fund. This new reimbursement has not yet been implemented, so stopping it would not take away existing benefits. The Department expects to implement it in July 2025. There is some overlap with work already done through the Accountable Care Collaborative (ACC).

Service costs are expected to increase in future years. The Fiscal Note assumed demand exceeds the supply of providers. Also, the Fiscal Note assumed more people will get credentialed to provide services as the program becomes established. The Fiscal Note projected General Fund costs will increase to $3.2 million in FY 2026-27 and continue increasing in future years.

Senate Bill 23-002 authorized the reimbursements and delegated authority to the Department to determine the specific covered services and required credentials. The bill defines a community health worker as a liaison between health and social service providers and community members to facilitate access and improve the quality and cultural responsiveness of service delivery. At a minimum, the Department must seek federal approval to reimburse for preventive services, group and individual health education and health coaching, health navigation, transitions of care supports, screenings and assessments for nonclinical and social needs, and individual support and health advocacy.

According to the Department's web site, community health workers provide health system navigation to help people engage with providers, adhere to treatment plans, self-manage chronic conditions, understand and access benefits, mitigate health barriers, and improve social determinants of health. They offer health promotion and coaching that trains people in setting health goals and creating action plans. They provide health education and training to raise awareness of research-supported methods for avoiding illness and lessening its effects.

Both the community health workers and the ACC are tasked with providing health system navigation and resource coordination. The Department says this is a primary function of the community health workers but a lower level priority of the ACC, which is shifting resources to focus on higher level transitions of care and inpatient readmission reduction. The Department describes health system navigation and resource coordination as helping to engage, re-engage, or ensure member-led follow-up in primary care, routine preventive care, adherence to treatment plans, and/or self-management of chronic conditions, including assisting beneficiaries to access covered services and other community resources necessary to promote health, address health care barriers and health related social needs.

Without this reimbursement, the availability of services is not expected to increase and it may decrease. To the extent the services are currently available, it is usually through the ACC, volunteering, charity, or grant funding, including time-limited federal grants available during the pandemic.

The Department says training programs across the state have pivoted to a community health worker specific program to comply with SB23-002 and in anticipation of Medicaid coverage. Training programs approved by the Department of Public Health and Environment include Fort Lewis College, Metro State University, Colorado School of Public Health, and the Center on Aging (CU School of Medicine).

Stop reimbursement for community health workers					
Item	Total Funds	General Fund	Cash Funds - HAS Fee	Federal Funds	FTE
Personal Services	-$98,246	-$49,123	$0	-$49,123	-1.0
Health, life, dental	-11,000	-5,500	0	-5,500	0.0
Short-term disability	-139	-69	0	-70	0.0
Paid Family and Medical Leave Insurance	-391	-195	0	-196	0.0
Amortization Equalization Disbursement Payments	-8,693	-4,346	0	-4,347	0.0
Operating Expenses	-1,350	-675	0	-675	0.0
Medicaid Management Information System	-180,000	-18,000	0	-162,000	0.0
Medical Services Premiums	-11,426,689	-2,729,115	-685,499	-8,012,075	0.0
Total	-$11,726,508	-$2,807,023	-$685,499	-$8,233,986	-1.0

➔ Continuous glucose monitoring [legislation]

Staff recommends legislation to stop a statutorily required expansion of conditions where the Department would cover continuous glucose monitors. The recommendation saves $278,683 General Fund in FY 2025-26 and $836,008 General Fund in FY 2026-27 and ongoing. The Department has not yet implemented the expanded benefit. The Department expects to implement it in November 2025. The Department already covers continuous glucose monitors for people who need constant monitoring.[13] The Department is not aware of any access to care issues with the current coverage.

[13] The Department's coverage includes Type I diabetes and people needing multiple daily insulin treatments and frequent insulin adjustments, which includes some people with higher acuity Type II and gestational diabetes:

Senate Bill 24-168 required the Department to expand coverage to align with Medicare. The Department's current coverage provides continuous glucose monitoring for all people with diabetes, approximately 30 percent of people with Type II diabetes, approximately 20 percent of people with gestational diabetes, and no members with only problematic blood sugar. The bill expands coverage to lower acuity populations with Type II diabetes, gestational diabetes, or problematic blood sugar. The Departments says these populations are not insulin dependent to the extent that requires continuous monitoring.

The Department expects low uptake of the expanded benefit. However, the eligible population is large, so even low uptake drives costs. The Fiscal Note projected 64,000 members would become eligible but only 2,717 would use the expanded benefit in the first year, growing to 5,434 in the second year.

This balancing option originally appeared in the JBC staff briefing and got included in the Governor's January 2, 2025, proposal for balancing.

➔ Remote patient monitoring [legislation]

Staff recommends legislation to stop new reimbursements for remote patient monitoring that are required by S.B. 24-168. The recommendation saves $260,733 General Fund in FY 2025-26, increasing to $336,293 General Fund in FY 2026-27 and on-going. The Department has not yet implemented the new payments. The Department expects to begin reimbursements in July 2025. The primary reason for the recommendation is that the Department has not yet implemented the reimbursements, and so stopping them does not remove existing benefits. Also, the benefit expansion is narrow. The Fiscal Note assumed it would impact 620 members in the first year.

For people receiving long-term home health, the Department already covers monitoring of patients through specialized equipment left in the member's home. Senate Bill 24-168 expanded the coverage to include people with diabetes, chronic obstructive pulmonary disease, heart failure, asthma, or pneumonia with at least 2 related inpatient or emergency room visits. The Department covers telehealth without the remote monitoring equipment for all patients.

The bill authorized a related grant program (described below) but the legislature could choose to stop one without stopping the other.

Without this funding, members would need to travel for care. Changes in health status could not be checked in real time. Adherence to treatment and health outcomes might decline.

This was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast.

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https://hcpf.colorado.gov/DMEPOS-manual#Therapeutic%20Continuous%20Glucose%20Monitor%20%28CGM%29%20Benefit%20Coverage

➔ Health benefits for children lacking access due to immigration status [legislation]

Staff recommends legislation to end the health benefits for children lacking access due to immigration status. The recommendation saves $19.2 million General Fund in FY 2025-26 and $32.1 million General Fund in FY 2026-27 and on-going. House Bill 22-1289 required the Department to cover children who would otherwise qualify for Medicaid or CHP+ except for their immigration status. The benefits and client costs mirror Medicaid and CHP+. The recommendation is based on the following:

- This is a new program.
- There is no federal match.
- The lower income end of the population would still qualify for emergency services under Medicaid.
- The Department projects much higher expenditures than assumed in the Fiscal Note.
- There is significant uncertainty and risk that the current projections might be too high or too low.

Federal law requires Medicaid to cover emergency services for people who would otherwise qualify except for their immigration status. CHP+ does not provide similar coverage. Although the population could access emergency services without this program, they couldn't get government support for primary and non-emergent specialty care or pharmaceuticals. Without this program, the population might go without care, seek charity care through safety net providers, or maybe get care through an employer.

The Department projects that the original Fiscal Note significantly understated the cost. The Department increased enrollment projections based on uptake rates for a similar program in Oregon and enrollment trends to date. In advance of the January 2025 implementation, the Department began passively enrolling people who qualified for emergency services under Medicaid within the last year who would not qualify for standard Medicaid or CHP+ due to immigration status. As of January 31, 2025, there were 9,934 children enrolled, compared to 1,344 children assumed in the Fiscal Note. Service costs were $2,732,794 for just January 2025, compared to the estimate in the Fiscal Note of $2,102,664 for the entire fiscal year. The Department decreased the expected per capita costs compared to the Fiscal Note but not nearly enough to offset the higher projected enrollment. Would the legislature have made different choices about the program if the Fiscal Note had been 7.5 times higher?

HB 22-1289 Service Costs for Children

Item	FY 2024-25	FY 2025-26
Fiscal Note	$2,102,664	$4,360,863
November 2024 Projection	$16,037,803	$32,075,606
Difference	$13,935,139	$27,714,743

There is significant uncertainty about service costs. The Department lacks traditional demographic and expenditure data for projections due to the immigration status of the population. Recent political developments may change both the population entering the United

States and the states where they choose to move. Statute requires the Department to pay the cost of the program, regardless of the original appropriation, and provides overexpenditure authority if enrollment or utilization is higher than the projection. Eliminating or capping the program would reduce uncertainty in expenditures.

The JBC staff assumes the Department would need until September 2025 to end the program, due to the time required for eligibility system changes. Service costs would continue for approximately one month after the end date, due to the lag between when services are delivered and paid. The Department would incur costs to remove outdated coding in the billing systems, too, but those could occur after the eligibility system changes. There would be nominal savings in Department staff and county administration, but those would not occur until FY 2025-26. The JBC staff is working on separating out the portion of the funding for administration included H.B. 22-1289 that was specifically related to the new benefit for children versus the other components of the bill.

The table below summarizes the staff recommendation and provides two alternatives that are described below the table.

Health benefits for children lacking access			
Item	FY 2025-26	FY 2026-27	FY 2027-28
Current Law			
Service Costs	$32,075,606	$32,075,606	$32,075,606
System Costs			
Eligibility	0	0	0
Billing	0	0	0
Total	$32,075,606	$32,075,606	$32,075,606
End the Program			
Assumed implementation	Sep-25		
Service Costs	-$21,383,737	-$32,075,606	-$32,075,606
System Costs			
Eligibility	328,320	0	0
Billing	1,860,208	0	0
Total	-$19,195,209	-$32,075,606	-$32,075,606
Cap Enrollment (est. 12,000)			
Assumed implementation	Sep-25		
Service Costs	-$969,668	-$1,454,502	-$1,454,502
System Costs			
Eligibility	508,345	0	0
Billing	0	0	0
Total	-$461,323	-$1,454,502	-$1,454,502
Cap Benefit (e.g. 4 visits per year)			
Assumed implementation		Mar-27	
Service Costs	$0	-$5,442,486	-$21,769,944
System Costs			
Eligibility	383,850	383,850	
Billing	1,143,352	1,143,352	

Health benefits for children lacking access			
Item	FY 2025-26	FY 2026-27	FY 2027-28
Total	$1,527,202	-$3,915,284	-$21,769,944

The alternative to the staff recommendation that would be easiest and quickest for the Department to implement would be an enrollment cap. The cost estimate above assumes that the Department implements an enrollment cap by September 2025 and that the enrollment is approximately 12,000 children. This option saves significantly less than the staff recommendation in FY 2025-26 and on-going. The General Assembly could increase the on-going savings by lowering the enrollment cap over time by not allowing new children to enroll as slots become available until the enrollment reaches a target threshold.

Another alternative to the staff recommendation would be to cap the benefits. This could produce significant savings in the long run, but it would be labor and time intensive to implement. There are a wide variety of ways the General Assembly could configure the benefit and the JBC staff did not attempt to estimate them all. Instead, the JBC staff asked the Department for an option that would keep the costs in line with the original Fiscal Note. The Department netted the projected increase in costs for children with the projected decrease in costs for pregnant women and determined that it would need to cut $21.8 million from the children's benefit. The Department estimates that limiting the coverage to four primary care or dental visits per year would reduce the expenditures to the level identified in the Fiscal Note.

The JBC staff identified two potential ways to mitigate the negative impacts on the clients and providers, though neither would remotely offset the loss of full insurance coverage.

First, the Department suggested increasing community benefit requirements for hospitals through the Hospital Transformation Program. This would make some of the HAS Fee supplemental payments contingent on hospitals working with clinic partners to increase charitable primary and specialty care to this population. In other words, the General assembly could create an unfunded mandate on hospitals to increase charitable primary care and specialty care. Maybe this concept could be paired with a state directed payment program to add some money for the hospitals alongside the new mandate.

Second, the JBC staff looked at increasing General Fund for the Primary Care Fund. An increase in General Fund for the Primary Care Fund would decrease the savings from ending the benefit, but appropriations to the Primary Care Fund can draw a federal match.

An increase in the Primary Care Fund could offset the impact on some providers of a decrease in the health benefits for children. It would not help hospitals, but hospitals get supplemental payments through the HAS Fee to offset uncompensated care and emergency services are already covered for immigrants as a mandatory benefit under Medicaid. It would not help specialty care providers. The clients would not have insurance and be dependent on charity care. That would likely reduce utilization, including the use of preventive services. The clients would need to cover their own prescription drug costs.

The Primary Care Fund mostly helps Federally Qualified Health Center (FQHCs). FQHCs represent a minority of care costs for this population. However, very preliminary data from the

first month suggests these specific clients get their care at FQHCs more often than children in the general Medicaid population.

The Primary Care Fund receives 19 percent of increased tobacco taxes. All of the money gets distributed annually to qualified providers. To qualify, a provider must be an FQHC or serve a majority of low income clients. This basic outline is in the Constitution and can't be changed without a vote. There is some additional detail in the statutes that could be changed. In FY 2021-22, the State started drawing a 50% federal match for the payments from the Primary Care Fund to Medicaid providers. Not all the recipients are Medicaid providers. Last year, there was one recipient (Open Bible Baptist Church in Colorado Springs) that was not a Medicaid provider. In FY 2023-24, the GA started supplementing the tobacco tax money that goes to the Primary Care Fund with General Fund.

The Primary Care Fund cannot match more federal funds than the cost of uncompensated care incurred by the recipients. HCPF knows the number of uninsured clients, but not the total cost of care. Based on the average visits per year, the Department estimates the cap on additional payments that could draw a federal match would be in the range of $88 million total funds ($44 million General Fund).

More information on the Primary Care Fund and who received funding in FY 2024-25 is available from the Department's web site.

In addition to services for children, H.B. 22-1289 expanded coverage for pregnant and postpartum women. The Department received a federal waiver to include the pregnant and postpartum women on Medicaid. The Department projects a net savings from reduced emergency services for the newly covered pregnant and postpartum women. Therefore, the JBC did not propose removing the new eligibility for pregnant and postpartum women as a budget balancing option.

➔ Equine services [legislation]

Staff recommends legislation to take ponies away from kids. The recommendation saves $396,029 total funds, including $198,014 General Fund. This is not a standard benefit under private insurance or Medicare and it serves a narrow population.

Hippotherapy uses a horse's movement to help develop and enhance motor skills, self-regulation, communication opportunities, and social and emotional well-being. House Bill 22-1068 required the Department to expand coverage of hippotherapy from two home- and community-based services (HCBS) waivers to the state plan. Under the HCBS waivers, the Department served 97 people in FY 2023-24. With the H.B. 22-1068 expansion, the Department projects to serve approximately 161 people annually. Most of the utilizers are children, although the services are available to adults. The Department pays $32.14 per 15 minutes for hippotherapy. The projected savings are based on stopping the coverage, rather than reverting to the coverage prior to H.B. 22-1068.

The Department says significant evidence supports that hippotherapy is beneficial. Also, evidence supports that other therapies covered under Medicaid improve motor skills, self-regulation, communication opportunities, and social and emotional well-being. Hippotherapy is

not a standard physical therapy, occupational therapy, or speech therapy covered under private insurance or Medicare. The benefit impacts a small number of clients and providers. It is not a core Medicaid service.

This is a difficult recommendation that the JBC staff takes seriously. Do not mistake the gallows humor for flippancy. Instead, the JBC staff intends to illustrate, in an evocative and memorable way, the absurdity of the choices available. Adopting the staff recommendation requires a bill and literally denying ponies to children. For all that political and emotional pain, it generates a mere $200 thousand in General Fund savings. And yet, the JBC staff views this as better than many of the alternatives available to the JBC. Based on the Governor's February 18, 2025, letter, the Office of State Planning and Budgeting agrees.

For similar savings, would you rather take ponies from children or cut OeHI and take computers from rural doctors? The computers are not as warm and fuzzy as ponies and the rural doctors are not as sweet and innocent as children. Computers in the hands of rural doctors impact more care. These are the Sophie's choice options available to the JBC. To be clear, the JBC staff recommends taking both the OeHI and equine services savings.

Ending equine services was included in the Governor's February 18, 2025, letter providing budget balancing options for addressing the increase in the Medicaid forecast.

(1) Executive Director's Office

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Healthcare Affordability and Sustainability Fee.

Executive Director's Office						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$596,323,495	$144,985,105	$79,044,148	$17,763,782	$354,530,460	801.4
Long Bill supplemental	$1,604,495	-$1,524,663	$790,013	$0	$2,339,145	0.0
Total FY 2024-25	$597,927,990	$143,460,442	$79,834,161	$17,763,782	$356,869,605	801.4
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$597,927,990	$143,460,442	$79,834,161	$17,763,782	$356,869,605	801.4
R6 Accountable Care Collaborative	3,050,000	709,485	449,765	0	1,890,750	0.0
R7a County escalation resolution unit	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0

Executive Director's Office						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
R7c CBMS development	214,909	-62,623	-29,592	43,582	263,542	0.0
R7d County eligibility administration	0	0	0	0	0	0.0
R8 Claims systems reprocurement	1,419,969	137,661	71,135	0	1,211,173	16.6
R10 HAS Fee admin & refinance	-5,081,811	-2,142,757	-398,148	0	-2,540,906	2.7
R11a CIH waiver	0	0	0	0	0	0.0
R11b Hospital backup unit expansion	234,155	58,539	0	0	175,616	0.0
R11e Supported employment for IDD	350,000	35,000	0	0	315,000	0.0
R13 Contract true up	991,470	356,062	39,673	0	595,735	0.0
R14 Convert contracts to FTE	-509,065	-66,999	-37,018	-186,227	-218,821	8.3
BA7 HRSN & reentry services	0	0	0	0	0	0.0
BA8 Technical adjustments	0	0	0	0	0	0.0
BA9 DOJ Settlement Agreement	815,803	472,957	0	0	342,846	10.2
BA10 Youth system of care	0	0	0	0	0	0.0
BA11 ARPA HCBS adjustments	614,008	0	569,481	0	44,527	0.0
BA12 Med transport reviews	-576,505	-172,951	-115,301	0	-288,253	0.0
BA14 All-Payer Claims Database	390,156	-929,943	685,936	0	634,163	0.0
BA17 Personal services reduction	-856,421	-371,429	-56,781	0	-428,211	-10.0
NP Equity Office realignment	74,921	74,921	0	0	0	0.0
Annualize prior year budget actions	-21,465,032	-6,098,850	-5,043,323	-41,569	-10,281,290	-42.5
Centralized appropriations	8,276,609	803,400	2,315,473	-97,745	5,255,481	0.0
Transfers to other state agencies	0	0	0	0	0	0.0
Indirect cost adjustment	-178,207	178,207	1,112	-231,098	-126,428	0.0
Temporary employees for leave	-5,944	-2,414	-383	-112	-3,035	0.0
Prepayment claims reviews	3,660,470	1,587,546	242,689	0	1,830,235	2.0
OeHI	2,596,190	0	0	0	2,596,190	0.0
Total FY 2025-26	$591,943,665	$138,026,254	$78,528,879	$17,250,613	$358,137,919	788.7
Changes from FY 2024-25	-$5,984,325	-$5,434,188	-$1,305,282	-$513,169	$1,268,314	-12.7
Percentage Change	-1.0%	-3.8%	-1.6%	-2.9%	0.4%	-1.6%
FY 2025-26 Executive Request	$631,309,648	$145,592,298	$83,153,767	$19,502,736	$383,060,847	819.2
Staff Rec. Above/-Below Request	-$39,365,983	-$7,566,044	-$4,624,888	-$2,252,123	-$24,922,928	-30.5

Line Item Detail

(A) General Administration

This subdivision contains the appropriations for the Department's FTE, employee-related expenses and benefits, operating expenses, and general contract services. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

Centrally Appropriated Line Items (set by JBC common policy)

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases, the common policy allocates costs to agencies for a centralized service based on prior year actual utilization of that service by the department. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items in this subdivision that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

Request: The Department requests funding adjustments based on the Governor's common policy requests.

Recommendation: Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below, including the way benefits for new FTE are handled. Note that the JBC's common policy was pending for some of the line items at the time this document was prepared. The amounts included in the numbers pages and department and division summary tables for the pending items are based on the request and will be updated to reflect the JBC's actions.

Centrally Appropriated Line Items
Health, Life, and Dental
Short-term Disability
Paid Family and medical Leave Insurance
Unfunded Liability Amortization Equalization Disbursement Payments
Salary Survey
Step Pay
PERA Direct Distribution
Workers' Compensation
Legal Services
Administrative Law Judge Services
Payments to Risk Management and Property Funds
Payments to OIT
CORE Operations

Personal Services

This line item contains the personal services for the Department's employees, including employee salaries and the employer contributions to PERA and Medicare taxes. Also, the line item includes funding for temporary employees, employee buy-outs, and some contract services. However, most of the Department's professional contract service costs are contained in separate line items.

Statutory authority: Section 25.5-1-104 et. seq., C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. The recommendation includes an adjustment

to the fund sources to align with the available revenue from indirect cost recoveries, based on the statewide indirect cost plan approved by the JBC.

Executive Director's Office, General Administration, Personal Services						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$73,536,395	$27,232,388	$7,611,802	$3,153,686	$35,538,519	798.4
Total FY 2024-25	$73,536,395	$27,232,388	$7,611,802	$3,153,686	$35,538,519	798.4
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$73,536,395	$27,232,388	$7,611,802	$3,153,686	$35,538,519	798.4
Centralized appropriations	1,900,577	816,490	113,274	8,932	961,881	0.0
R8 Claims systems reprocurement	1,278,661	123,690	63,917	0	1,091,054	16.6
BA11 ARPA HCBS adjustments	1,273,720	0	636,149	0	637,571	0.0
BA9 DOJ Settlement Agreement	974,536	377,209	0	0	597,327	10.2
BA8 Technical adjustments	834,248	358,393	49,721	3,921	422,213	0.0
R14 Convert contracts to FTE	539,301	84,654	48,141	163,628	242,878	8.3
R10 HAS Fee admin & refinance	236,669	0	118,335	0	118,334	2.7
Prepayment claims reviews	144,570	62,700	9,585	0	72,285	2.0
NP Equity Office realignment	73,571	73,571	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
R7c CBMS development	0	0	0	0	0	0.0
Indirect cost adjustment	0	178,207	0	-178,207	0	0.0
BA10 Youth system of care	0	0	0	0	0	0.0
R11a CIH waiver	0	0	0	0	0	0.0
R7a County escalation resolution unit	0	0	0	0	0	0.0
BA7 HRSN & reentry services	0	0	0	0	0	0.0
Annualize prior year budget actions	-4,792,825	126,610	-2,534,535	3,921	-2,388,821	-42.5
BA17 Personal services reduction	-605,521	-262,615	-40,146	0	-302,760	-10.0
Total FY 2025-26	$75,393,902	$29,171,297	$6,076,243	$3,155,881	$36,990,481	785.7
Changes from FY 2024-25	$1,857,507	$1,938,909	-$1,535,559	$2,195	$1,451,962	-12.7
Percentage Change	2.5%	7.1%	-20.2%	0.1%	4.1%	-1.6%
FY 2025-26 Executive Request	$77,712,005	$29,455,997	$6,708,491	$3,223,836	$38,323,681	816.2
Staff Rec. Above/-Below Request	-$2,318,103	-$284,700	-$632,248	-$67,955	-$1,333,200	-30.5

Operating expenses

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Statutory Authority: Section 25.5-1-104, C.R.S.

Staff recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, General Administration, Operating Expenses						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$3,323,116	$1,331,689	$307,042	$61,415	$1,622,970	0.0
Total FY 2024-25	$3,323,116	$1,331,689	$307,042	$61,415	$1,622,970	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$3,323,116	$1,331,689	$307,042	$61,415	$1,622,970	0.0
R8 Claims systems reprocurement	141,308	13,971	7,218	0	120,119	0.0
R14 Convert contracts to FTE	68,202	10,099	5,683	21,293	31,127	0.0
R10 HAS Fee admin & refinance	23,466	25,122	-13,389	0	11,733	0.0
Prepayment claims reviews	15,900	6,896	1,054	0	7,950	0.0
NP Equity Office realignment	1,350	1,350	0	0	0	0.0
R7c CBMS development	0	0	0	0	0	0.0
BA10 Youth system of care	0	0	0	0	0	0.0
R11a CIH waiver	0	0	0	0	0	0.0
R7a County escalation resolution unit	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
BA7 HRSN & reentry services	0	0	0	0	0	0.0
Annualize prior year budget actions	-214,600	-48,572	-41,379	-32,637	-92,012	0.0
BA9 DOJ Settlement Agreement	-55,594	-18,446	0	0	-37,148	0.0
BA11 ARPA HCBS adjustments	-8,818	0	-3,374	0	-5,444	0.0
BA17 Personal services reduction	-7,350	-3,188	-487	0	-3,675	0.0
Total FY 2025-26	$3,286,980	$1,318,921	$262,368	$50,071	$1,655,620	0.0
Changes from FY 2024-25	-$36,136	-$12,768	-$44,674	-$11,344	$32,650	0.0
Percentage Change	-1.1%	-1.0%	-14.5%	-18.5%	2.0%	n/a
FY 2025-26 Executive Request	$3,574,015	$1,374,974	$323,374	$57,946	$1,817,721	0.0
Staff Rec. Above/-Below Request	-$287,035	-$56,053	-$61,006	-$7,875	-$162,101	0.0

Leased Space

This line item pays for the Department's leased space at 303 E. 17th Ave.

Statutory Authority: Section 25.5-1-104, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, General Administration, Leased Space						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$3,785,963	$1,497,656	$357,434	$38,849	$1,892,024	0.0
Total FY 2024-25	$3,785,963	$1,497,656	$357,434	$38,849	$1,892,024	0.0
FY 2025-26 Recommended Appropriation						

Executive Director's Office, General Administration, Leased Space						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation	$3,785,963	$1,497,656	$357,434	$38,849	$1,892,024	0.0
BA9 DOJ Settlement Agreement	46,911	18,393	0	0	28,518	0.0
R8 Claims systems reprocurement	0	0	0	0	0	0.0
R10 HAS Fee admin & refinance	0	-35,967	35,967	0	0	0.0
R14 Convert contracts to FTE	0	0	0	0	0	0.0
BA10 Youth system of care	0	0	0	0	0	0.0
R7a County escalation resolution unit	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
R7c CBMS development	0	0	0	0	0	0.0
BA11 ARPA HCBS adjustments	0	0	-5	0	5	0.0
BA7 HRSN & reentry services	0	0	0	0	0	0.0
Annualize prior year budget actions	-114,069	14,125	-71,159	0	-57,035	0.0
BA17 Personal services reduction	-46,500	-20,167	-3,083	0	-23,250	0.0
Total FY 2025-26	$3,672,305	$1,474,040	$319,154	$38,849	$1,840,262	0.0
Changes from FY 2024-25	-$113,658	-$23,616	-$38,280	$0	-$51,762	0.0
Percentage Change	-3.0%	-1.6%	-10.7%	0.0%	-2.7%	n/a
FY 2025-26 Executive Request	$3,956,898	$1,212,263	$677,206	$52,366	$2,015,063	0.0
Staff Rec. Above/-Below Request	-$284,593	$261,777	-$358,052	-$13,517	-$174,801	0.0

General Professional Services and Special Projects

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Nursing Home Penalties, and the IDD Services Cash Fund. The federal match rate varies based on the specific contracts.

Statutory Authority: Section 25.5-1-104, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, General Administration, General Professional Services and Special Projects						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$42,607,300	$15,114,152	$3,948,972	$81,000	$23,463,176	0.0
Long Bill supplemental	-1,938,600	-484,650	0	0	-1,453,950	0.0
Total FY 2024-25	$40,668,700	$14,629,502	$3,948,972	$81,000	$22,009,226	0.0

Executive Director's Office, General Administration, General Professional Services and Special Projects						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$40,668,700	$14,629,502	$3,948,972	$81,000	$22,009,226	0.0
Prepayment claims reviews	3,500,000	1,517,950	232,050	0	1,750,000	0.0
R6 Accountable Care Collaborative	2,100,000	649,635	400,365	0	1,050,000	0.0
R10 HAS Fee admin & refinance	450,000	0	225,000	0	225,000	0.0
R11e Supported employment for IDD	350,000	35,000	0	0	315,000	0.0
R13 Contract true up	18,580	9,290	0	0	9,290	0.0
BA10 Youth system of care	0	0	0	0	0	0.0
R7a County escalation resolution unit	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
R7c CBMS development	0	0	0	0	0	0.0
BA7 HRSN & reentry services	0	0	0	0	0	0.0
Annualize prior year budget actions	-5,065,656	-2,147,834	-1,068,947	0	-1,848,875	0.0
BA11 ARPA HCBS adjustments	-798,098	0	-39,639	0	-758,459	0.0
BA12 Med transport reviews	-576,505	-172,951	-115,301	0	-288,253	0.0
R14 Convert contracts to FTE	-249,804	-77,439	-47,463	0	-124,902	0.0
BA9 DOJ Settlement Agreement	-50,000	-25,000	0	0	-25,000	0.0
Total FY 2025-26	$40,347,217	$14,418,153	$3,535,037	$81,000	$22,313,027	0.0
Changes from FY 2024-25	-$321,483	-$211,349	-$413,935	$0	$303,801	0.0
Percentage Change	-0.8%	-1.4%	-10.5%	0.0%	1.4%	n/a
FY 2025-26 Executive Request	$44,109,124	$15,387,438	$3,860,278	$81,000	$24,780,408	0.0
Staff Rec. Above/-Below Request	-$3,761,907	-$969,285	-$325,241	$0	-$2,467,381	0.0

(B) Information Technology Contracts and Projects

Medicaid Management Information System Maintenance and Projects

This line item pays for maintenance and development of the Medicaid Management Information System (MMIS). MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives a 65 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

Statutory Authority: Section 25.5-4-204, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$109,284,939	$18,284,124	$9,357,439	$12,204	$81,631,172	0.0
Total FY 2024-25	$109,284,939	$18,284,124	$9,357,439	$12,204	$81,631,172	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$109,284,939	$18,284,124	$9,357,439	$12,204	$81,631,172	0.0
R6 Accountable Care Collaborative	950,000	59,850	49,400	0	840,750	0.0
BA11 ARPA HCBS adjustments	247,200	0	24,720	0	222,480	0.0
R11b Hospital backup unit expansion	234,155	58,539	0	0	175,616	0.0
R10 HAS Fee admin & refinance	0	-1,264,646	1,264,646	0	0	0.0
Annualize prior year budget actions	-5,451,561	-2,103,779	-24,616	0	-3,323,166	0.0
BA9 DOJ Settlement Agreement	-523,299	-52,330	0	0	-470,969	0.0
Total FY 2025-26	$104,741,434	$14,981,758	$10,671,589	$12,204	$79,075,883	0.0
Changes from FY 2024-25	-$4,543,505	-$3,302,366	$1,314,150	$0	-$2,555,289	0.0
Percentage Change	-4.2%	-18.1%	14.0%	0.0%	-3.1%	n/a
FY 2025-26 Executive Request	$104,741,434	$16,246,404	$9,406,943	$12,204	$79,075,883	0.0
Staff Rec. Above/-Below Request	$0	-$1,264,646	$1,264,646	$0	$0	0.0

CBMS Operating and Contract Expenses

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

Statutory Authority: Section 25.5-5-101, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$78,835,873	$13,150,314	$7,112,800	$13,892,091	$44,680,668	0.0
Total FY 2024-25	$78,835,873	$13,150,314	$7,112,800	$13,892,091	$44,680,668	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$78,835,873	$13,150,314	$7,112,800	$13,892,091	$44,680,668	0.0
R10 HAS Fee admin & refinance	1,058,652	-119,680	649,006	0	529,326	0.0
R7c CBMS development	214,909	-62,623	-29,592	43,582	263,542	0.0
BA9 DOJ Settlement Agreement	16,816	1,682	0	0	15,134	0.0
BA8 Technical adjustments	0	0	0	0	0	0.0
R7b S.B. 22-235 implementation	0	0	0	0	0	0.0
R14 Convert contracts to FTE	-866,764	-84,313	-43,379	-371,148	-367,924	0.0
Annualize prior year budget actions	-721,830	-492,133	85,081	0	-314,778	0.0
Total FY 2025-26	$78,537,656	$12,393,247	$7,773,916	$13,564,525	$44,805,968	0.0
Changes from FY 2024-25	-$298,217	-$757,067	$661,116	-$327,566	$125,300	0.0
Percentage Change	-0.4%	-5.8%	9.3%	-2.4%	0.3%	n/a
FY 2025-26 Executive Request	$89,998,092	$13,037,445	$8,004,878	$15,667,388	$53,288,381	0.0
Staff Rec. Above/-Below Request	-$11,460,436	-$644,198	-$230,962	-$2,102,863	-$8,482,413	0.0

CBMS Health Care and Economic Security Staff Development Center

This line item pays for the Colorado Benefits Management System's staff development center that provides training to users of CBMS, including other state departments, the 64 county departments of social/human services, medical assistance sites, and presumptive eligibility and certified application assistance sites for Medicaid and CHP+.

Statutory Authority: Section 25.5-5-101, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$2,172,998	$689,160	$383,151	$73	$1,100,614	0.0
Total FY 2024-25	$2,172,998	$689,160	$383,151	$73	$1,100,614	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$2,172,998	$689,160	$383,151	$73	$1,100,614	0.0
Annualize prior year budget actions	594	297	0	0	297	0.0
R7c CBMS development	0	0	0	0	0	0.0
R10 HAS Fee admin & refinance	0	3,896	-3,896	0	0	0.0

Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Total FY 2025-26	$2,173,592	$693,353	$379,255	$73	$1,100,911	0.0
Changes from FY 2024-25	$594	$4,193	-$3,896	$0	$297	0.0
Percentage Change	0.0%	0.6%	-1.0%	0.0%	0.0%	n/a
FY 2025-26 Executive Request	$2,748,849	$764,142	$395,860	$73	$1,588,774	0.0
Staff Rec. Above/-Below Request	-$575,257	-$70,789	-$16,605	$0	-$487,863	0.0

Office of eHealth Innovations Operations

This line item pays for the operations of the Office of eHealth Innovations, created by Executive Order B 2015-008, to provide advice and guidance on advancing health information technology. The Department serves as the fiscal agent for procurement, contracting, accounting, and payments to vendors.

Statutory Authority: Section 25.5-1-205, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Information Technology Contracts and Projects, Office of eHealth Innovations Operations						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$6,465,845	$3,372,367	$0	$0	$3,093,478	3.0
Long Bill supplemental	-250,000	-250,000	0	0	0	0.0
Total FY 2024-25	$6,215,845	$3,122,367	$0	$0	$3,093,478	3.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$6,215,845	$3,122,367	$0	$0	$3,093,478	3.0
OeHI	2,596,190	0	0	0	2,596,190	0.0
Transfers to other state agencies	0	0	0	0	0	0.0
R10 HAS Fee admin & refinance	0	-671,985	671,985	0	0	0.0
Total FY 2025-26	$8,812,035	$2,450,382	$671,985	$0	$5,689,668	3.0
Changes from FY 2024-25	$2,596,190	-$671,985	$671,985	$0	$2,596,190	0.0
Percentage Change	41.8%	-21.5%	n/a	n/a	83.9%	0.0%
FY 2025-26 Executive Request	$8,029,825	$3,763,362	$0	$0	$4,266,463	3.0
Staff Rec. Above/-Below Request	$782,210	-$1,312,980	$671,985	$0	$1,423,205	0.0

All-Payer Claims Database

This line item helps subsidize operations of the All-Payer Claims Database. A portion of the line item for Medicaid's share of costs receives a federal match. The line item also includes

$500,000 General Fund for a scholarship program to promote access to the All-Payer Claims Database.

Statutory Authority: Section 25.5-1-204 (4)(b), C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Information Technology Contracts and Projects, All-Payer Claims Database						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$5,435,778	$4,471,011	$0	$0	$964,767	0.0
Long Bill supplemental	$3,793,095	$0	$0	$0	$3,793,095	0.0
Total FY 2024-25	$9,228,873	$4,471,011	$0	$0	$4,757,862	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$9,228,873	$4,471,011	$0	$0	$4,757,862	0.0
BA14 All-Payer Claims Database	390,156	-929,943	685,936	0	634,163	0.0
Total FY 2025-26	$9,619,029	$3,541,068	$685,936	$0	$5,392,025	0.0
Changes from FY 2024-25	$390,156	-$929,943	$685,936	$0	$634,163	0.0
Percentage Change	4.2%	-20.8%	n/a	n/a	13.3%	n/a
FY 2025-26 Executive Request	$12,642,781	$6,901,743	$0	$0	$5,741,038	0.0
Staff Rec. Above/-Below Request	-$3,023,752	-$3,360,675	$685,936	$0	-$349,013	0.0

(C) Eligibility Determinations and Client Services

Contracts for Special Eligibility Determinations

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital. The source of cash funds is the HAS Fee.

Statutory Authority: Sections 25.5-4-105, 25.5-6-104, 25.5-4-205, and 25.5-4-402.4 (3)(a), C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$12,039,555	$1,134,071	$4,338,468	$0	$6,567,016	0.0
Total FY 2024-25	$12,039,555	$1,134,071	$4,338,468	$0	$6,567,016	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$12,039,555	$1,134,071	$4,338,468	$0	$6,567,016	0.0
R13 Contract true up	400,000	100,000	0	0	300,000	0.0
R10 HAS Fee admin & refinance	-6,850,598	0	-3,425,299	0	-3,425,299	0.0
Total FY 2025-26	$5,588,957	$1,234,071	$913,169	$0	$3,441,717	0.0
Changes from FY 2024-25	-$6,450,598	$100,000	-$3,425,299	$0	-$3,125,299	0.0
Percentage Change	-53.6%	8.8%	-79.0%	n/a	-47.6%	n/a
FY 2025-26 Executive Request	$5,188,957	$1,134,071	$913,169	$0	$3,141,717	0.0
Staff Rec. Above/-Below Request	$400,000	$100,000	$0	$0	$300,000	0.0

County Administration

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds. The federal match is 75 percent match for maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

Statutory Authority: Sections 25.5-1-120 through 122, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, County Administration						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$123,048,230	$21,004,349	$26,624,750	$0	$75,419,131	0.0
Total FY 2024-25	$123,048,230	$21,004,349	$26,624,750	$0	$75,419,131	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$123,048,230	$21,004,349	$26,624,750	$0	$75,419,131	0.0
R7d County eligibility administration	0	0	0	0	0	0.0
Annualize prior year budget actions	-9,552,670	-2,371,182	-618,991	0	-6,562,497	0.0
Total FY 2025-26	$113,495,560	$18,633,167	$26,005,759	$0	$68,856,634	0.0

Executive Director's Office, Eligibility Determinations and Client Services, County Administration						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Changes from FY 2024-25	-$9,552,670	-$2,371,182	-$618,991	$0	-$6,562,497	0.0
Percentage Change	-7.8%	-11.3%	-2.3%	n/a	-8.7%	n/a
FY 2025-26 Executive Request	$134,495,560	$21,257,016	$30,361,711	$0	$82,876,833	0.0
Staff Rec. Above/-Below Request	-$21,000,000	-$2,623,849	-$4,355,952	$0	-$14,020,199	0.0

Medical Assistance Sites

This line item provides funding for on-location Medicaid eligibility determination activities. The sites offer additional points of contact for Medicaid eligibility determination and eligibility workers are stationed at places such as schools, clinics, and hospitals in order to assist clients. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet

Statutory Authority: Section 25.5-1-120, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Administrative Case Management

This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

Statutory Authority: Sections 25.5-1-120 through 122, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Customer Outreach

This line item provides funding for outreach and case management for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program promotes access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the HAS Fee. The federal match rate is 50.0 percent.

Statutory Authority: Sections 25.5-5-102 (1)(g) and 25.5-5-406 (1)(a)(II), C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, Customer Outreach						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$3,461,519	$1,394,139	$336,621	$0	$1,730,759	0.0
Total FY 2024-25	$3,461,519	$1,394,139	$336,621	$0	$1,730,759	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$3,461,519	$1,394,139	$336,621	$0	$1,730,759	0.0
R10 HAS Fee admin & refinance	0	-253,049	253,049	0	0	0.0
Total FY 2025-26	$3,461,519	$1,141,090	$589,670	$0	$1,730,759	0.0
Changes from FY 2024-25	$0	-$253,049	$253,049	$0	$0	0.0
Percentage Change	0.0%	-18.2%	75.2%	n/a	0.0%	n/a
FY 2025-26 Executive Request	$3,461,519	$1,394,139	$336,621	$0	$1,730,759	0.0
Staff Rec. Above/-Below Request	$0	-$253,049	$253,049	$0	$0	0.0

Centralized Eligibility Vendor Contract

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

Statutory Authority: Section 25.5-4-102 and 402.4, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Connect for Health Colorado Eligibility Determinations

This line item reimburses Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

Statutory Authority: Section 25.5-1-120, C.R.S.

Request: The Department requests annualizations of prior year budget actions.

Recommendation: Staff recommends the requested funding.

Eligibility Overflow Processing Center

This line item pays for a contract to handle eligibility determination backlogs for Medicaid and CHP+.

Statutory Authority: Section 25.5-1-120, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, Eligibility Overflow Processing Center						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$1,904,677	$285,320	$190,849	$0	$1,428,508	0.0
Total FY 2024-25	$1,904,677	$285,320	$190,849	$0	$1,428,508	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$1,904,677	$285,320	$190,849	$0	$1,428,508	0.0
R10 HAS Fee admin & refinance	0	28,618	-28,618	0	0	0.0
Total FY 2025-26	$1,904,677	$313,938	$162,231	$0	$1,428,508	0.0
Changes from FY 2024-25	$0	$28,618	-$28,618	$0	$0	0.0
Percentage Change	0.0%	10.0%	-15.0%	n/a	0.0%	n/a
FY 2025-26 Executive Request	$1,904,677	$285,320	$190,849	$0	$1,428,508	0.0
Staff Rec. Above/-Below Request	$0	$28,618	-$28,618	$0	$0	0.0

Returned Mail Processing

This line item pays for the centralized processing of returned mail for public assistance programs administered by both the Department and the Department of Human Services.

Statutory Authority: Section 25.5-1-120, C.R.S.

Request: The Department requests continuation funding.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, Returned Mail Processing						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$3,298,808	$985,808	$244,919	$111,942	$1,956,139	0.0
Total FY 2024-25	$3,298,808	$985,808	$244,919	$111,942	$1,956,139	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$3,298,808	$985,808	$244,919	$111,942	$1,956,139	0.0
R10 HAS Fee admin & refinance	0	-199,928	199,928	0	0	0.0
Total FY 2025-26	$3,298,808	$785,880	$444,847	$111,942	$1,956,139	0.0
Changes from FY 2024-25	$0	-$199,928	$199,928	$0	$0	0.0
Percentage Change	0.0%	-20.3%	81.6%	0.0%	0.0%	n/a

Executive Director's Office, Eligibility Determinations and Client Services, Returned Mail Processing						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Executive Request	$3,298,808	$985,808	$244,919	$111,942	$1,956,139	0.0
Staff Rec. Above/-Below Request	$0	-$199,928	$199,928	$0	$0	0.0

Income Verification Programs

This line item pays for a contract to provide electronic verification of income.

Statutory Authority: Section 25.5-4-205, C.R.S.

Request: The Department requests an adjustment related to R8 and a line item name change to "Income Verification Programs".

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Executive Director's Office, Eligibility Determinations and Client Services, Income Verification Programs						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$11,341,713	$1,741,440	$1,093,988	$0	$8,506,285	0.0
Total FY 2024-25	$11,341,713	$1,741,440	$1,093,988	$0	$8,506,285	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$11,341,713	$1,741,440	$1,093,988	$0	$8,506,285	0.0
R10 HAS Fee admin & refinance	0	127,958	-127,958	0	0	0.0
Total FY 2025-26	$11,341,713	$1,869,398	$966,030	$0	$8,506,285	0.0
Changes from FY 2024-25	$0	$127,958	-$127,958	$0	$0	0.0
Percentage Change	0.0%	7.3%	-11.7%	n/a	0.0%	n/a
FY 2025-26 Executive Request	$11,341,713	$1,741,440	$1,093,988	$0	$8,506,285	0.0
Staff Rec. Above/-Below Request	$0	$127,958	-$127,958	$0	$0	0.0

Non-emergent Medical Transportation Broker

This line item was created in the supplemental bill for FY 2024-25 to better track expenditures for the regional non-emergent medical transportation broker and the Department's planned transition to a statewide broker. This funding was previously included in Medical Services Premiums. The source of cash funds is the HAS Fee.

Statutory Authority:

Recommendation: Staff recommends continuation funding.

(D) Utilization and Quality Review Contracts

Professional Services Contracts

This line item contains the professional contracts related to reviewing acute care utilization, long-term care utilization, external quality review, and drug utilization review. These contracts ensure that the benefits and services provided to Medicaid clients are medically necessary and appropriate.

Acute care utilization performs prior authorization review for services such as audiology, pediatric behavioral therapy, diagnostic imaging, durable medical equipment (DME), speech therapy, inpatient out-of-state admissions, medical services including transplant and bariatric surgeries, physical and occupational therapy, pediatric long-term home health (LTHH), private duty nursing, certain office administered drugs, and vision. The federal match rate is 75.0 percent.

Long-term care utilization review includes prior authorization reviews to determine medical necessity, level of care, and target population determinations. It also includes periodic reevaluations of services. The federal match for the majority of services is 75.0 percent.

External quality review performs reviews to validate performance improvement projects, conduct compliance site reviews, conduct satisfaction surveys, collect and validate Healthcare Effectiveness Data and Information Set (HEDIS) measures and other performance measures for managed-care organizations and fee-for-service providers, and complete other encounter data audits. The federal match rate is 75.0 percent.

Drug utilization review performs prior authorization reviews, retrospective reviews, and provider education to ensure appropriate drug therapy according to explicit predetermined standards.

Statutory Authority: Sections 25.5-5-405, 506, and 411, C.R.S.

Recommendation: The staff recommendations are summarized in the table below. See the discussion of the decision items for more detail.

Executive Director's Office, Utilization and Quality Review Contracts, Professional Service Contracts

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$29,644,825	$7,910,405	$2,223,661	$0	$19,510,759	0.0
Total FY 2024-25	$29,644,825	$7,910,405	$2,223,661	$0	$19,510,759	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$29,644,825	$7,910,405	$2,223,661	$0	$19,510,759	0.0
Annualize prior year budget actions	8,394,005	2,098,501	0	0	6,295,504	0.0
Total FY 2025-26	$38,038,830	$10,008,906	$2,223,661	$0	$25,806,263	0.0
Changes from FY 2024-25	$8,394,005	$2,098,501	$0	$0	$6,295,504	0.0

Executive Director's Office, Utilization and Quality Review Contracts, Professional Service Contracts						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Percentage Change	28.3%	26.5%	0.0%	n/a	32.3%	n/a
FY 2025-26 Executive Request	$38,038,830	$10,008,906	$2,223,661	$0	$25,806,263	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

(E) Provider Audits and Services

Professional Audit Contracts

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.
- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.
- Community mental health audits -- Annual audits of the Community Mental Health Centers
- Regional Center Cost Reporting and Auditing – Cost reports to ensure Regional Centers are properly compensated according to their actual costs
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.
- Managed Care Organization Audits -- Audits on financial reports and encounter data from physical and behavioral health managed care organizations that are used in rate setting and federal compliance.
- Primary Care Program – These audits improve performance and ensure sound fiscal management of the Primary Care Program.

The sources of cash funds are the Hospital Provider Fee, Nursing Facility Fee, CHP+ Trust, and Primary Care Fund. The federal match rate is 50.0 percent.

Statutory Authority: Sections 25.5-6-201 and 202, 25.5-6-204, 25.5-4-401 (1)(a), 25.5-4-402, 25.5-5-408 (1)(d), 25.5-6-106, 25.5-6-107, 25.5-4-105, and 25.5-4-402.4 (3)(a), C.R.S.

Request: The Department requests annualizations of prior year budget decisions.

Recommendation: The staff recommended changes are summarized in the table below. See the description of the decision items for more detail.

Executive Director's Office, Provider Audits and Services, Professional Audit Contracts						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$4,135,919	$1,598,629	$540,301	$0	$1,996,989	0.0
Total FY 2024-25	$4,135,919	$1,598,629	$540,301	$0	$1,996,989	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$4,135,919	$1,598,629	$540,301	$0	$1,996,989	0.0
R13 Contract true up	572,890	246,772	39,673	0	286,445	0.0
Total FY 2025-26	$4,708,809	$1,845,401	$579,974	$0	$2,283,434	0.0
Changes from FY 2024-25	$572,890	$246,772	$39,673	$0	$286,445	0.0
Percentage Change	13.9%	15.4%	7.3%	n/a	14.3%	n/a
FY 2025-26 Executive Request	$4,708,809	$1,885,074	$540,301	$0	$2,283,434	0.0
Staff Rec. Above/-Below Request	$0	-$39,673	$39,673	$0	$0	0.0

(F) Recoveries and Recoupments

Estate Recovery

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

Statutory Authority: Section 25.5-4-301, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Third-Party Liability Cost Avoidance Contract

This line item pays for a contract to identify third party health coverage that takes precedence before Medicaid claims.

Statutory Authority: Section 25.5-4-301 (4) through (6), C.R.S.

Recommendation: Staff recommends the requested continuation funding.

(G) Indirect Cost Recoveries

Statewide Indirect Cost Assessment

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB).

Statutory Authority: Section 24-75-112, C.R.S.

Recommendation: Staff recommends the request based on the indirect cost plan approved by the JBC.

Executive Director's Office, Indirect Cost Assessment, Indirect Cost Assessment						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$1,059,807	$0	$276,775	$132,407	$650,625	0.0
Total FY 2024-25	$1,059,807	$0	$276,775	$132,407	$650,625	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$1,059,807	$0	$276,775	$132,407	$650,625	0.0
Indirect cost adjustment	-178,207	0	1,112	-52,891	-126,428	0.0
Total FY 2025-26	$881,600	$0	$277,887	$79,516	$524,197	0.0
Changes from FY 2024-25	-$178,207	$0	$1,112	-$52,891	-$126,428	0.0
Percentage Change	-16.8%	na/	0.4%	-39.9%	-19.4%	n/a
FY 2025-26 Executive Request	$881,600	$0	$277,887	$79,516	$524,197	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

(2) Medical Services Premiums

This division provides funding for physical health and most long-term services and supports for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term services and supports for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with

health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$12,086,735,818	$3,625,759,766	$1,400,058,793	$119,588,730	$6,941,328,529	0.0
Long Bill supplemental	$371,869,517	$42,480,360	$24,058,119	$0	$305,331,038	0.0
Total FY 2024-25	$12,458,605,335	$3,668,240,126	$1,424,116,912	$119,588,730	$7,246,659,567	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$12,458,605,335	$3,668,240,126	$1,424,116,912	$119,588,730	$7,246,659,567	0.0
R1 Medical Services Premiums	804,806,948	220,272,801	76,666,621	0	507,867,526	0.0
Annualize prior year budget actions	77,622,622	35,090,320	-9,398,726	0	51,931,028	0.0
R6 Accountable Care Collaborative	29,615,110	9,517,143	1,186,189	0	18,911,778	0.0
Transfers to other state agencies	692,960	346,480	0	0	346,480	0.0
BA9 DOJ Settlement Agreement	539,339	237,309	0	0	302,030	0.0
Community First Choice	0	-47,770,663	0	0	47,770,663	0.0
R16 CF transfers & enterprise	0	0	0	0	0	0.0
R11a CIH waiver	0	0	0	0	0	0.0
BA12 Med transport reviews	0	0	0	0	0	0.0
SBIRT training grants	0	-1,500,000	1,500,000	0	0	0.0
NP CU School of Medicine	0	0	20,000,000	-20,000,000	0	0.0
R9/R15/BA16 Provider rates	-106,064,233	-28,189,914	-15,462,936	0	-62,411,383	0.0
Prepayment claims reviews	-19,600,000	-7,208,806	-927,940	0	-11,463,254	0.0
BA10 Youth system of care	-13,074,000	-6,537,000	0	0	-6,537,000	0.0
BA11 ARPA HCBS adjustments	-12,358,071	0	-7,526,065	0	-4,832,006	0.0
Adult dental annual cap	-8,481,669	0	-2,153,665	0	-6,328,004	0.0
R12 BH and primary care integration	-7,717,826	-1,803,688	-576,581	0	-5,337,557	0.0
Update payment rules	-6,594,299	-1,978,290	-461,601	0	-4,154,408	0.0
Aspheric lenses pending rule	-5,526,506	-2,763,253	0	0	-2,763,253	0.0
BA7 HRSN & reentry services	-3,989,322	-810,511	-236,796	0	-2,942,015	0.0
R11b Hospital backup unit expansion	-1,073,442	-536,721	0	0	-536,721	0.0
R11c Alternative Care Facilities rates	-717,626	-358,813	0	0	-358,813	0.0
Total FY 2025-26	$13,186,685,320	$3,834,246,520	$1,486,725,412	$99,588,730	$7,766,124,658	0.0
Changes from FY 2024-25	$728,079,985	$166,006,394	$62,608,500	-$20,000,000	$519,465,091	0.0
Percentage Change	5.8%	4.5%	4.4%	-16.7%	7.2%	n/a
FY 2025-26 Executive Request	$12,912,351,147	$3,848,282,969	$1,456,014,509	$99,588,730	$7,508,464,939	0.0
Staff Rec. Above/-Below Request	$274,334,173	-$14,036,449	$30,710,903	$0	$257,659,719	0.0

Line Item Detail

Medical and Long-term Care Services for Medicaid Eligible Individuals

This line item provides funding for physical health and most long-term care services for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term care services for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. This is the only line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

Statutory Authority: Section 25.5-5-101 et seq., C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$12,086,735,818	$3,625,759,766	$1,400,058,793	$119,588,730	$6,941,328,529	0.0
Long Bill supplemental	$371,869,517	$42,480,360	$24,058,119	$0	$305,331,038	0.0
Total FY 2024-25	$12,458,605,335	$3,668,240,126	$1,424,116,912	$119,588,730	$7,246,659,567	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$12,458,605,335	$3,668,240,126	$1,424,116,912	$119,588,730	$7,246,659,567	0.0
R1 Medical Services Premiums	804,806,948	220,272,801	76,666,621	0	507,867,526	0.0
Annualize prior year budget actions	77,622,622	35,090,320	-9,398,726	0	51,931,028	0.0
R6 Accountable Care Collaborative	29,615,110	9,517,143	1,186,189	0	18,911,778	0.0
Transfers to other state agencies	692,960	346,480	0	0	346,480	0.0
BA9 DOJ Settlement Agreement	539,339	237,309	0	0	302,030	0.0
Community First Choice	0	-47,770,663	0	0	47,770,663	0.0
R16 CF transfers & enterprise	0	0	0	0	0	0.0
R11a CIH waiver	0	0	0	0	0	0.0
BA12 Med transport reviews	0	0	0	0	0	0.0
SBIRT training grants	0	-1,500,000	1,500,000	0	0	0.0
NP CU School of Medicine	0	0	20,000,000	-20,000,000	0	0.0
R9/R15/BA16 Provider rates	-106,064,233	-28,189,914	-15,462,936	0	-62,411,383	0.0
Prepayment claims reviews	-19,600,000	-7,208,806	-927,940	0	-11,463,254	0.0
BA10 Youth system of care	-13,074,000	-6,537,000	0	0	-6,537,000	0.0
BA11 ARPA HCBS adjustments	-12,358,071	0	-7,526,065	0	-4,832,006	0.0

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Adult dental annual cap	-8,481,669	0	-2,153,665	0	-6,328,004	0.0
R12 BH and primary care integration	-7,717,826	-1,803,688	-576,581	0	-5,337,557	0.0
Update payment rules	-6,594,299	-1,978,290	-461,601	0	-4,154,408	0.0
Aspheric lenses pending rule	-5,526,506	-2,763,253	0	0	-2,763,253	0.0
BA7 HRSN & reentry services	-3,989,322	-810,511	-236,796	0	-2,942,015	0.0
R11b Hospital backup unit expansion	-1,073,442	-536,721	0	0	-536,721	0.0
R11c Alternative Care Facilities rates	-717,626	-358,813	0	0	-358,813	0.0
Total FY 2025-26	$13,186,685,320	$3,834,246,520	$1,486,725,412	$99,588,730	$7,766,124,658	0.0
Changes from FY 2024-25	$728,079,985	$166,006,394	$62,608,500	-$20,000,000	$519,465,091	0.0
Percentage Change	5.8%	4.5%	4.4%	-16.7%	7.2%	n/a
FY 2025-26 Executive Request	$12,912,351,147	$3,848,282,969	$1,456,014,509	$99,588,730	$7,508,464,939	0.0
Staff Rec. Above/-Below Request	$274,334,173	-$14,036,449	$30,710,903	$0	$257,659,719	0.0

(5) Indigent Care Program

The division contains funding for the safety net provider payments, pediatric specialty hospital payments, the Primary Care Fund Program, the Children’s Basic Health Plan, and other safety net provider payments. These programs and payments are designed to serve Colorado’s underinsured, uninsured, or otherwise medically indigent populations. The sources of cash funds are the Hospital Provider Fee, tobacco tax money, tobacco settlement money, enrollment fees for the Children's Basic Health Plan, and recoveries and recoupments. The tobacco tax money primarily goes through the Primary Care Fund to provide primary care grants. The tobacco settlement money primarily goes through the Children's Basic Health Plan Trust.

Indigent Care Program					
Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2024-25 Appropriation					
FY 2024-25 Appropriation	$570,781,464	$58,345,271	$185,189,877	$327,246,316	0.0
Long Bill supplemental	$6,039,786	$4,842,484	-$2,728,559	$3,925,861	0.0
Total FY 2024-25	$576,821,250	$63,187,755	$182,461,318	$331,172,177	0.0
FY 2025-26 Recommended Appropriation					
FY 2024-25 Appropriation	$576,821,250	$63,187,755	$182,461,318	$331,172,177	0.0
R3 Child Health Plan Plus	31,742,387	8,995,528	2,114,307	20,632,552	0.0
Annualize prior year budget actions	-10,415,656	-5,802,934	207,455	-4,820,177	0.0
Total FY 2025-26	$598,147,981	$66,380,349	$184,783,080	$346,984,552	0.0
Changes from FY 2024-25	$21,326,731	$3,192,594	$2,321,762	$15,812,375	0.0
Percentage Change	3.7%	5.1%	1.3%	4.8%	0.0%
FY 2025-26 Executive Request	$582,036,678	$57,440,357	$188,084,116	$336,512,205	0.0
Staff Rec. Above/-Below Request	$16,111,303	$8,939,992	-$3,301,036	$10,472,347	0.0

Line Item Detail

This line item provides funding to partially reimburse hospitals for uncompensated and undercompensated care provided through the federal Disproportionate Share Hospital (DSH) payments. The hospitals offer discounted care on a sliding scale based on income to people with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. This is NOT an insurance program with defined benefits for the clients. Providers may choose what services beyond emergency care that they will offer to clients. The source of cash funds is the Healthcare Affordability and Sustainability Fee and the federal match rate is at the standard Medicaid match.

Statutory authority: Sections 25.5-3-108 (1) through (5), 25.5-3-104, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Pediatric Specialty Hospital Payments

The line item provides supplemental payments to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides funding for the Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six-years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

Statutory Authority: Section 24-22-117 (1)(c)(I)(B), C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Appropriation from Tobacco Tax Fund to General Fund

Statue requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund and then 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

Statutory Authority: Section 24-22-117(1)(c)(I)(A), C.R.S.; Section 24-22-117(1)(c)(I)(B.5), C.R.S.

Recommendation: Staff requests permission to adjust this line item based on the March revenue forecast selected by the JBC for budget balancing, and permission to make the corresponding adjustment to fund sources in the Children's Basic Health Plan line item.

Primary Care Fund

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The Primary Care Fund receives 19 percent of tobacco tax collections annually.

Statutory Authority: Section 25.5-3-301 through 303, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. Notably, the change includes a reduction of $13.0 million total funds, including $6.5 million General Fund, to reflect the end of one-time funding provided by the General Assembly in FY 2024-25. Staff requests permission to adjust this line item based on the March revenue forecast selected by the JBC for budget balancing.

Indigent Care Program, Primary Care Fund

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$49,079,682	$6,500,000	$18,175,554	$0	$24,404,128	0.0
Total FY 2024-25	$49,079,682	$6,500,000	$18,175,554	$0	$24,404,128	0.0

Indigent Care Program, Primary Care Fund						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$49,079,682	$6,500,000	$18,175,554	$0	$24,404,128	0.0
Annualize prior year budget actions	-13,000,000	-6,500,000	0	0	-6,500,000	0.0
Total FY 2025-26	$36,079,682	$0	$18,175,554	$0	$17,904,128	0.0
Changes from FY 2024-25	-$13,000,000	-$6,500,000	$0	$0	-$6,500,000	0.0
Percentage Change	-26.5%	-100.0%	0.0%	n/a	-26.6%	n/a
FY 2025-26 Executive Request	$36,079,682	$0	$18,175,554	$0	$17,904,128	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Children's Basic Health Plan (CHP+) Administration

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System. The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee.

contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients. Auxiliary administrative functions are contracted out separately to various vendors for professional services such as actuarial analysis, claims audit, quality assurance, and the consumer assessment of healthcare providers and systems (CAHPS) survey. The actuarial analysis is used to update capitation rates and project claims that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services collect Health Plan Employer Data and Information Set (HEDIS) quality data. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey provides information on client satisfaction to comply with federal requirements.

Statutory Authority: Section 25.5-8-111 and 107, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Children's Basic Health Plan Medical and Dental Costs

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

If actual expenditures run higher than the forecast based on the eligibility criteria and plan benefits, the budget is usually adjusted. However, states have more options and flexibility

under CHP+ rules to keep costs within the budget than under Medicaid rules. Correspondingly, the statutes provide less overexpenditure authority for CHP+ than for Medicaid. Pursuant to Section 24-75-109(1)(a.5), C.R.S. the Department can make unlimited overexpenditures from cash fund sources, including the CHP+ Trust Fund, but annual overexpenditures from the General Fund are capped at $250,000.

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced rate indexed to the standard state match, except that no federal match is provided for enrollment fees. The projected federal match for FY 2025-26 is 65 percent.

Statutory Authority: Section 25.5-8-107 et seq., C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$277,481,023	$45,117,765	$52,065,593	$0	$180,297,665	0.0
Long Bill supplemental	$6,039,786	$4,842,484	-$2,728,559	$0	$3,925,861	0.0
Total FY 2024-25	$283,520,809	$49,960,249	$49,337,034	$0	$184,223,526	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$283,520,809	$49,960,249	$49,337,034	$0	$184,223,526	0.0
R3 Child Health Plan Plus	31,742,387	8,995,528	2,114,307	0	20,632,552	0.0
Annualize prior year budget actions	2,584,344	697,066	207,455	0	1,679,823	0.0
Total FY 2025-26	$317,847,540	$59,652,843	$51,658,796	$0	$206,535,901	0.0
Changes from FY 2024-25	$34,326,731	$9,692,594	$2,321,762	$0	$22,312,375	0.0
Percentage Change	12.1%	19.4%	4.7%	n/a	12.1%	n/a
FY 2025-26 Executive Request	$301,736,237	$50,712,851	$54,959,832	$0	$196,063,554	0.0
Staff Rec. Above/-Below Request	$16,111,303	$8,939,992	-$3,301,036	$0	$10,472,347	0.0

(6) Other Medical Services

This division contains the funding for miscellaneous other expenditures, such as:

- the state's obligation under the Medicare Modernization Act for prescription drug benefits for people dually eligible for Medicare and Medicaid;
- certified public expenditure financing for public school health services; and
- funding for health training programs.

The division also includes funding for health programs that are not Medicaid or CHP+, such as:

- health benefits for children lacking access due to immigration status;
- the Old Age Pension State-Only Medical Program;
- senior dental program
- reproductive health for individuals not eligible for Medicaid; and
- various grant programs.

The sources of cash funds include certified public expenditures by school districts, the Old Age Pension Health and Medical Fund, and the Marijuana Tax Cash Fund. The source of reappropriated funds is a transfer from the Department of Higher Education for the Commission on Family Medicine.

Other Medical Services						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$513,141,186	$275,890,858	$120,787,947	$225,000	$116,237,381	0.0
Long Bill supplemental	$657,001	$657,001	$0	$0	$0	0.0
Total FY 2024-25	$513,798,187	$276,547,859	$120,787,947	$225,000	$116,237,381	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$513,798,187	$276,547,859	$120,787,947	$225,000	$116,237,381	0.0
R1b Health benefits for children lacking access due to immigration status	13,779,605	13,779,605	0	0	0	0.0
R4 Medicare Modernization Act	30,389,662	30,389,662	0	0	0	0.0
BA11 ARPA HCBS adjustments	842,626	0	842,626	0	0	0.0
BA13 Public school health services	-21,188,422	0	-9,978,112	0	-11,210,310	0.0
Annualize prior year budget actions	-3,084,428	-2,241,802	-842,626	0	0	0.0
Remote monitoring tech grants	-500,000	-500,000	0	0	0	0.0
SBIRT training grants	-1,500,000	0	-1,500,000	0	0	0.0
Total FY 2025-26	$532,537,230	$317,975,324	$109,309,835	$225,000	$105,027,071	0.0
Changes from FY 2024-25	$18,739,043	$41,427,465	-$11,478,112	$0	-$11,210,310	0.0
Percentage Change	3.6%	15.0%	-9.5%	0.0%	-9.6%	0.0%
FY 2025-26 Executive Request	$530,625,974	$314,564,068	$110,809,835	$225,000	$105,027,071	0.0
Staff Rec. Above/-Below Request	$1,911,256	$3,411,256	-$1,500,000	$0	$0	0.0

Old Age Pension State Medical Program

This line item funds health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases using a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund.

With the expansion of Medicaid that was authorized in S.B. 13-200, a large portion of the people eligible for an old age pension are also eligible for Medicaid. All $10.0 million of the constitutional allocation of sales tax is appropriated in this line item to ensure the funds are available to serve eligible people who do not qualify for Medicaid. Any funds left over are

reappropriated to the Medical Services Premiums line item to offset the need for General Fund in that line item for people who are dually eligible for Medicaid and the Old Age Pension Health and Medical Program.

The Department pays providers for the Old Age Pension Health and Medical Program based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation. With most of the clients now dually eligible for both Medicaid and the Old Age Pension Health and Medical Program, the Department has been able to pay for services at 100 percent of the Medicaid rates.

Statutory Authority: Article XXIV, Section 7, Colorado Constitution; Section 25.5-2-101, C.R.S.; Section 25.5-3-401 et seq., C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Senior Dental Program

This line item pays for grants to dental providers to serve low-income seniors who do not otherwise have access to dental care through Medicaid, the Old Age Pension Health and Medical Program, or private insurance. The grants for dental services through the Colorado Dental Program for Low-income Seniors are financed with General Fund.

Statutory Authority: Section 25.5-3-401 through 406, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Commission on Family Medicine

This line item provides payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). The funding in this line item goes directly to the residency programs, with the exception of funds to support and develop rural family medicine residency programs pursuant to S.B 14-144. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

Statutory Authority: Section 25-1-902 (1) and 903 (1)(c), C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Medicare Modernization Act State Contribution Payment

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual

payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, in some prior years the General Assembly applied federal bonus payments received for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

Statutory Authority: Section 25.5-4-105, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Other Medical Services, Medicare Modernization Act State Contribution Payment						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$241,755,970	$241,755,970	$0	$0	$0	0.0
Long Bill supplemental	$657,001	$657,001	$0	$0	$0	0.0
Total FY 2024-25	$242,412,971	$242,412,971	$0	$0	$0	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$242,412,971	$242,412,971	$0	$0	$0	0.0
R4 Medicare Modernization Act	30,389,662	30,389,662	0	0	0	0.0
Total FY 2025-26	$272,802,633	$272,802,633	$0	$0	$0	0.0
Changes from FY 2024-25	$30,389,662	$30,389,662	$0	$0	$0	0.0
Percentage Change	12.5%	12.5%	n/a	n/a	n/a	n/a
FY 2025-26 Executive Request	$268,891,377	$268,891,377	$0	$0	$0	0.0
Staff Rec. Above/-Below Request	$3,911,256	$3,911,256	$0	$0	$0	0.0

Public School Health Services Contract Administration; and

Public School Health Services

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children with disabilities who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under-, or uninsured children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for

administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts. The Public School Health Services line item represents the payments to the school districts and boards of cooperative education services.

Statutory Authority: Section 25.5-5-318, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Other Medical Services, Public School Health Services						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$219,752,395	$0	$109,260,099	$0	$110,492,296	0.0
Total FY 2024-25	$219,752,395	$0	$109,260,099	$0	$110,492,296	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$219,752,395	$0	$109,260,099	$0	$110,492,296	0.0
BA13 Public school health services	-21,188,422	0	-9,978,112	0	-11,210,310	0.0
Total FY 2025-26	$198,563,973	$0	$99,281,987	$0	$99,281,986	0.0
Changes from FY 2024-25	-$21,188,422	$0	-$9,978,112	$0	-$11,210,310	0.0
Percentage Change	-9.6%	#VALUE!	-9.1%	n/a	-10.1%	n/a
FY 2025-26 Executive Request	$198,563,973	$0	$99,281,987	$0	$99,281,986	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

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

This line item pays for grants to organizations to provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The source of cash funds is the Marijuana Tax Cash Fund.

Statutory Authority: Sections 25.5-5-208, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$1,500,000	$0	$1,500,000	$0	$0	0.0
Total FY 2024-25	$1,500,000	$0	$1,500,000	$0	$0	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$1,500,000	$0	$1,500,000	$0	$0	0.0
SBIRT training grants	-1,500,000	0	-1,500,000	0	0	0.0
Total FY 2025-26	$0	$0	$0	$0	$0	0.0
Changes from FY 2024-25	-$1,500,000	$0	-$1,500,000	$0	$0	0.0
Percentage Change	-100.0%	#VALUE!	-100.0%	n/a	n/a	n/a
FY 2025-26 Executive Request	$1,500,000	$0	$1,500,000	$0	$0	0.0
Staff Rec. Above/-Below Request	-$1,500,000	$0	-$1,500,000	$0	$0	0.0

Reproductive Health Care for Individuals Not Eligible for Medicaid

This line funds reproductive health care for people not eligible for Medicaid only because of their citizenship or immigration status.

Statutory Authority: Sections 25.5-1-201, C.R.S.

Recommendation: Staff recommends the requested continuation funding.

Denver Health and Hospital Authority

This line item provides funding to support the financial stability of Denver Health.

Statutory Authority: Sections 25.5-4-427, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Other Medical Services, Denver Health and Hospital Authority						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$5,000,000	$5,000,000	$0	$0	$0	0.0
Total FY 2024-25	$5,000,000	$5,000,000	$0	$0	$0	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$5,000,000	$5,000,000	$0	$0	$0	0.0
Annualize prior year budget actions	-5,000,000	-5,000,000	0	0	0	0.0
Total FY 2025-26	$0	$0	$0	$0	$0	0.0
Changes from FY 2024-25	-$5,000,000	-$5,000,000	$0	$0	$0	0.0

Other Medical Services, Denver Health and Hospital Authority						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Percentage Change	-100.0%	-100.0%	n/a	n/a	n/a	n/a
FY 2025-26 Executive Request	$0	$0	$0	$0	$0	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Health Benefits for Children Lacking Access Due to Immigration Status

This line item provides look-alike coverage to Medicaid and the Children's Basic Health Plan (CHP+) for low-income children regardless of immigration status.

Statutory Authority: Sections 25.5-2-104 and 105, C.R.S.

Recommendation: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

Other Medical Services, Health Benefits for Children Lacking Access Due to Immigration Statuts						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
FY 2024-25 Appropriation	$16,037,803	$16,037,803	$0	$0	$0	0.0
Total FY 2024-25	$16,037,803	$16,037,803	$0	$0	$0	0.0
FY 2025-26 Recommended Appropriation						
FY 2024-25 Appropriation	$16,037,803	$16,037,803	$0	$0	$0	0.0
R1b Health benefits for children lacking access due to immigration status	13,779,605	13,779,605	0	0	0	0.0
Annualize prior year budget actions	2,258,198	2,258,198	0	0	0	0.0
Total FY 2025-26	$32,075,606	$32,075,606	$0	$0	$0	0.0
Changes from FY 2024-25	$16,037,803	$16,037,803	$0	$0	$0	0.0
Percentage Change	100.0%	100.0%	n/a	n/a	n/a	n/a
FY 2025-26 Executive Request	$32,075,606	$32,075,606	$0	$0	$0	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

(7) Transfers to Other State Department Medicaid-Funded Programs

This section contains funding for programs administered by other departments that are funded with Medicaid dollars. General Fund is appropriated in this section, matched with anticipated federal funds, and then transferred to the other departments, where the Medicaid funds are reflected as reappropriated funds. The majority of the money goes to the Department of Human Services.

Recommendation: Staff requests permission to update the appropriations in this section based on the JBC's figure setting decisions for the departments administering these programs.

Long Bill Footnotes

Staff recommends **continuing and modifying** the following footnotes.

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

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System. The footnote allows the Department to respond when service needs shift between operations and the staff development center.

24 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses; Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2025-26 state fiscal year.

Comment: This long-standing footnote provides roll-forward authority for a limited portion of the appropriations for the Colorado Benefits Management System (CBMS). Contract payments for CBMS often unexpectedly cross fiscal years based on when the contractors complete key milestones. In addition, the flexibility helps the Department respond to unplanned events, like bugs or new legislative requirements.

29 Department of Health Care Policy and Financing, Transfers to Other State Department Medicaid-Funded Programs, Human Services, Executive Director's Office -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the headnotes to the Long Bill, the Department of Human Services may transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing may make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

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

30 Department of Health Care Policy and Financing, Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $900,000 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $107,671,715, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $107,671,715 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

Comment: This footnote explains the General Assembly's assumptions about supplemental payments to the University of Colorado School of Medicine. Staff requests permission to update the footnote based on the JBC's decisions regarding funding for the University of Colorado School of Medicine.

Staff recommends **eliminating** the following footnotes.

24a Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- This appropriation includes $12,676 total funds, including $6,338 General Fund, for the purpose of increasing provider rates for maternal care to $800 for billing code S0199, $1,000 for billing code 59840, and $1,600 for billing code 59841.

Comment: This footnote explains the purpose of the appropriation to increase provider rates for certain maternal care codes. The Department complied with the footnote and it is no longer needed.

28 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., in accordance with the requirements set forth in that section.

Comment: The footnote explains the purpose of the appropriation to support the grant program for screening, brief intervention, and referral to treatment for individuals at risk of

substance abuse. Consistent with the staff recommendation to eliminate the grant program, the JBC staff recommends removing the footnote.

Requests for Information

Staff recommends **continuing and modifying** the following requests for information.

Requests Affecting Multiple Departments

3 Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1 each year.

Comment: The request for information holds the University of Colorado accountable for the public benefits agreed to in exchange for receiving the increased federal matching funds through this interagency agreement.

Health Care Policy and Financing

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

Comment: This long-standing request for information provides useful information for tracking Medicaid expenditures and caseload through the year.

4 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The

report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted the report as requested. The full report is available from the Department's website for Legislative Requests for Information.

When schools provide health services to public school children with disabilities, as required by federal and state law, and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, and specialized non-emergency transportation services. In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

Appendix A: Numbers Pages

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
Kim Bimestefer, Executive Director						
(1) EXECUTIVE DIRECTOR'S OFFICE						
Primary functions: Provides all of the administrative, audit and oversight functions for the Department.						
(A) General Administration						
Personal Services	62,060,344	80,135,753	73,536,395	77,712,005	75,393,902	*
FTE	704.7	805.2	798.4	816.2	785.7	
General Fund	21,628,822	28,314,157	27,232,388	29,455,997	29,171,297	
Cash Funds	5,859,142	7,604,505	7,611,802	6,708,491	6,076,243	
Reappropriated Funds	1,388,133	2,070,808	3,153,686	3,223,836	3,155,881	
Federal Funds	33,184,247	42,146,283	35,538,519	38,323,681	36,990,481	
Health, Life, and Dental	9,139,400	10,639,237	12,911,669	14,076,212	13,258,679	*
General Fund	3,552,746	4,148,063	5,465,466	5,433,101	5,656,363	
Cash Funds	796,123	849,729	854,712	1,172,426	670,159	
Reappropriated Funds	229,292	221,797	59,708	39,880	0	
Federal Funds	4,561,239	5,419,648	6,531,783	7,430,805	6,932,157	
Short-term Disability	93,895	100,903	65,134	57,761	51,482	*
General Fund	35,944	38,739	52,016	25,428	23,826	
Cash Funds	7,760	8,239	8,218	967	402	
Reappropriated Funds	2,119	1,911	568	282	0	
Federal Funds	48,072	52,014	4,332	31,084	27,254	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
Paid Family and Medical Leave Insurance	0	0	363,855	396,481	377,655	*
General Fund	0	0	156,036	150,159	152,639	
Cash Funds	0	0	21,973	36,077	27,098	
Reappropriated Funds	0	0	1,705	846	0	
Federal Funds	0	0	184,141	209,399	197,918	
S.B. 04-257 Amortization Equalization Disbursement	2,935,436	3,356,675	0	0	0	
General Fund	1,123,363	1,293,879	0	0	0	
Cash Funds	243,684	269,385	0	0	0	
Reappropriated Funds	66,241	62,817	0	0	0	
Federal Funds	1,502,148	1,730,594	0	0	0	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	2,935,437	3,356,675	0	0	0	
General Fund	1,123,363	1,293,878	0	0	0	
Cash Funds	243,684	269,386	0	0	0	
Reappropriated Funds	66,241	62,817	0	0	0	
Federal Funds	1,502,149	1,730,594	0	0	0	
Unfunded Liability Amortization Equalization Disbursement Payments	0	0	8,616,195	8,337,050	7,918,630	*
General Fund	0	0	3,467,483	3,233,688	3,391,947	
Cash Funds	0	0	753,289	668,082	365,358	
Reappropriated Funds	0	0	37,888	18,793	0	
Federal Funds	0	0	4,357,535	4,416,487	4,161,325	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
Salary Survey	1,739,584	3,665,128	2,734,825	2,299,634	1,465,386	
General Fund	701,453	1,410,514	1,174,883	901,957	572,676	
Cash Funds	117,370	269,531	162,995	195,885	117,052	
Reappropriated Funds	32,730	53,934	12,853	0	(3,921)	
Federal Funds	888,031	1,931,149	1,384,094	1,201,792	779,579	
Step Pay	0	0	834,248	151,359	151,359	
General Fund	0	0	358,393	45,592	58,370	
Cash Funds	0	0	49,721	23,663	10,885	
Reappropriated Funds	0	0	3,921	0	0	
Federal Funds	0	0	422,213	82,104	82,104	
PERA Direct Distribution	667,352	187,622	1,448,480	1,638,428	1,638,428	
General Fund	0	77,283	622,267	641,130	663,316	
Cash Funds	74,345	13,659	86,329	141,003	118,817	
Reappropriated Funds	21,079	2,869	6,808	0	0	
Federal Funds	571,928	93,811	733,076	856,295	856,295	
Temporary Employees Related to Authorized Leave	0	5,978	5,978	5,944	0	*
General Fund	0	2,414	2,414	2,348	0	
Cash Funds	0	400	400	449	0	
Reappropriated Funds	0	112	112	112	0	
Federal Funds	0	3,052	3,052	3,035	0	
Worker's Compensation	194,996	184,274	254,896	230,444	230,444	*
General Fund	74,668	68,015	92,516	95,612	94,801	
Cash Funds	16,333	16,898	27,708	12,387	13,198	
Reappropriated Funds	6,497	7,224	7,224	7,224	7,224	
Federal Funds	97,498	92,137	127,448	115,221	115,221	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
Operating Expenses	3,091,508	3,167,767	3,323,116	3,574,015	3,286,980	*
General Fund	1,398,738	1,429,780	1,331,689	1,374,974	1,318,921	
Cash Funds	339,880	341,279	307,042	323,374	262,368	
Reappropriated Funds	59,204	13,921	61,415	57,946	50,071	
Federal Funds	1,293,686	1,382,787	1,622,970	1,817,721	1,655,620	
Legal Services	956,323	1,814,684	2,825,964	1,680,205	1,680,205	*
General Fund	371,762	663,061	1,014,264	(709,025)	(445,250)	
Cash Funds	92,356	197,130	327,629	849,838	586,063	
Reappropriated Funds	21,289	47,151	71,089	71,089	71,089	
Federal Funds	470,916	907,342	1,412,982	1,468,303	1,468,303	
Administrative Law Judge Services	890,066	544,650	822,526	2,354,030	2,354,030	
General Fund	249,650	198,961	300,504	728,921	752,777	
Cash Funds	77,698	59,203	89,409	426,743	402,887	
Reappropriated Funds	117,685	14,161	21,350	21,350	21,350	
Federal Funds	445,033	272,325	411,263	1,177,016	1,177,016	
Payment to Risk Management and Property Funds	383,340	567,472	249,605	140,773	140,773	
General Fund	126,297	233,022	87,781	24,052	44,145	
Cash Funds	45,201	40,825	27,132	36,527	16,434	
Reappropriated Funds	20,172	9,889	9,889	9,889	9,889	
Federal Funds	191,670	283,736	124,803	70,305	70,305	
Leased Space	2,339,116	2,677,250	3,785,963	3,956,898	3,672,305	*
General Fund	871,723	1,138,701	1,497,656	1,212,263	1,474,040	
Cash Funds	265,993	190,024	357,434	677,206	319,154	
Reappropriated Funds	31,842	9,900	38,849	52,366	38,849	
Federal Funds	1,169,558	1,338,625	1,892,024	2,015,063	1,840,262	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
Payments to OIT	6,481,886	9,133,004	14,280,872	17,439,278	16,919,104	*
General Fund	2,306,188	3,239,622	5,658,740	4,796,167	5,848,686	
Cash Funds	917,510	1,190,936	1,444,834	3,769,781	2,569,127	
Reappropriated Funds	16,751	29,027	41,739	41,739	41,739	
Federal Funds	3,241,437	4,673,419	7,135,559	8,831,591	8,459,552	
IT Accessibility	0	17,682	0	0	0	
General Fund	0	8,841	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	8,841	0	0	0	
CORE Operations	168,766	134,190	35,330	127,961	127,961	
General Fund	65,526	49,530	8,631	35,970	42,819	
Cash Funds	15,046	14,586	3,773	22,749	15,900	
Reappropriated Funds	6,740	5,261	5,261	5,261	5,261	
Federal Funds	81,454	64,813	17,665	63,981	63,981	
General Professional Services and Special Projects	24,920,490	46,946,295	40,668,700	44,109,124	40,347,217	*
General Fund	5,695,511	6,874,711	14,629,502	15,387,438	14,418,153	
Cash Funds	6,848,472	7,833,874	3,948,972	3,860,278	3,535,037	
Reappropriated Funds	60,500	15,000	81,000	81,000	81,000	
Federal Funds	12,316,007	32,222,710	22,009,226	24,780,408	22,313,027	
ARPA Appropriations	0	14,188,392	0	0	0	
General Fund	0	0	0	0	0	
Cash Funds	0	14,188,392	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Merit Pay	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Capitol Complex Leased Space	625,497	0	0	0	0
General Fund	275,727	0	0	0	0
Cash Funds	48,468	0	0	0	0
Reappropriated Funds	588	0	0	0	0
Federal Funds	300,714	0	0	0	0
Universal Contract for Behavioral Health Services	1,019,520	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	1,019,520	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - (A) General Administration	120,642,956	180,823,631	166,763,751	178,287,602	169,014,540
FTE	704.7	805.2	798.4	816.2	785.7
General Fund	39,601,481	50,483,171	63,152,629	62,835,772	63,239,526
Cash Funds	17,028,585	33,357,981	16,083,372	18,925,926	15,106,182
Reappropriated Funds	2,147,103	2,628,599	3,615,065	3,631,613	3,478,432
Federal Funds	61,865,787	94,353,880	83,912,685	92,894,291	87,190,400

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	186,850	193,940	0	0	0
General Fund	93,425	96,970	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	93,425	96,970	0	0	0
Early Intervention, Early Childhood	4,003,824	4,299,441	0	0	0
General Fund	1,769,044	2,102,358	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,234,780	2,197,083	0	0	0
Nurse Home Visitor Program, Early Childhood	268,101	221,455	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	111,259	98,964	0	0	0
Federal Funds	156,842	122,491	0	0	0
Host Home Regulation, Local Affairs	95,760	122,100	0	0	0
General Fund	47,880	61,050	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	47,880	61,050	0	0	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	208,808	187,466	0	0	0
General Fund	104,404	93,733	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	104,404	93,733	0	0	0
Facility Survey and Certification, Public Health and Environment	7,073,798	7,653,916	0	0	0
General Fund	2,484,420	2,895,627	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,589,378	4,758,289	0	0	0
Prenatal Statistical Information, Public Health and Environment	5,888	5,888	0	0	0
General Fund	2,944	2,944	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,944	2,944	0	0	0
Nurse Aide Certification, Regulatory Agencies	324,040	324,042	0	0	0
General Fund	147,369	147,370	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	14,651	14,651	0	0	0
Federal Funds	162,020	162,021	0	0	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Reviews, Regulatory Agencies	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Hospital Tax Exemptions, Revenue	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - (B) Transfers to Other Departments	12,167,069	13,008,248	0	0	0
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	4,649,486	5,400,052	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	125,910	113,615	0	0	0
Federal Funds	7,391,673	7,494,581	0	0	0

(C) Information Technology Contracts and Projects

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Medicaid Management Information System Maintenance and Projects	7,767,294	79,066,420	109,284,939	104,741,434	104,741,434 *
General Fund	16,340	8,677,661	18,284,124	16,246,404	14,981,758
Cash Funds	1,495,618	4,774,968	9,357,439	9,406,943	10,671,589
Reappropriated Funds	0	0	12,204	12,204	12,204
Federal Funds	6,255,336	65,613,791	81,631,172	79,075,883	79,075,883

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Colorado Benefits Management Systems, Operating and Contract Expenses	52,741,144	61,220,523	78,835,873	89,998,092	78,537,656 *
General Fund	9,741,310	11,157,074	13,150,314	13,037,445	12,393,247
Cash Funds	6,364,853	6,542,630	7,112,800	8,004,878	7,773,916
Reappropriated Funds	1,556	6,398,330	13,892,091	15,667,388	13,564,525
Federal Funds	36,633,425	37,122,489	44,680,668	53,288,381	44,805,968
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	1,635,740	1,827,327	2,172,998	2,748,849	2,173,592 *
General Fund	528,326	559,052	689,160	764,142	693,353
Cash Funds	283,227	353,592	383,151	395,860	379,255
Reappropriated Funds	19	73	73	73	73
Federal Funds	824,168	914,610	1,100,614	1,588,774	1,100,911
Office of eHealth Innovations Operations	5,096,812	5,366,706	6,215,845	8,029,825	8,812,035
FTE	0.0	0.0	3.0	3.0	3.0
General Fund	2,621,444	2,869,668	3,122,367	3,763,362	2,450,382
Cash Funds	0	0	0	0	671,985
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,475,368	2,497,038	3,093,478	4,266,463	5,689,668
All-Payer Claims Database	7,406,357	8,249,242	9,228,873	12,642,781	9,619,029 *
General Fund	4,254,769	4,354,828	4,471,011	6,901,743	3,541,068
Cash Funds	0	0	0	0	685,936
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,151,588	3,894,414	4,757,862	5,741,038	5,392,025

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
SUBTOTAL - (C) Information Technology Contracts and Projects	74,647,347	155,730,218	205,738,528	218,160,981	203,883,746	
FTE	0.0	0.0	3.0	3.0	3.0	
General Fund	17,162,189	27,618,283	39,716,976	40,713,096	34,059,808	
Cash Funds	8,143,698	11,671,190	16,853,390	17,807,681	20,182,681	
Reappropriated Funds	1,575	6,398,403	13,904,368	15,679,665	13,576,802	
Federal Funds	49,339,885	110,042,342	135,263,794	143,960,539	136,064,455	
(D) Eligibility Determinations and Client Services						
Contracts for Special Eligibility Determinations	2,839,066	3,859,251	12,039,555	5,188,957	5,588,957	
General Fund	718,427	948,563	1,134,071	1,134,071	1,234,071	
Cash Funds	459,509	514,330	4,338,468	913,169	913,169	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,661,130	2,396,358	6,567,016	3,141,717	3,441,717	
County Administration	102,184,661	113,295,137	123,048,230	134,495,560	113,495,560	*
General Fund	19,193,620	20,478,568	21,004,349	21,257,016	18,633,167	
Cash Funds	25,643,473	20,118,688	26,624,750	30,361,711	26,005,759	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	57,347,568	72,697,881	75,419,131	82,876,833	68,856,634	
Medical Assistance Sites	805,753	820,540	1,531,968	1,531,968	1,531,968	
General Fund	0	0	0	0	0	
Cash Funds	402,984	402,983	402,984	402,984	402,984	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	402,769	417,557	1,128,984	1,128,984	1,128,984	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Administrative Case Management	2,603,944	599,592	869,744	869,744	869,744
General Fund	1,301,972	299,796	434,872	434,872	434,872
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,301,972	299,796	434,872	434,872	434,872
Customer Outreach	2,596,573	3,217,570	3,461,519	3,461,519	3,461,519
General Fund	979,335	1,275,230	1,394,139	1,394,139	1,141,090
Cash Funds	318,951	333,555	336,621	336,621	589,670
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,298,287	1,608,785	1,730,759	1,730,759	1,730,759
Centralized Eligibility Vendor Contract Project	6,777,665	6,813,178	7,959,455	7,959,455	7,959,455
General Fund	0	0	0	0	0
Cash Funds	2,279,719	2,249,919	2,753,409	2,753,409	2,753,409
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,497,946	4,563,259	5,206,046	5,206,046	5,206,046
Connect for Health Colorado Eligibility Determination	8,680,778	8,242,386	11,174,846	11,174,846	11,174,846
General Fund	0	0	0	0	0
Cash Funds	4,504,089	4,746,203	4,995,156	4,995,156	4,995,156
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,176,689	3,496,183	6,179,690	6,179,690	6,179,690

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Eligibility Overflow Processing Center	1,542,528	1,540,773	1,904,677	1,904,677	1,904,677
General Fund	208,691	230,808	285,320	285,320	313,938
Cash Funds	176,941	154,385	190,849	190,849	162,231
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,156,896	1,155,580	1,428,508	1,428,508	1,428,508
Returned Mail Processing	1,936,317	2,567,981	3,298,808	3,298,808	3,298,808
General Fund	598,008	811,112	985,808	985,808	785,880
Cash Funds	138,267	184,978	244,919	244,919	444,847
Reappropriated Funds	44,751	58,051	111,942	111,942	111,942
Federal Funds	1,155,291	1,513,840	1,956,139	1,956,139	1,956,139
Work Number Verification	1,896,699	1,908,503	11,341,713	11,341,713	11,341,713
General Fund	635,584	639,539	1,741,440	1,741,440	1,869,398
Cash Funds	312,766	314,712	1,093,988	1,093,988	966,030
Reappropriated Funds	0	0	0	0	0
Federal Funds	948,349	954,252	8,506,285	8,506,285	8,506,285
Non-emergent Medical Transportation Broker	0	0	3,950,066	0	3,950,066
General Fund	0	0	1,185,020	0	1,185,020
Cash Funds	0	0	790,013	0	790,013
Federal Funds	0	0	1,975,033	0	1,975,033

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
SUBTOTAL - (D) Eligibility Determinations and Client Services	131,863,984	142,864,911	180,580,581	181,227,247	164,577,313
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	23,635,637	24,683,616	28,165,019	27,232,666	25,597,436
Cash Funds	34,236,699	29,019,753	41,771,157	41,292,806	38,023,268
Reappropriated Funds	44,751	58,051	111,942	111,942	111,942
Federal Funds	73,946,897	89,103,491	110,532,463	112,589,833	100,844,667
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	15,350,105	19,494,073	29,644,825	38,038,830	38,038,830
General Fund	6,750,711	5,243,412	7,910,405	10,008,906	10,008,906
Cash Funds	1,292,227	1,590,445	2,223,661	2,223,661	2,223,661
Reappropriated Funds	0	0	0	0	0
Federal Funds	7,307,167	12,660,216	19,510,759	25,806,263	25,806,263
SUBTOTAL - (E) Utilization and Quality Review Contracts	15,350,105	19,494,073	29,644,825	38,038,830	38,038,830
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	6,750,711	5,243,412	7,910,405	10,008,906	10,008,906
Cash Funds	1,292,227	1,590,445	2,223,661	2,223,661	2,223,661
Reappropriated Funds	0	0	0	0	0
Federal Funds	7,307,167	12,660,216	19,510,759	25,806,263	25,806,263

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
(F) Provider Audits and Services					
Professional Audit Contracts	3,151,518	3,533,858	4,135,919	4,708,809	4,708,809
General Fund	1,418,458	1,446,790	1,598,629	1,885,074	1,845,401
Cash Funds	157,301	320,139	540,301	540,301	579,974
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,575,759	1,766,929	1,996,989	2,283,434	2,283,434
SUBTOTAL - (F) Provider Audits and Services	3,151,518	3,533,858	4,135,919	4,708,809	4,708,809
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,418,458	1,446,790	1,598,629	1,885,074	1,845,401
Cash Funds	157,301	320,139	540,301	540,301	579,974
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,575,759	1,766,929	1,996,989	2,283,434	2,283,434
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	961,962	675,394	1,165,841	1,165,841	1,165,841
General Fund	0	0	0	0	0
Cash Funds	480,981	337,697	582,920	582,920	582,920
Reappropriated Funds	0	0	0	0	0
Federal Funds	480,981	337,697	582,921	582,921	582,921
Third-Party Liability Cost Avoidance Contract	2,279,120	3,064,990	8,838,738	8,838,738	8,838,738
General Fund	763,341	1,021,143	2,916,784	2,916,784	2,916,784
Cash Funds	376,219	511,352	1,502,585	1,502,585	1,502,585
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,139,560	1,532,495	4,419,369	4,419,369	4,419,369

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	3,241,082	3,740,384	10,004,579	10,004,579	10,004,579
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	763,341	1,021,143	2,916,784	2,916,784	2,916,784
Cash Funds	857,200	849,049	2,085,505	2,085,505	2,085,505
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,620,541	1,870,192	5,002,290	5,002,290	5,002,290
(H) Indirect Cost Assessment					
Indirect Cost Assessment	1,054,856	1,113,873	1,059,807	881,600	881,600
General Fund	0	0	0	0	0
Cash Funds	112,605	196,956	276,775	277,887	277,887
Reappropriated Funds	90,368	93,623	132,407	79,516	79,516
Federal Funds	851,883	823,294	650,625	524,197	524,197
SUBTOTAL - (H) Indirect Cost Assessment	1,054,856	1,113,873	1,059,807	881,600	881,600
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	112,605	196,956	276,775	277,887	277,887
Reappropriated Funds	90,368	93,623	132,407	79,516	79,516
Federal Funds	851,883	823,294	650,625	524,197	524,197
TOTAL - (1) Executive Director's Office	362,118,917	520,309,196	597,927,990	631,309,648	591,109,417
FTE	704.7	805.2	801.4	819.2	788.7
General Fund	93,981,303	115,896,467	143,460,442	145,592,298	137,667,861
Cash Funds	61,828,315	77,005,513	79,834,161	83,153,767	78,479,158
Reappropriated Funds	2,409,707	9,292,291	17,763,782	19,502,736	17,246,692
Federal Funds	203,899,592	318,114,925	356,869,605	383,060,847	357,715,706

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation	
(2) MEDICAL SERVICES PREMIUMS						
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.						
Medical and Long-Term Care Services for Medicaid Eligible Individuals	10,921,010,282	11,386,151,835	12,458,605,335	12,912,351,147	13,186,685,320	*
General Fund	2,630,296,339	2,134,324,780	2,420,959,793	2,601,002,636	2,586,966,187	
General Fund Exempt	0	1,179,901,546	1,247,280,333	1,247,280,333	1,247,280,333	
Cash Funds	1,294,227,032	1,314,296,704	1,424,116,912	1,456,014,509	1,486,725,412	
Reappropriated Funds	90,000,798	99,207,497	119,588,730	99,588,730	99,588,730	
Federal Funds	6,906,486,113	6,658,421,308	7,246,659,567	7,508,464,939	7,766,124,658	
TOTAL - (2) Medical Services Premiums	10,921,010,282	11,386,151,835	12,458,605,335	12,912,351,147	13,186,685,320	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,630,296,339	2,134,324,780	2,420,959,793	2,601,002,636	2,586,966,187	
General Fund Exempt	0	1,179,901,546	1,247,280,333	1,247,280,333	1,247,280,333	
Cash Funds	1,294,227,032	1,314,296,704	1,424,116,912	1,456,014,509	1,486,725,412	
Reappropriated Funds	90,000,798	99,207,497	119,588,730	99,588,730	99,588,730	
Federal Funds	6,906,486,113	6,658,421,308	7,246,659,567	7,508,464,939	7,766,124,658	

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	259,498,036	246,618,300	226,610,308	226,610,308	226,610,308
General Fund	0	0	0	0	0
Cash Funds	122,721,974	122,034,489	113,305,154	113,305,154	113,305,154
Reappropriated Funds	0	0	0	0	0
Federal Funds	136,776,062	124,583,811	113,305,154	113,305,154	113,305,154
Pediatric Specialty Hospital	10,764,010	10,764,010	13,455,012	13,455,012	13,455,012
General Fund	4,746,928	5,274,365	6,727,506	6,727,506	6,727,506
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	6,017,082	5,489,645	6,727,506	6,727,506	6,727,506
Appropriation from Tobacco Tax Fund to the General Fund	339,124	303,203	291,034	291,034	291,034
General Fund	0	0	0	0	0
Cash Funds	339,124	303,203	291,034	291,034	291,034
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Primary Care Fund	47,449,654	53,474,732	49,079,682	36,079,682	36,079,682
General Fund	0	7,000,000	6,500,000	0	0
Cash Funds	21,438,852	19,608,672	18,175,554	18,175,554	18,175,554
Reappropriated Funds	0	0	0	0	0
Federal Funds	26,010,802	26,866,060	24,404,128	17,904,128	17,904,128

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Children's Basic Health Plan Administration	1,403,394	1,674,518	3,864,405	3,864,405	3,864,405
General Fund	0	0	0	0	0
Cash Funds	432,716	577,578	1,352,542	1,352,542	1,352,542
Reappropriated Funds	0	0	0	0	0
Federal Funds	970,678	1,096,940	2,511,863	2,511,863	2,511,863
Children's Basic Health Plan Medical and Dental Costs	118,283,242	184,933,218	283,520,809	301,736,237	317,847,540
General Fund	381,798	22,640,521	49,669,215	50,421,817	59,361,809
General Fund Exempt	0	303,203	291,034	291,034	291,034
Cash Funds	36,255,947	40,743,413	49,337,034	54,959,832	51,658,796
Reappropriated Funds	0	0	0	0	0
Federal Funds	81,645,497	121,246,081	184,223,526	196,063,554	206,535,901
TOTAL - (4) Indigent Care Program	437,737,460	497,767,981	576,821,250	582,036,678	598,147,981
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	5,128,726	34,914,886	62,896,721	57,149,323	66,089,315
General Fund Exempt	0	303,203	291,034	291,034	291,034
Cash Funds	181,188,613	183,267,355	182,461,318	188,084,116	184,783,080
Reappropriated Funds	0	0	0	0	0
Federal Funds	251,420,121	279,282,537	331,172,177	336,512,205	346,984,552

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	41,155	589,696	10,000,000	10,000,000	10,000,000
General Fund	0	0	0	0	0
Cash Funds	41,155	589,696	10,000,000	10,000,000	10,000,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Senior Dental Program	3,972,404	3,930,117	3,990,358	3,990,358	3,990,358
General Fund	3,962,510	3,930,117	3,962,510	3,962,510	3,962,510
Cash Funds	9,894	0	27,848	27,848	27,848
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Commission on Family Medicine Residency Training Programs	9,513,898	9,490,170	9,490,170	9,490,170	9,490,170
General Fund	3,997,108	4,430,100	4,520,085	4,520,085	4,520,085
Cash Funds	0	0	0	0	0
Reappropriated Funds	198,450	220,500	225,000	225,000	225,000
Federal Funds	5,318,340	4,839,570	4,745,085	4,745,085	4,745,085
Medicare Modernization Act State Contribution Payment	216,337,023	244,361,309	242,412,971	268,891,377	272,802,633
General Fund	216,337,023	244,361,309	242,412,971	268,891,377	272,802,633
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Public School Health Services Contract Administration	915,650	1,253,344	2,000,000	2,000,000	2,000,000
General Fund	457,825	626,672	1,000,000	1,000,000	1,000,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	457,825	626,672	1,000,000	1,000,000	1,000,000
Public School Health Services	152,899,688	191,357,388	219,752,395	198,563,973	198,563,973 *
General Fund	0	0	0	0	0
Cash Funds	68,247,434	90,710,963	109,260,099	99,281,987	99,281,987
Reappropriated Funds	0	0	0	0	0
Federal Funds	84,652,254	100,646,425	110,492,296	99,281,986	99,281,986
Rural Provider Access and Affordability Fund, Created in Section 25.5-1-207 (6)(a), C.R.S.	0	1,000,000	0	0	0
General Fund	0	1,000,000	0	0	0
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	1,500,000	1,500,000	1,500,000	1,500,000	0
General Fund	0	0	0	0	0
Cash Funds	1,500,000	1,500,000	1,500,000	1,500,000	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Reproductive Health Care for Individuals Not Eligible for Medicaid	242,952	1,356,927	3,614,490	3,614,490	3,614,490
General Fund	242,952	1,356,927	3,614,490	3,614,490	3,614,490
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
ARPA HCBS State-only Funds	8,758,574	21,418,222	0 0.0	0 0.0	0 0.0
General Fund	0	0	0	0	0
Cash Funds	8,758,574	21,418,222	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Denver Health and Hospital Authority	5,000,000	1,000,000	5,000,000	0	0
General Fund	5,000,000	1,000,000	5,000,000	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Health Benefits for Colorado Children and Pregnant Persons	0	0	16,037,803	32,075,606	32,075,606 *
General Fund	0	0	16,037,803	32,075,606	32,075,606
Telehealth Remote Monitoring Grant Program	0	0	0	500,000	0
General Fund	0	0	0	500,000	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
Urban Indian Health Organizations State Only Payments	48,025	0	0	0	0
General Fund	48,025	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Primary Care and Behavioral Health Statewide Integration Grant Program	127,944	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	127,944	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
TOTAL - (5) Other Medical Services	399,357,313	477,257,173	513,798,187	530,625,974	532,537,230
FTE	0.0	0.0	NaN	0.0	0.0
General Fund	230,045,443	256,705,125	276,547,859	314,564,068	317,975,324
Cash Funds	78,685,001	114,218,881	120,787,947	110,809,835	109,309,835
Reappropriated Funds	198,450	220,500	225,000	225,000	225,000
Federal Funds	90,428,419	106,112,667	116,237,381	105,027,071	105,027,071

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	156,318,850	95,424,956	0	0	0
FTE	704.7	0.0	0.0	0.0	0.0
General Fund	63,303,334	44,853,892	0	0	0
Cash Funds	7,779,925	1,935,723	0	0	0
Reappropriated Funds	1,388,133	0	0	0	0
Federal Funds	83,847,458	48,635,341	0	0	0

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation

(1) TRANSFERS TO OTHER STATE DEPARTMENT MEDICAID-FUNDED PROGRAMS

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

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
TOTAL - (1) Transfers to Other State Department Medicaid-Funded Programs			148,164,908	150,141,457	150,361,939
FTE			0.0	0.0	0.0
General Fund			67,889,677	68,826,649	72,369,457
Cash Funds			1,938,903	1,986,723	1,986,723
Reappropriated Funds			14,652	14,652	14,652
Federal Funds			78,321,676	79,313,433	75,991,107

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	FY 2025-26 Recommendation
TOTAL - Department of Health Care Policy and Financing	12,276,542,822	12,976,911,141	14,295,317,670	14,806,464,904	15,058,841,887
FTE	1,409.4	805.2	801.4	819.2	788.7
General Fund	3,022,755,145	2,586,695,150	2,971,754,492	3,187,134,974	3,181,068,144
General Fund Exempt	0	1,180,204,749	1,247,571,367	1,247,571,367	1,247,571,367
Cash Funds	1,623,708,886	1,690,724,176	1,809,139,241	1,840,048,950	1,861,284,208
Reappropriated Funds	93,997,088	108,720,288	137,592,164	119,331,118	117,075,074
Federal Funds	7,536,081,703	7,410,566,778	8,129,260,406	8,412,378,495	8,651,843,094

Appendix B: Additional Balancing Options

As part of staff budget briefings in November and December 2024, staff identified budget reduction options for each department that the JBC could consider in addition to or instead of the options presented in the budget request. **Items staff recommends and items that agencies have requested formally are addressed earlier in this packet.** Other items that could be considered, if needed to bring the budget into balance, are listed below.

Additional Options for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
Subtotal - Revenue	$0	$0		
Expenditure Reductions				
Provider rates				
Nursing facility rates	-$5,234,773	-5,296,129	Y	Eliminate the statutory 1.5% increase for nursing
1% provider rate reduction	-28,545,582	-55,240,921	N	1% reduction in provider rates
Eligibility/benefit changes				
Prenatal choline supplements	-247,359	-277,041	Y	Halt prenatal coverage of choline supplements without a prescription, per S.B. 24-175, scheduled to start 7/25
Reproductive health for individuals not eligible for Medicaid	-3,614,490	0	Y	Eliminate (or cap) the benefit, which primarily pays for long acting reversible contraceptives for people ineligible for Medicaid due to immigration status
Denture benefit	-2,909,548	-12,124,826	Y	Eliminate the adult denture benefit
CHP+ children/pregnant 206-265% FPL	-40,600,423	-75,400,787	Y	Eliminate CHP+ coverage of children and pregnant women from 206%-265% FPL and repurpose the HAS Fee savings to offset GF
Grants/special payments				
Family medicine residencies	-4,520,085	-4,520,085	N	Eliminate or reduce GF and matching FF for family medicine residency training programs
Pediatric Specialty Hospital	-6,727,506	-6,727,506	N	Eliminate or reduce supplemental payments to Children's Hospital
Senior Dental Program	-3,962,510	-27,848	Y	Eliminate or reduce grants for dental care to seniors ineligible for Medicaid. No federal match.
Admin/other				
General Professional Services	-1,500,000	0	N	Reduce contract services based on reversions of $5.7 million General Fund in FY 2023-24 and $1.5 million General Fund in FY 2022-23.
Subtotal - Expenditures	-$98,802,811	-$160,585,638		
Net General Fund Relief	$98,802,811			

Provider Rates

Nursing facility rates [requires legislation]

Eliminating the 1.5 percent increase in nursing home rates required in statute for FY 2025-26 would save $5.2 million General Fund. Historically, nursing home rates increased by 3.0 percent annually. House Bill 23-1228 changed the increases to:

- 10 percent in FY 2023-24
- 3 percent in FY 2024-25
- 1.5 percent in FY 2025-26
- a rate subject to available appropriations in subsequent years

This change might be more palatable to providers in combination with enterprising the nursing provider fees and increasing the nursing fees to draw additional federal funds.

1% Provider rate reduction

Each 1.0 percent across-the-board decrease in provider rates saves $28.5 million General Fund.

Eligibility/benefit changes

Prenatal choline supplements [legislation]

Halting prenatal coverage of choline supplements without a prescription would save $257,359 General Fund. Senate Bill 24-175 authorized the new benefit.

This new benefit has not yet been implemented. The Department expects to implement it in July 2025.

Without this benefit, clients could still get coverage of choline supplements with a prescription or pay over-the-counter.

Advocates argue that requiring a prescription for coverage creates a barrier to access and reduces health outcomes. Writing a prescription when recommending choline supplements is not standard clinical practice. The supplements are available over-the-counter. Requiring a prescription causes confusion for physicians and pharmacists.

Reproductive health for individuals not eligible for Medicaid [legislation]

Eliminating the reproductive health benefit for people not eligible for Medicaid due to their immigration status would save $3.6 million General Fund. The money primarily pays for Long

Acting Reversible Contraceptives (LARCs). In FY 2023-24, there were 4,206 distinct utilizers. There is no federal match for the program.

Eliminating the program may increase Medicaid expenditures for unwanted pregnancies.

There is a cushion between the appropriations and expenditures that could be removed with a change in statute. Utilization is trending up, but the Department underspent the appropriation by $2,257,563 in FY 2023-24. The benefits and eligibility are defined in statute with no clear means for the Department to manage costs within the appropriation. If the statute allowed cost containment measures, such as caps, or provided overexpenditure authority for the line item, then the legislature could appropriate to the expected expenditure and not maintain a cushion.

The JBC staff is planning to recommend overexpenditure authority for the program as part of the JBC's discussion about reauthorizing the overexpenditure statutes. If the Department had overexpenditure authority for the program, the JBC staff estimates that the appropriation could be reduced $1,908,270 General Fund, based on current projected expenditures. However, without overexpenditure authority, the JBC staff believes the Department needs some cushion in the appropriation to avoid exceeding the appropriation due to an unexpected increase in utilization. Rather than granting overexpenditure authority, the JBC could consider providing statutory authority for the Department to cap the program to live within the appropriation. That is an alternative way to achieve the $1.9 million General Fund savings.

Denture benefit [legislation]

Eliminating the denture benefit would save $2.9 million General Fund, mostly by reducing the General Fund obligation for a TABOR refund. The denture benefit is financed with transfers from the Unclaimed Property Trust Fund (UPTF) and a small amount of General Fund for people with intellectual and developmental disabilities. The UPTF is exempt from TABOR, but transfers to support the denture benefit cross the TABOR boundary. The denture benefit was added by H.B. 14-1336. Emergency services and services for children would still be covered, because they are required benefits.

CHP+ children/pregnant 206-265% [legislation]

Eliminating coverage under the Child Health Plan Plus (CHP+) for children and pregnant women with income from 206 percent to 265 percent of the federal poverty guidelines and repurposing the savings in the Healthcare Affordability and Sustainability Fee (HAS Fee) to offset General Fund would save $40.6 million General Fund. In a family of three, the change would impact people with annual income from $53,189 to $68,423. The change would remove coverage for a projected 33,947 children and 1,154 pregnant women.

Outside of the buy-in programs for people with disabilities, this is the highest income population served by the Department's health programs. The population is relatively healthier with lower medical needs than the typical Medicaid population, due to age and income. Federal

tax credits could help people in this income range purchase private insurance through the individual market.

Under current law, the net cost after subsidies for a family of 2 to purchase insurance through the exchange (instead of CHP+) would be in the range of $108 - $186. The estimate is based on the gold plan that the Division of Insurance says is the most popular for this income. The range represents both the highest and lowest ends of the income range and differences in cost for a plan in Greely vs Denver.

The Department argues that studies show almost no "crowd-out" between CHP+ and other insurance options. The Department says people without CHP+ are most likely to go without income. However, the Department also previously said that people leaving Medicaid because of the unwind of continuous coverage during COVID would find insurance through the exchange.

First year savings would be lower due to the time and cost to implement necessary eligibility and claims system changes. Other administrative savings would be minimal, since the Department would still need to operate a smaller version of CHP+.

Grants/special payments

Family medicine residencies

Eliminating funding for the family medicine residencies would save $4.5 million General Fund. The Commission on Family Medicine organizes and financially supports family medicine residencies, particularly in rural and underserved areas.

Eliminating or reducing this funding affects teaching and development of the provider network, rather than direct services. Impacts on access to care and health, life, and safety would be indirect and in the future.

Residents increase provider capacity during their training. A high portion end up practicing where they train.

Pediatric Specialty Hospital

Eliminating the Pediatric Specialty Hospital payments would save $6.7 million General Fund. These payments go to Children's Hospital. There is a 50 percent federal match. Of the total funds, $11.5 million supports outpatient behavioral health services, $1.5 million goes to an alternative educational placement for children with complex medical needs, and $0.5 million supports the KidStreet childcare program for children 6 weeks to 3 years with complex medical needs. The legislature could reduce the funding, rather than eliminating it.

These are narrowly targeted supplemental payments above and beyond the standard Medicaid reimbursement for services.

The funding for outpatient behavioral health increases provider reimbursement for services otherwise covered under Medicaid. Children's Hospital argues the standard Medicaid

reimbursement is insufficient. This supplemental payment allows the hospital to maintain and expand outpatient behavioral health services.

Without the alternative educational placement, school districts would need to make other accommodations for children with complex medical needs. School district costs would increase and the alternatives might not be as robust as this established program.

Children's Hospital argues that the KidStreet program reduces utilization of more expensive private duty nursing, provides therapies that would be covered under Medicaid, and allows parents to work.

Senior Dental Program [legislation]

Eliminate funding for the grant program that supports dental care for seniors who do not qualify for Medicaid would save $4.0 million General Fund. This is a grant program above and beyond the Department's core services. There is no federal match. Eliminating the program would require a bill, but reducing the program would not.

Administration/other

General Professional Services

The Department reverted $5.7 million General Fund in FY 2023-24 and $1.5 million General Fund in FY 2022-23. That was 39 percent and 17 percent of the General Fund appropriations respectively.

The Department says it needs the entire appropriation in FY 2025-26 to support initiatives approved by the General Assembly and to satisfy federal requirements. According to the Department, any reduction in General Professional Services would need to be coupled with eliminating or reducing the programs supported by the contract services.

The Department did not explain why FY 2025-26 would be so different from the actual experience with contract services in FY 2024-25 and FY 2023-24.

The table below shows the Department's projected expenditures from the General Professional Services line item in FY 2025-26.

General Professional Services Projection FY 2025-26

Description	Expenditure
Cover All Coloradoans	$10,678,371
Primary Care Alternative Payment Model (APM)	5,099,840
Special Financing Projects	2,411,250
Third Party Assessments-PDN / LTHH	1,938,600
Actuarial Review of HMO, PACE and MH Rates	1,652,370
SUD Patient Placement and Benefit Waiver	1,430,744
Import Prescription Drugs from Canada	1,296,160
Community Based Access to Services	1,206,700
Cost Allocation Vendor Consolidation	1,067,842
Medicaid Payment Reform Pilot Program (ACC)	650,000
Asset Verification Program (AVP)	648,256

General Professional Services Projection FY 2025-26	
Description	Expenditure
Health-Care Practice Transformation	378,750
Member Experience and Testing	329,304
Drug Cost Containment Initiatives	300,500
Pharmacy Technical & Pricing Efficiencies (SMAC)	300,000
County Administration, Oversight and Accountability	269,304
Federal Managed Care Services	253,750
Periodic Review of Provider Rates (MPRRAC)	250,000
Access to Benefits	250,000
Continuous Eligibility	180,000
HCBS Final Rule Review	179,550
Behavioral Health Administration	169,000
Advancing Birthing Equity	165,000
CUSOM - UPL	162,000
Clinical Evidence Advisory Committee (CEAC)	150,000
Medicaid Recovery & Third-Party Liability (TPL)	120,000
Access to Managed Care Covered Services	101,500
CLAG and HCBS Final Rule Review	100,000
Medicaid Ombudsman Contract	100,000
Medicaid Buy-in Age 65 and Older	100,000
Comprehensive Primary Care Initiatives	75,000
Senior Dental Grant Program	75,000
Nursing Home Fees & Order of Payments	60,000
Inpatient Hospital DRG (FQHC & RHC)	60,000
Assignment of Rights and Eligibility Determinations	50,000
Unemployment Insurance	30,000
Alternative Language Services	30,000
Total	$32,318,791
General Fund	11,685,822
Cash Funds	2,393,115
Reappropriated Funds	81,000
Federal Funds	18,158,854