FY 2019-20 Long-Range Financial Plan

COLORADO
Department of Health Care Policy & Financing

Table of Contents

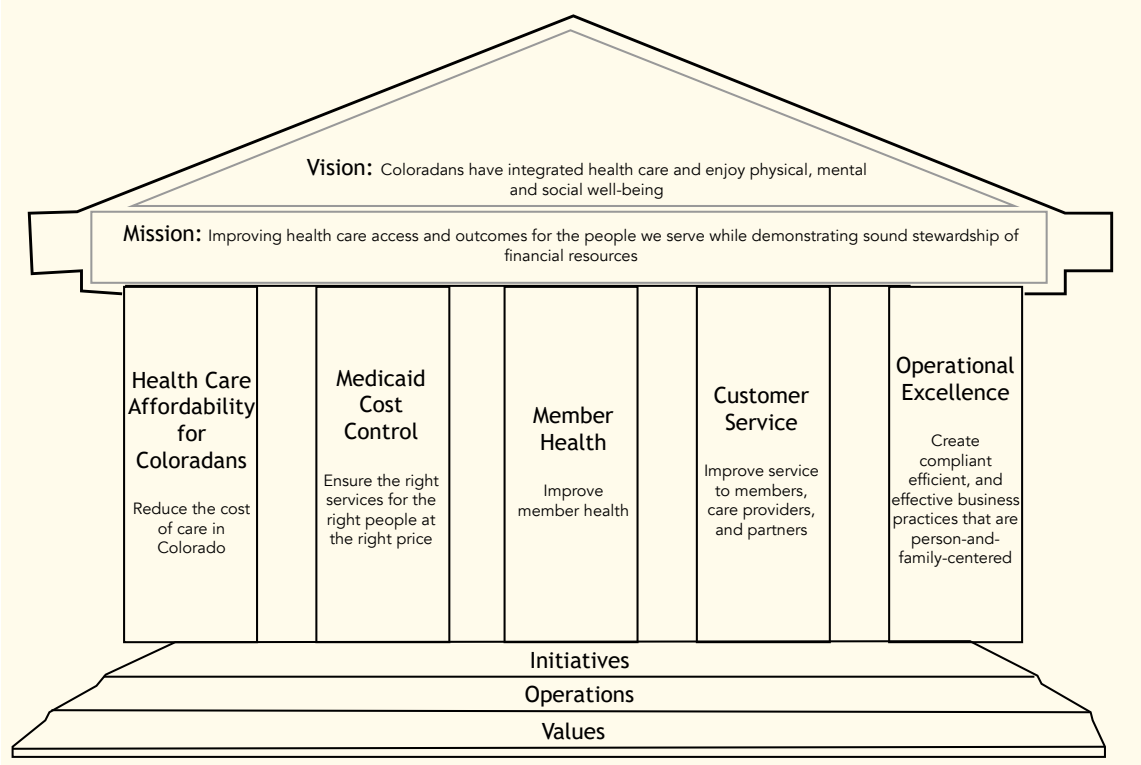
In accordance with C.R.S. 2-3-209, each state agency is required to submit an annual long-range financial plan. The intent of the long-range financial plan is to allow each Department to prepare a strategic financial plan to prepare for economic impacts in the future. The elements required in the plan include:

- Statement of an agency's mission
- Description of an agency's major functions
- Description of an agency's performance goals
- Performance evaluation of an agency's major programs with recommendations to improve performance
- Description of anticipated trends, conditions, or events affecting the agency
- Description of any programs funded by federal funds or gifts, grants, and donations that may decrease in the future

The long-range financial plan provides context to the State's strategic financial direction from FY 2019-20 through FY 2023-24. While the long-range financial plans are submitted to the legislature alongside the Governor's FY 2020-21 budget request, the long-range plans are intended as an apolitical administrative resource to support effective planning and resource allocation. As such, agency financial projections are based on FY 2019-20 appropriations and do not reflect the Governor's FY 2020-21 budget request.

The Office of State Planning and Budgeting (OSPB) has developed a statewide overview of the long-range plan submissions, which can be viewed on OSPB's website at: https://www.colorado.gov/governor/office-state-planning-budgeting

Section 1: Introduction to the State Agency



Department Overview

The Department is the single Colorado state agency responsible for administering the Medicaid program (Title XIX of the Social Security Act) and the Children's Health Insurance Program (Title XXI of the Social Security Act). Colorado's Medicaid program is known publicly as Health First Colorado. In addition to these programs, we administer the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, and the School Health Services Program. We also provide health care policy leadership – including cost control guidance – for the state's executive and legislative branches and to purchasers at large.

We serve Coloradans who are eligible for and/or enrolled in Medicaid and the Children's Health Insurance Program (CHIP), and those who receive services through the other programs described above. In serving these customers, we partner with medical, dental, behavioral health, and long-term services and supports providers; other state agencies; the Centers for Medicare & Medicaid Services (CMS); groups that advocate for member populations; the Governor's Office and the Legislature of the State of Colorado; service contractors; expert consultants and advisors; various non-profit entities; commercial carriers; and entities that help eligible individuals apply for benefits such as Colorado counties, local government agencies, and medical assistance sites.

Colorado's Medicaid program receives approximately 59% of its funding from the federal government, and its CHIP program is approximately 79% federally funded.

Strategic Framework

The Colorado Department of Health Care Policy and Financing is in the process of modernizing its mission and vision. All employees are engaged in this effort, along with our Member Experience Advisory Council. This work will be complete by the Fall of 2019.

The image above includes our current mission and vision statements. The table on page 5 lists our five strategic pillars with performance measures for achieving them.

Strategic Pillar	Performance Measures
Health Care Affordability for Coloradans: Reduce the cost of care in Colorado	Conduct extensive educational outreach to businesses, constituents and thought leaders about Colorado's Health Care Affordability Roadmap to identify the cost drivers and best practices in health care. Increase engagement in the Roadmap from 2,220 (2019) to 3,500 (2020). • Develop a report by December 31, 2019 to inform effective prescription cost control policy. • Implement a Colorado payer prescription tool by June 30, 2020 that results in lower prescription drug costs. • Receive CMS approval for Colorado's Hospital Transformation Program (HTP). • Implement no fewer than 10 HTP standards by June 30, 2020, that are focused on lowering hospital costs.
Medicaid Cost Control: Ensure the right services for the right people at the right price	Achieve $6,837 per member per year ($570 per member per month) in average annual Medicaid per-capita total cost of care, excluding all supplemental and other financing payments. Work with the Regional Accountable Entities (RAEs) to better manage the highest risk and highest cost Medicaid members. Identify the members who would benefit the most from RAE support, and identify the areas where Medicaid health care costs are rising by September 1, 2019. • Work with the RAEs to identify programs that will improve Medicaid member health and better control costs by March 1, 2020. • Conduct stakeholder feedback by May 15, 2020.
Member Health: Improve member health	Decrease the # of opioid pills dispensed among members who use the prescription drug benefit by 8%, from 8.11 to 7.46, by June 30, 2020. Develop a baseline risk score for every member and aggregate those scores to be used for future specific member risk score targets and State agency shared goals by June 30, 2020.
Customer Service: Improve service to members, care providers, and partners	Maintain provider call average speed of answer at or below 61 seconds for FY 2019–20.
Operational Excellence: Create compliant, efficient, and effective business practices that are person- and family-centered	Complete contract management training for 100% of contract managers and executive team leaders by June 30, 2020.

Section 2: Program & Goal Evaluation

Section 2.1: Operational Metrics

The Department's strategic pillars and many of the operational metrics below are new as of FY 2019-20. Many current year metrics are project-based activities with short term milestones gauging performance. As a result, "N/A" denotes where prior year and future targets are not applicable. In other cases, lagging data indicated by "TBD" will be reported once it becomes available.

Strategic Pillar 1: Health Care Affordability for Coloradans							
	Description	**Data Type**	**FY22**	**FY21**	**FY20** (YTD as of Sept 2019)	**FY19**	**FY18**
Key Performance Measure	Conduct extensive educational outreach to businesses, constituents, and thought leaders on Colorado's Health Care Affordability Roadmap to identify the cost drivers and best practices in health care. Increase engagement in the Roadmap from 2,220 to 3,500 by June 30, 2020	**Actual**	N/A	N/A	3,107	2,220	N/A
		Target	N/A	N/A	3,500	1,000	N/A
Supporting Initiative	**Rx Shared Provider Tool**: Implement a Colorado payer prescription tool by June 30, 2020	**Actual**	N/A	N/A	15%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A
	Hospital Transformation Program (HTP): Receive CMS approval for Colorado's HTP Waiver by June 30, 2020	**Actual**	N/A	N/A	76%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A

Strategic Pillar 2: Medicaid Cost Control							
	Description	**Data Type**	**FY22**	**FY21**	**FY20**[1] (YTD as of Sept 2019)	**FY19**	**FY18**
Key Performance Measure	**Medicaid Per-Capita Total Cost of Care Per Member Per Year**: Achieve $6,837 per member per year ($570 per member per month) in average annual Medicaid per-capita total cost of care, excluding all supplemental and other financing payments	**Actual**	TBD	TBD	TBD[2]	$6,378	$5,764
		Target	$7,458	$7,111	$6,837	$5,973	$5,791
Supporting Initiative	**RAE Cost Collaborative**: Manage rising trends and high-risk, high-cost members	**Actual**	N/A	N/A	60%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A

[1] FY20 per capita goal adjusted in October 2019 based on changes in the November budget forecast for FY 2019-20.
[2] A projected annual average YTD for FY20 will be available in February 2020.

Strategic Pillar 2: Medicaid Cost Control							
	Description	**Data Type**	**FY22**	**FY21**	**FY20** (YTD as of Sept 2019)	**FY19**	**FY18**
Supporting Initiative	**Member Health Risk Stratification**: Calculate current and prospective risk scores for each member using diagnostic cost group (DCG) risk methodology and enhance baseline scores by December 2019	**Actual**	N/A	N/A	100%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A
	Controlling Rx Costs: Develop a report by December 31, 2019 to inform effective prescription cost control policy	**Actual**	N/A	N/A	85%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A

Strategic Pillar 3: Member Health							
	Description	**Data Type**	**FY22**	**FY21**	**FY20** (YTD as of Sept 2019)	**FY19**	**FY18**
Key Performance Measure	**Opioid Strategy**: Decrease the number of opioid pills dispensed among members who use the prescription drug benefit by 8%, from 8.11 to 7.46 per member per month by the end of FY20	**Actual**	TBD	TBD	8.66[1]	8.11[2]	9.85
		Target	6.32	6.86	7.46	9.59	10.09
Supporting Initiative	Develop a baseline risk score for every member and aggregate those scores to be used for future specific member risk score targets and State agency shared goals by June 30, 2020	**Actual**	N/A	N/A	20%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A

[1] Data lagging by two months, represents July 2019 figure.
[2] Figure representing FY19 is from April, the latest month available when FY20-FY22 targets were established.

Strategic Pillar 4: Customer Service							
	Description	**Data Type**	**FY22**	**FY21**	**FY20** (YTD as of Sept 2019)	**FY19**	**FY18**
Key Performance Measure	**Average Speed of Answer (ASA) a** Less than 61 second monthly average of the telephone calls coming into our provider service center from Medicaid providers	**Actual**	TBD	TBD	48	52	N/A
		Target	61	61	61	61	N/A

Strategic Pillar 5: Operational Excellence							
	Description	**Data Type**	**FY22**	**FY21**	**FY20** (YTD as of Sept 2019)	**FY19**	**FY18**
Key Performance Measure	**Contract Management**: Complete contract management training for 100% of contract managers and executive team leaders by June30, 2020	**Actual**	N/A	N/A	0%	N/A	N/A
		Target	N/A	N/A	100%	N/A	N/A
Supporting Initiative	**Administration Budget Management Discipline and Accountability**: Administration expenditures will be within 1% of total appropriated funds for FY 2019-20[1]	**Actual**	TBD	TBD	$44.5 million	$311.7 million	N/A
		Target	TBD	TBD	$436.9 million	$388.9 million	N/A
	PEAK*Health* App Optimization: Increase the percentage of targeted Medicaid households using the PEAKHealth mobile app from 36% to 45% (at least a 25% increase) by June 30, 2020	**Actual**	TBD	TBD	40%	36%	22%
		Target	TBD	35%	45%	26%	23%

[1] Measure tracks total administrative expenditures against target of 1% under total annual spending authority for administrative expenditures, or, against the sum of all line item appropriations designated by the Department as "administration" less 1%. The FY20 Actual of $44.5 million is the year-to-date sum of expenditures from these line items.

2.2 Performance Evaluation

The Department's strategic pillars and supporting initiatives described below are new as of FY 2019-20. Current year ramp-up efforts are creating a foundation to achieve Governor Polis' health-related goals, and new data will help set a baseline to evaluate performance.

Many of these initiatives are project-based activities with short-term milestones gauging performance. As a result, year-over-year performance data beyond what is provided above in section 2.1 is not yet available.

Strategic Pillar 1: Health Care Affordability for Coloradans	
Supporting Initiative	**Description and Strategic Alignment**
Rx Shared Provider Tool	During FY 2019-20 we will be implementing a tool that will provide physicians and other prescribers with insights allowing them to: • Compare the costs associated with prescription therapy alternatives specific to each patient's health plan • Use available information to assess the patient's risk of addiction • Enable the physician to prescribe health plan programs to address the root of the condition The tool will improve quality of care, improve member health outcomes, and provide information about efficacy and cost to reduce prescription drug expenditures.
Hospital Transformation Program	This is a five-year hospital reform initiative that builds upon the hospital supplemental payment program to incorporate value-based purchasing strategies into existing hospital quality and payment improvement initiatives. Hospitals will be required to implement quality-based initiatives, improve clinical and operational efficiencies, and embark on community development projects to receive supplemental payments.
Cost and Quality Assessment Tools	In FY 2018-19, the Department finished rolling out a suite of powerful cost and quality assessment capabilities to the seven Regional Accountable Entities (RAEs), as well as hospitals and Primary Care Medical Providers (PCMPs). These analytics tools enable the Department to identify potentially avoidable costs on member care provided by individual physicians, PCMPs, specialists and hospitals. This information enables providers to improve their referral patterns towards more cost-effective, higher quality physicians and hospitals, and allows hospitals to identify and self-correct inefficient, lower quality care delivery.

Strategic Pillar 1: Health Care Affordability for Coloradans	
Supporting Initiative	**Description and Strategic Alignment**
Hospitals Centers of Excellence	The purpose of this initiative is to encourage hospitals to collaborate to refer patients to the higher quality, lower cost site alternative (Center of Excellence) for specific and common procedures. This alternative payment methodology approach improves outcomes and lowers costs for patients, lowers costs for employers and other payers (thereby lowering insurance premiums), improves volume at Centers of Excellence providers, and rewards hospitals for referring care out of their site when it is in the best interest of the patient.
All-Payer Claims Database (APCD) Reporting	The APCD is a valuable data collection resource that can help payers identify opportunities for efficiency, measure access to health care, and compare reimbursement rates by comparing their claims data to other health insurance providers in Colorado. Emerging APCD priorities: Improvements to cost and quality analytics, Health Care Affordability Roadmap reporting insights, and reporting support for self-funded employers.

Strategic Pillar 2: Medicaid Cost Control	
Supporting Initiative	**Description and Strategic Alignment**
Accountable Care Collaborative (ACC) Evolution and Strategy	The ACC continues to integrate behavioral and physical health care coordination, strengthen care support, and improve overall health among Medicaid members. The Department identified an opportunity for additional refinement, including a more efficient allocation of ACC capitated payments. Specifically, we are collaborating with our Federally Qualified Health Centers, Primary Care Medical Providers, and RAEs to consider adjusting their requirement to track down members who are churning in and out of the Medicaid program, and redirecting those efforts toward members who clearly need RAE and PCMP assistance. We are also working with these essential partners to develop programs to improve member health and better control costs.
Regional Accountable Entities (RAEs) Cost Collaborative	The RAEs formed the Cost Collaborative to provide a forum to develop key success factors and evidence-based, best practice recommendations to support better outcomes, improve quality, and lower costs. The Cost Collaborative developed a statewide approach to clinically stratify the population and define the performance pool metrics for FY 2018-19. Focus initiatives for FY 2019-20: refining key performance indicators and creating performance pool metrics that focus on outcomes; implementing chronic condition management and complex care management programs that effectively address the needs of our most vulnerable populations while also supporting upstream health management; introducing cost and health outcome metrics to track RAE performance and guide continuous improvement.
Provider Cost and Quality Variation Reports	Variation in health care delivery, costs, and outcomes is a critical factor in the quality of care members receive and the cost of the Medicaid program as a whole. Cost and Quality Variation Reports use claims data and insights to analyze and display variation in costs and health outcomes across providers in our health care delivery systems. The goal is to identify the highest quality, most cost-effective care sites for members. Two reports have been created: A hospital report measuring variation in procedures, surgeries, and aftercare, and a Federally Qualified Health Center (FQHC) report to gather feedback, hear concerns, and refine how FQHCs are measured. A primary care report is in development and a RAE/Primary Care Medical Provider report is also being designed.

Strategic Pillar 2: Medicaid Cost Control	
Supporting Initiative	**Description and Strategic Alignment**
Long-Term, Direct Care Workforce	The demand for direct care workers is increasing rapidly at a pace that will far outgrow supply without active and intentional intervention. Failure to proactively address this workforce shortfall will result in increased costs for aging adults and their families, inappropriate placement of individuals in long-term care facilities, over-medicating, social exclusion, reduced quality of life, and significantly worse health outcomes. The Department's efforts to increase and stabilize the direct care workforce for all individuals who require these long-term care services have the following strategies and priorities: ● Identifying challenges facing the direct care workforce and their employers and eliciting recommendations for changes to current policies and programs ● Creating a Training Advisory Committee to examine best practices and efforts around direct care workforce training and career advancement ● Implementing wage pass-through legislation that requires specific wage increases through Department rate increases ● Coordinating all state-level efforts and identifying key areas for collaboration and partnership across agencies
Member Health Risk Stratification	The Department developed a tool to clinically stratify our member population to identify members who are most vulnerable and in need of care coordination and other support from the RAEs. The goal is to improve member health outcomes and reduce the costs of care. The RAEs will use the clinical risk stratification tool to more effectively focus their care and condition management efforts. The Department calculated current and prospective risk scores for each member using diagnostics cost group (DCG) risk methodology. The risk score methodology requires enhancement to improve the predictive value of key influencing factors. These enhancements to the baseline scores will be completed by December 2019.
Controlling Rx Costs	Increases in the costs of medications, especially specialty drugs, are a significant challenge. In our program, 1.25% of our claims are for specialty drugs that are so expensive they consume 40% of our prescription drug spending. Current tools used to control drug costs include a preferred drug list, prior authorization, quantity limits, review of member drug utilization, and value-based contracts. We will also be releasing a comprehensive prescription drug report in calendar year 2019 that will help inform cost control policy for Medicaid and other payers.

Strategic Pillar 3: Member Health	
Supporting Initiative	**Description and Strategic Alignment**
Opioid Strategy	Reducing the amount of prescribed opioids to Medicaid members is a priority in our member health strategy. We have taken numerous actions, which resulted in reducing the number of opioid pills prescribed by 50% over the past five years while ensuring appropriate access to pain management: • Short-acting opioids have been added to our Preferred Drug List • Morphine Milligram Equivalent (MME) limit has been reduced in increments of 50 over the past few years • We implemented stricter limits on opioids for dental procedures • Pain specialist consultations help manage pain and opioid use
Informing Opioid Use Disorder Services with Data	A data analytics project focused on opiate use disorder care in the state that was completed in 2018 has provided powerful insights regarding development of policies and programs focused on services for these members: • Improving strategies for managing maternal opioid misuse and babies born with neonatal abstinence syndrome • Helping obstetric and pediatric practices that want to better integrate substance use disorder care into their clinics • Informing design of the residential substance use disorder benefit starting July 2020 Data resources emerging from the project are being shared with behavioral health initiatives across the Department and other agencies.
Tax-Exempt Hospital Accountability	Medicaid members will benefit from HB 19- 1320 which requires hospitals that are tax-exempt due to nonprofit status to improve the transparency of their annual community health needs assessments (CHNAs). These assessments are required to help the federal government measure the investments tax-exempt hospitals are making in their local communities, an obligation of their tax-exempt status. This bill will help communities dialogue with their local hospitals to ensure that their investments truly improve the health of the community, including the health of Medicaid members.

Strategic Pillar 3: Member Health	
Supporting Initiative	**Description and Strategic Alignment**
Residential and Inpatient Substance Use Disorder Treatment	Provisions of a 2018 law passed by the Colorado legislature enable the Department to provide inpatient and residential treatment, including withdrawal management, to members suffering from substance use disorders (SUD). The Department is applying for a waiver for federal funds and preparing to have the benefit available to members in July 2020. All Medicaid members will be eligible, and those who need it will be able to access the services through their Regional Accountable Entity, which will manage the benefit. In the future, SUD services will range from early intervention, outpatient, residential, and inpatient to recovery support services. Upcoming milestones include: ⬣ Waiver submission date targeted for October 31, 2019 ⬣ Implementation plan TBD within 90 days of approval (draft in process) ⬣ Evaluation design TBD within 180 days of approval

Strategic Pillar 4: Customer Service	
Supporting Initiative	**Description and Strategic Alignment**
Improving Service for our Providers	Since implementing the Colorado interChange systems that replaced our legacy Medicaid Management Information System (MMIS) we have dedicated significant resources to improving customer service to our providers. This includes Customer Service Representative training and analytics to identify what system enhancements are needed to address provider issues.
Maintaining an Average Speed of Answer (ASA) of Less than 61 seconds	The Department has managed the contractor to make continual improvements in their Provider Call Center to address wait time issues that existed after the launch of the new Medicaid Management Information System. Since that time, the contractor has focused on meeting service level agreements in this area and has committed additional resources and focus to ensure calls are answered in less than 61 seconds.
Improving Call Quality	The Department is focused on the quality of the interaction providers have with our contractor's Provider Call Center with the goal of transitioning calls from simple transactions to quality interactions that deliver providers meaningful service that satisfies their needs. Action items we will implement: ● Strategic meetings with Provider Call Center leaders to identify and address areas of concern ● Routine call calibration sessions with the contractor to ensure expectations are clear and are being met ● Examination and adjustment of the call-quality scoring process ● Identifying changes and improvements to the call center script to drive service improvements ● Implementation of additional targeted training on soft-skills, claim processing, and adjudication and program-specific requirements for call center agents
Revising Performance Measures in Current Service Level Agreements	The original contract contained 26 Service Level Agreements (SLAs), each with an associated monthly quality measurement payment. Many of those SLAs were achievable with little or no effort by the contractor, or they did not measure performance that was meaningful to the Department. A contract amendment holding the contractor accountable to the 20 new SLAs is expected to be executed in FY 2019-20.

[2] The "original contract" is the agreement with the Department's fiscal agent, DXC, for the design, development, implementation, operations, and maintenance of the Department's Medicaid Management Information System and the performance of services associated with the system (such as the operations of the provider call center). In general a "Service Level Agreement" or "SLA" is a performance standard that is measured under a contractual agreement (such as acceptable hold times, call wait times, and timelines for information updates into a system). These SLAs are what set the standards for vendor performance, so in the case of the provider call center, they set standards for our interaction with Medicaid providers through our contractor, DXC.

Strategic Pillar 4: Customer Service	
Supporting Initiative	**Description and Strategic Alignment**
Reduce Suspended and Aged Claim Volume	One component of improving the provider customer experience is reducing the number of days suspended claims age before they are worked by staff and adjudicated, which results in faster claim payment and/or claim decision for the provider. The number of claims suspended for questions was reduced by 32% between January and June 2019.
Redesign of Transmittal Workflow and Approval Process	The Department processes over 180 transmittals per month. These transmittals provide instruction to the contractor to make configuration adjustments to the Colorado interChange (claim system) that impact provider rates, mass adjustments to previously processed claims, and lump sum provider payments. A pilot project has been initiated to promote tighter control over the transmittal submission process and share details with leaders across the Department of those transmittals that are high-risk. To further reduce errors in our processes, we are piloting an e-clearance process in our Health Programs Office that requires a division director to approve all transmittal requests prior to submission to ensure there are no negative downstream impacts to other areas.

Strategic Pillar 5: Operational Excellence	
Supporting Initiative	**Description and Strategic Alignment**
Administration Budget Management Discipline and Accountability	Department budget allocations include the monies that finance full- and part-time staff and vendor partner contracts necessary to administer programs under the Department's authority such as Medicaid and CHIP. In advancing our Operational Excellence pillar, this allocation aims to more clearly track and communicate investment in cost control programs to better manage Medicaid claim costs and trends.
Contract Management	In FY 2018-19, we set and achieved the goal of transferring accountability and oversight for each of our 350+ vendor contracts to a member of our Executive Leadership Team (ELT). In FY 2019-20, we are building on that foundation by improving our vendor contracting and oversight process through a three-pronged approach: • First, implement a new set of tools that will ensure the content of our contracts creates strong vendor accountability and alignment of financial incentives with desired functional performance. • Second, the ELT member with oversight of the functional area is required to sign off on this form, indicating that best-practices were followed to ensure a strong vendor contract. • Third, we are mandating new and more robust training for contract managers and ELT staff. The training focuses on improving vendor contractor oversight skills and contract performance and on maximizing use of the newly available contract management tools. Together, these three focus areas will increase the quality of the work performed, reduce delays resulting from rework of vendor deliverables, improve execution on cost control and other key strategies.
Integrated Performance Management Program	The Department is further enhancing operational excellence through its integrated performance management (IPM) program. The IPM program helps internal teams develop strategy, focus their operations, and make continuous improvements. It provides them with tailored facilitation and training in Lean for the purpose of setting and achieving goals and improving performance. This process enables clearer direction and purpose for teams that want to sharpen their focus and develop a blueprint for the future. Operational planning through the IPM program allows teams to identify and overcome barriers to achieving their goals, and sets them up for continued success. They evaluate how their resources are being used and make changes necessary to achieve their mission. Through operational planning, teams map their day-to-day functions to monitor and improve performance, and use data to identify problems and develop solutions.

Section 3: Financial Structure

Total Appropriations						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$1,690,688,001	$809,452,060	$1,156,297,382	$17,003,651	$5,438,943,180	$9,112,384,274
FY 2016-17	$1,798,860,293	$830,634,257	$1,022,925,553	$15,426,584	$5,409,785,027	$9,077,631,714
FY 2017-18	$1,989,739,026	$821,142,006	$1,212,347,879	$77,491,711	$5,795,608,107	$9,896,328,729
FY 2018-19	$2,071,721,281	$885,763,242	$1,389,264,217	$83,491,228	$5,944,110,291	$10,374,350,259
Current Appropriation	$2,253,251,728	$898,118,536	$1,386,291,098	$93,615,672	$6,057,784,830	$10,689,061,864

Totals exclude Capital Construction appropriations.

Executive Director's Office						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$61,494,693	$0	$31,343,500	$3,668,890	$181,300,513	$9,112,384,274
FY 2016-17	$61,544,145	$0	$32,444,772	$3,523,924	$178,986,066	$9,077,631,714
FY 2017-18	$62,027,666	$0	$40,720,410	$4,004,743	$184,074,527	$291,016,161
FY 2018-19	$75,047,213	$0	$48,175,326	$4,004,743	$213,578,319	$340,805,511
Current Appropriation	$86,628,734	$0	$54,197,823	$4,514,382	$245,426,150	$390,767,089

Programs aligned with "Executive Director's Office":

- Medicaid
- Children's Health Insurance Program
- State Programs
- General Department Administration

Comments:

This Long Bill group contains appropriations for general Department administration in support of all of the Department's programs. Specific appropriations include funding for Department payroll and benefits, operating, and contracting. Further, these appropriations

include funding to administer key components of the Medicaid programs, such as the Department's claims system (the Medicaid Management Information System), eligibility system (the Colorado Benefits Management System) and determinations, utilization management, audits and recoveries, other professional services, transfers to other State departments, and indirect costs. Finally, some funding is appropriated for payments to outside entities, such as Connect for Health Colorado and the All-Payer Claims Database.

Medical Services Premiums						
	General Fund	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Total**
FY 2015-16	$1,029,653,420	$809,024,467	$819,317,292	$9,145,518	$4,210,283,978	$6,877,424,675
FY 2016-17	$1,106,167,109	$830,201,667	$698,906,376	$9,102,709	$4,149,759,791	$6,794,137,652
FY 2017-18	$1,255,856,070	$820,701,666	$866,879,029	$70,731,431	$4,567,845,864	$7,582,014,060
FY 2018-19	$1,290,515,379	$885,333,333	$1,027,854,986	$79,040,579	$4,536,570,893	$7,819,315,170
Current Appropriation	$1,387,975,341	$897,710,833	$983,543,298	$88,876,290	$4,537,311,766	$7,895,417,528

Programs aligned with "Medical Services Premiums":

- Medicaid
- Children's Health Insurance Program

Comments:

This Long Bill group contains appropriations for physical health and certain long-term services and supports for people enrolled in Health First Colorado, Colorado's Medicaid program. Some children and pregnant women who are eligible for the Children's Health Insurance Program receive services through Health First Colorado.

Behavioral Health Community Programs						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$170,136,807	$0	$10,266,952	$0	$437,815,182	$618,218,941
FY 2016-17	$170,423,670	$0	$18,132,712	$0	$425,726,312	$614,282,694
FY 2017-18	$173,502,009	$0	$23,499,835	$0	$338,172,782	$535,174,626
FY 2018-19	$188,367,662	$0	$29,000,474	$0	$446,117,475	$663,485,611
Current Appropriation	$201,872,261	$0	$38,385,780	$0	$482,816,394	$723,074,435

Programs aligned with "Behavioral Health Community Programs":

- Medicaid
- Children's Health Insurance Program

Comments:

This Long Bill group contains appropriations for behavioral health and substance use disorder services for people enrolled in Health First Colorado, Colorado's Medicaid program. Some children and pregnant women who are eligible for the Children's Health Insurance Program receive services through Health First Colorado.

Office of Community Living						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$242,627,030	$0	$35,394,381	$1,695,000	$231,743,375	$511,459,786
FY 2016-17	$256,885,832	$0	$7,395,268	$308,229	$238,446,589	$503,035,918
FY 2017-18	$271,545,879	$0	$7,516,096	$0	$256,507,545	$535,569,520
FY 2018-19	$292,123,556	$0	$2,277,218	$295,906	$272,274,015	$566,970,695
Current Appropriation	$346,434,955	$0	$7,751,685	$0	$329,191,915	$683,378,555

Programs aligned with "Office of Community Living":

- Medicaid
- Family Support Services
- State Supported Living Services
- Supported Employment Pilot Program

Comments:

This Long Bill group contains appropriations for long-term services and supports provided to people with intellectual and developmental disabilities enrolled in the Medicaid program. In addition, this Long Bill group contains appropriations for certain programs for people with intellectual and developmental disabilities who do not qualify for Medicaid.

Indigent Care Program						
	General Fund	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Total**
FY 2015-16	$11,730,871	$427,593	$208,254,868	$0	$274,665,639	$495,078,971
FY 2016-17	$11,817,602	$432,590	$207,673,644	$0	$309,699,410	$529,623,246
FY 2017-18	$9,968,662	$440,340	$208,257,707	$0	$332,935,422	$551,602,131
FY 2018-19	$9,758,522	$429,909	$210,455,500	$0	$349,365870	$570,009,801
Current Appropriation	$9,747,199	$407,703	$228,555,396	$0	$334,427,200	$573,137,498

Programs aligned with "Other Medical Services":

- Medicaid
- Children's Health Insurance Program
- Clinic Based Indigents Care
- Pediatric Specialty Hospital
- Primary Care Fund Program

Comments:

This Long Bill group contains appropriations for supplemental payments to hospitals as part of the Medicaid program; services for individuals enrolled in the Children's Health Insurance Program; payments to hospitals and clinics to for uncompensated care; and, payments to providers that serve medically indigent or uninsured patients.

Other Medical Services						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$123,027,864	$0	$49,767,175	$2,491,722	$46,784,451	$222,071,212
FY 2016-17	$139,684,674	$0	$56,506,639	$2,491,722	$52,056,097	$250,739,132
FY 2017-18	$162,019,412	$0	$63,585,899	$2,566,722	$58,837,944	$287,009,977
FY 2018-19	$157,026,598	$0	$69,611,900	$150,000	$64,932,463	$291,720,961
Current Appropriation	$162,002,713	$0	$71,968,213	$225,000	$67,631,973	$301,827,899

Programs aligned with "Other Medical Services":

- Medicaid
- Old Age Pension State Medical Program
- Senior Dental Program
- Commission on Family Medicine Residency Training Programs
- Screening, Brief Intervention, and Referral to Treatment Training Grant Program

Comments:

This Long Bill group contains appropriations for: Medicaid payments to public schools, state university teaching hospitals, and prescription drug costs for full-benefit Medicare-Medicaid enrollees; state-only programs for people who do not qualify for coverage under Medicaid; payments using Medicaid funding for family medicine residency training; and, grants to train providers in Screening, Brief Intervention, and Referral to Treatment (SBIRT) methods.

Department of Human Services Medicaid-Funded Programs						
	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2015-16	$52,017,316	$0	$2,521	$2,491,722	$56,350,042	$110,323,093
FY 2016-17	$52,337,261	$0	$0	$2,491,722	$55,110,762	$109,314,165
FY 2017-18	$54,819,328	$0	$0	$2,566,722	$57,234,023	$113,942,254
FY 2018-19	$58,882,351	$0	$0	$150,000	$61,271,256	$122,042,510
Current Appropriation	$58,590,525	$0	$0	$225,000	$60,979,432	$121,458,860

Programs aligned with "Department of Human Services Medicaid-Funded Programs":

- Medicaid

Comments:

This Long Bill group contains appropriations that are transferred to the Colorado Department of Human Services (CDHS) when Medicaid funding is available for programs that are administered by CDHS. Examples include funding for: administration; information technology; child welfare programs; early childhood programs; mental health institutes; high-risk pregnant women; regional centers; adult assistance programs, youth services; and, indirect costs.

Capital Construcion: IT Projects						
	General Fund	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Total**
FY 2015-16	$0	$0	$0	$0	$0	$0
FY 2016-17	$0	$0	$0	$0	$0	$0
FY 2017-18	$0	$0	$0	$0	$0	$0
FY 2018-19	$1,875,500	$0	$0	$0	$4,729,500	$6,605,000
Current Appropriation	$1,140,833	$0	$0	$0	$10,267,500	$11,408,333

Programs aligned with "Capital Construction: IT Projects":

- Colorado Health IT Roadmap

Comments:

The appropriations in the Capital Construction section of the Long Bill support the Governor's Office of eHealth Innovation.

Section 4: Financial Forecast

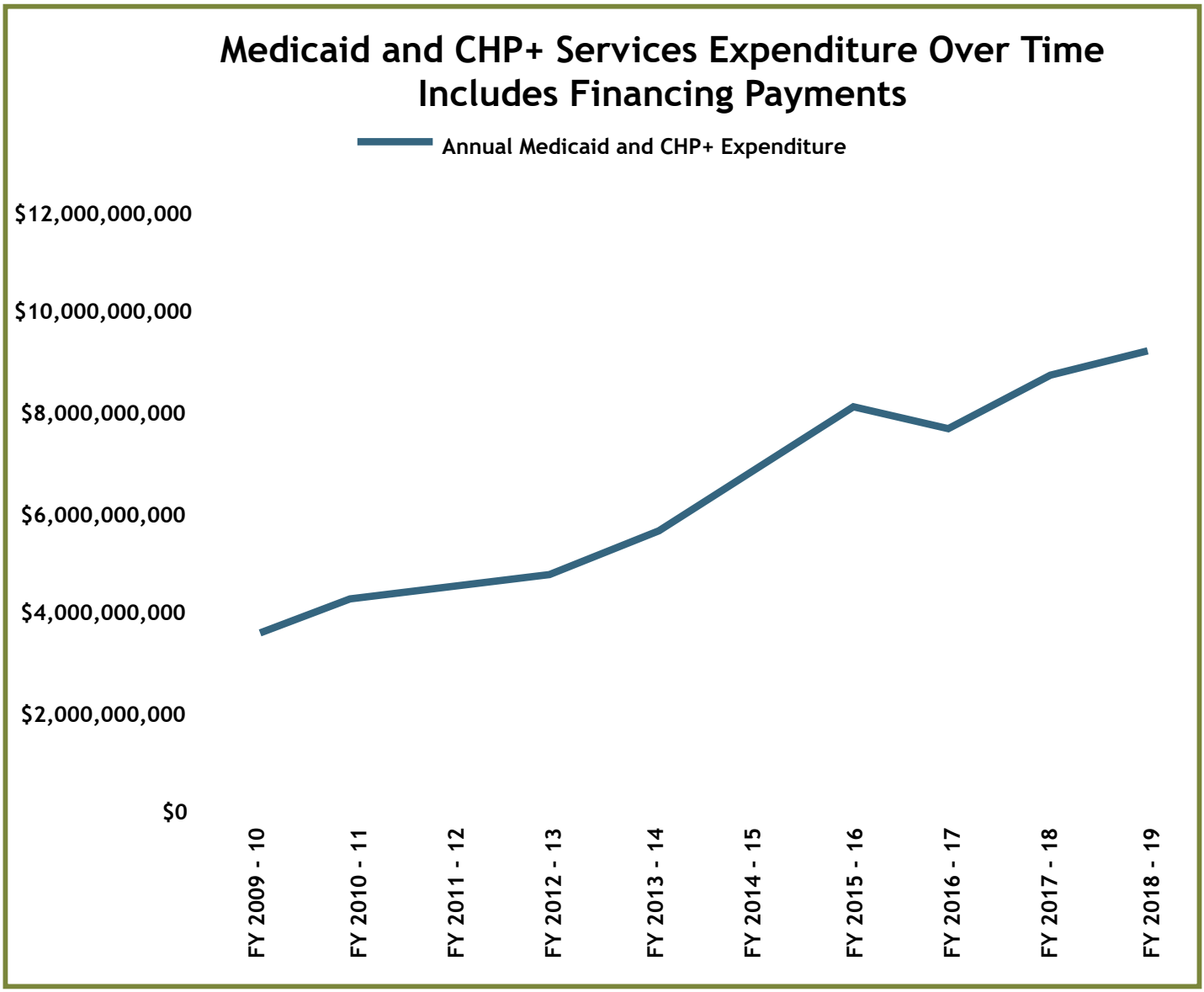
Baseline Forecast: Budget Drivers in the FY 2019-20 - FY 2023-24 Timeframe

The following tables provide estimates of appropriations for FY 2020-21 through FY 2023-24. Estimates are derived based on expected increases to the budget from approved legislative or budget items from 2019 and prior, and include estimates for increasing costs in the Medicaid and CHP+ programs based on the Department's November 1, 2019 budget requests R-1 through R-5.

Summary of Total Appropriation					
Fiscal Year	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Total**
FY 2020-21*	$3,394,339,038	$1,522,651,796	$93,615,277	$6,303,909,535	$11,314,515,646
FY 2021-22*	$3,608,758,531	$1,595,600,009	$93,615,277	$6,632,332,849	$11,930,306,666
FY 2022-23*	$3,826,770,824	$1,679,680,682	$93,615,277	$6,990,189,681	$12,590,256,464
FY 2023-24*	$4,058,494,735	$1,768,965,800	$93,615,277	$7,368,802,100	$13,289,877,912

*Estimated Appropriation

Summary of Medicaid and CHP+ Services Expenditure Projections Includes Financing Payments				
Expenditure	**Total Funds**	**Year-over-year change (%)**	**General Fund and GFE**	**Year-over-year change (%)**
FY 2014-15	$6,939,858,587		$2,186,616,569	
FY 2015-16	$8,117,695,980	16.97%	$2,333,118,180	6.70%
FY 2016-17	$7,697,641,270	-5.17%	$2,380,039,744	2.01%
FY 2017-18	$8,834,315,118	14.77%	$2,669,311,200	12.15%
FY 2018-19	$9,270,087,304	4.93%	$2,800,281,710	4.91%
FY 2019-20 Projection	$9,680,257,757	4.42%	$3,002,321,948	7.21%
FY 2020-21 Projection	$10,232,439,121	5.70%	$3,198,006,853	6.52%
FY 2021-22 Projection	$10,854,372,871	6.08%	$3,415,581,096	6.80%
FY 2022-23 Projection	$11,514,134,522	6.08%	$3,633,435,161	6.38%
FY 2023-24 Projection	$12,214,035,716	6.08%	$3,865,298,945	6.38%



Narrative: Agency Budget Drivers or the Agency Environment

The Department's primary budget drivers can be classified into four major categories:

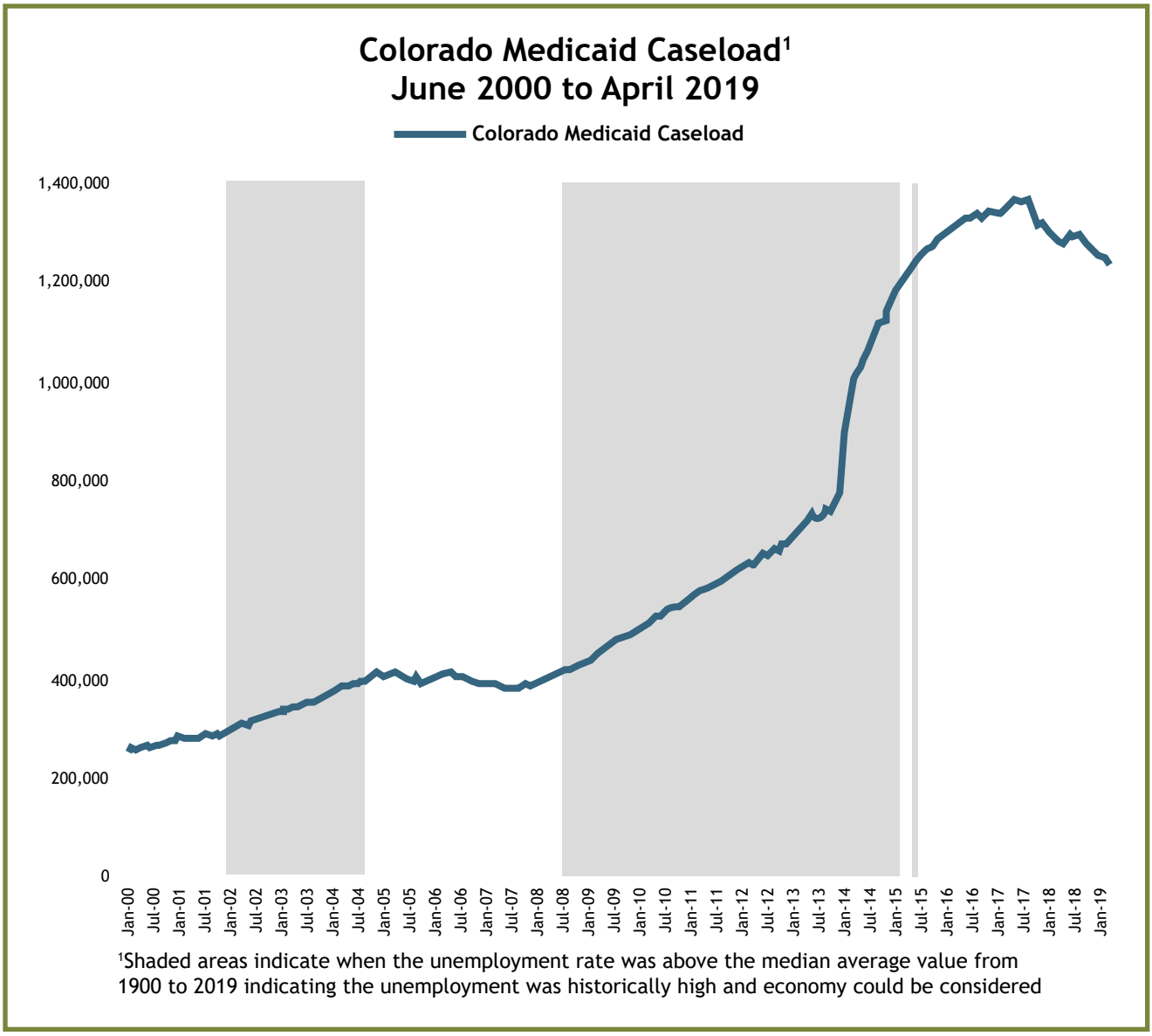
1.Changes in economic conditions
2.Changes in Colorado's demographics
3.Increasing health care costs
4.Federal policy changes

Changes in Economic Conditions

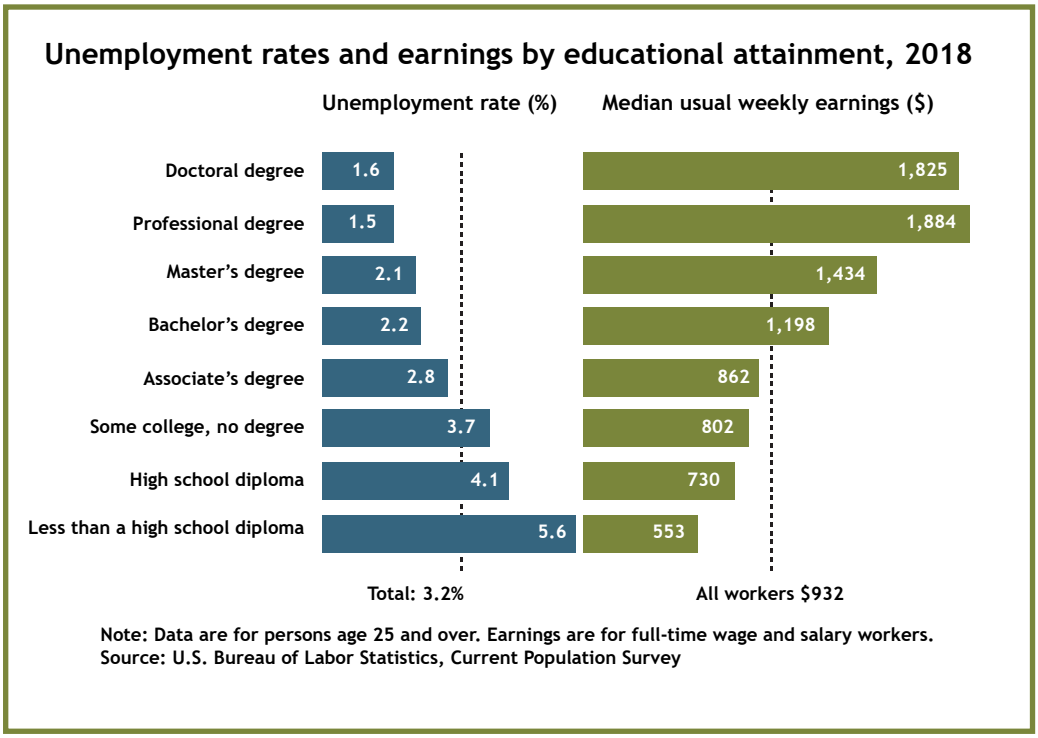
A large majority of people enrolled in the Medicaid and Children's Health Insurance Program (CHIP)[3] qualify for the programs because their income is below specific thresholds. Colorado expanded eligibility criteria under federal law, and for Medicaid, adults and children must have income below 133% of the federal poverty level to qualify. For CHIP, children and pregnant women must have income below 250% of the federal poverty level to qualify.

During times of recession or other economic contraction, caseload increases rapidly. As unemployment rises and people lose their jobs, income, and health insurance, people quickly apply for coverage through the Department's programs. This immediately drives costs for the State as people enroll in the Department's programs and begin to use services. For example, a 10% increase in caseload for adults and children would drive a fiscal impact of approximately $300 million total funds, $84 million General Fund. This creates a double-edged problem for the State: Medicaid and CHIP costs are driven up by the influx of new caseload while the State collects lower General Fund revenues. Compounding the problem is the fact that Medicaid is an entitlement program, which means that the State cannot cap enrollment or turn away new enrollees. Further, federal law prohibits the State from reducing the amount, scope, or duration of services due to a lack of state funding. As a result, there are limited opportunities to reduce Medicaid growth during an economic downturn.

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



ositive changes in economic conditions do not reduce costs in the same way that economic contractions increase costs. As the economy recovers, program caseload falls slowly. There are several key reasons for this. First, federal and state requirements for transitional programs allow people to stay enrolled for up to a year to prevent sharp drops in caseload as people return to work. Second, economic recoveries tend to affect people with lower income expectations more slowly. This means that while major economic indicators (such as unemployment and gross domestic product) may show that the economy is improving, people with less education and people who are competing for low-wage jobs will generally take longer to find work. As a result, Medicaid caseload tends to continue to increase for up to two years after a recession is officially over. Finally, people who leave public assistance programs during economic recoveries tend to be healthier and have lower costs than those people that remain. As a result, as caseload goes down, expenditure decreases by an amount lower than might otherwise expected, because the people that are leaving have lower than average per capita costs. Collectively, this continues to put pressure on the State's General Fund and limits the opportunity to restore funding to other State programs that received funding reductions during recessions.



Changes in Colorado's Demographics

The combination of Colorado's increasing population and a greater proportion of adults over 65 will continue to drive costs in the Department's programs. The State Demography Office predicts total population growth of close to 430,000 people (7.4%) between 2019 and 2024.[2] Growth rates are even higher among older adults, with 23% growth of people between the ages of 65-74, and 21% growth of people aged 75 and older.[3] Colorado's population growth rates are expected to exceed national population growth by a significant margin in this time frame. Longer term projections from the State Demography Office's indicates that Colorado's population will exceed over 8 million people by the year 2050. By 2050, they estimate that the population of people 65 and older will more than double, and that there will be over 1,000,000 households of people 65 and older.

The increasing population, and Colorado's rapidly aging population, will undoubtedly affect the Department's spending. As the population grows, caseload in Medicaid and CHIP will also grow. Critically, the growth in adults 65 and older will continue to create significant budgetary pressure. As people age and spend down their resources, they become eligible for Medicaid. Further, people who require assistance with activities of daily living qualify for Medicaid at higher income levels. Older adults have higher per capita costs than adults and children and receive the least amount of federal funding available.

Increasing Health Care Costs

The Centers for Medicare and Medicaid Services (CMS) predict that national health spending is projected to grow at an average rate of 5.5% per year between 2018 and 2027, outstripping growth in the nation's Gross Domestic Product.[4] Prices for health care goods and services are projected to grow at a rate of 2.5% per year in the same time window. Overall, CMS predicts that Medicaid spending will also grow at a rate of 5.5%, which is between the projected rate of Medicare growth at 7.4% and private health insurance growth at 4.8%. CMS identifies that key trends involve rapid increases in prescription drug spending, hospital spending, and physician and clinical services.

[2] https://demography.dola.colorado.gov/births-deaths-migration/data/components-change/#components-of-change
[3] https://demography.dola.colorado.gov/population/population-totals-counties/#population-totals-for-colorado-counties
[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

For Colorado, this will continue to create budgetary pressures. Health care providers will continue to face cost pressures due to the rising cost of wages, capital costs, health insurance, and other factors common to most businesses. Further, the aging population and growth in caseload for people with disabilities will also continue to be a strong factor in the need for increasing appropriations. In order to ensure continued provider participation in public assistance programs and meet requirements in the Social Security Act, Medicaid provider rates must be sufficient to ensure that there are enough providers to meet the needs of the program. While the Department continues to implement new payment methodologies, condition a portion of reimbursements on outcomes and performance metrics, and implement regulatory structures that prioritize member health, inflationary pressures will continue.

In some cases, federal or state law requires the Department to increase rates to keep pace with provider costs. Examples include nursing facility rates, payments for pharmaceuticals, rates for behavioral health services, and rates for federally qualified health care centers. For most providers, however, the General Assembly has significant control of Medicaid rates as rate increases for most providers are tied to the appropriations process; without new appropriations, most Medicaid rates will stay the same year-over-year. If rates are too low, the State risks losing key providers from its provider network or causing cost-shifting to private insurance. The adequacy of payments rates is a key factor in ensuring that there are enough providers; when there are not enough providers, members may go without necessary services and ultimately use higher cost options. A critical example involves providers who provide home- and-community based services (HCBS) to members. The availability of HCBS allows a person to age in place and remain in their home as they age; without these services, that same person would need to live in a nursing facility or other institution to ensure their safety and wellbeing. Further, these services are also critically important to assisting younger people with disabilities to remain in their communities. Many of these services are provided by people who are paid at or near the State's minimum wage. There are already shortages of qualified people to provide HCBS to members, and if the Department does not pay competitive wages, providers will find other jobs. Without enough providers, people may have no other option but to move out of their homes and into nursing facilities, which would cause dramatic increases in Medicaid costs.

Federal Policy Changes

Medicaid and CHIP are programs that are funded jointly by the federal government and Colorado. As such, any change in federal policy for these programs can have a budgetary impact for the State. Most major policy changes require an act of Congress, and therefore, there is uncertainty in what may occur in the next five years.

There is no clear consensus at the federal level about how Medicaid and CHIP may change in the future. Possibilities that have been discussed at the federal level recently include:

- **Repealing the Affordable Care Act (ACA).** The elimination of the Medicaid eligibility provisions of the ACA could cause approximately 379,000 people to lose coverage through Health First Colorado. It is possible that some people could gain private insurance, though this is not certain; many people who gained coverage during the Medicaid expansion were previously uninsured. If there is no replacement federal health program, there are likely to be downstream effects to the State, including economic contraction and job loss. Without medical coverage, this population could increase State costs in other areas, such as human services programs and corrections. A straight repeal would jeopardize at least $1.75 billion in federal funds for Colorado.[5]

- **Converting Medicaid to a block grant program.** Under a block grant, there would be a limit to how much federal funding was available for the Medicaid program. This could have the effect of shifting expenditures from the federal government to the State, Medicaid benefit reductions, or eligibility reductions. The nature of any change to the State budget would depend on the structure of a block grant. The details of the block grant program would be critically important to the financial effect on Colorado; for example, approaches that do not adjust funding for changes in enrollment would impact Colorado differently than proposals that are based on per capita costs. The Kaiser Family Foundation found that recent federal block grant proposals would reduce Colorado's available federal funds by $2.9 billion between 2020 and 2026.[6]

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

[5] Colorado Healthcare Affordability and Sustainability Enterprise Update, February 2019, page 5.
[6] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%202019%20FEB%2C%20CHASE%20Update.pdf 6 https://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-changes-in-federal-spending-on-health-care-under-the-graham-cassidy-bill/

- **Medicaid waivers and Executive Action.** The Social Security Act allows the approval of "…experimental, pilot, or demonstration projects that are found by the Secretary [of Health and Human Services] to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.[7]" In recent years, the federal government has approved waivers that allow for drastic changes in the Medicaid program, such as work requirements (also known as "community engagement"), enhanced coverage for substance use disorder treatment, and other Medicaid redesigns. The increasing availability of these waivers may provide options for Colorado to reform Medicaid programs beyond what was approved in the past. In addition to waivers, the federal government may change the Medicaid program via new regulations. This type of Executive Action could have significant effects on the operation and financing of the Medicaid program; for example, regulatory action could reduce or eliminate Colorado's ability to finance portions of the Medicaid program using provider fees. Should this type of action reduce the availability of federal funding, it could increase the State's need to use General Fund to maintain the current program, cause increasing caseload and expenditures for other public assistance programs if people lose health coverage, or drive other effects that may require additional appropriations from the General Assembly.

Scenario Evaluation: Downturn

Effects of an Economic Downturn on Core Functions

An economic downturn primarily affects the Department by increasing caseload for the Medicaid and CHIP programs. During an economic downturn, unemployment rises rapidly, particularly for those people with lower income expectations. As a result, caseload rises rapidly. For example: During the last recession and the years immediately following the recession where unemployment remained above historical averages, Medicaid caseload increased from 391,962 in FY 2007-08 to 682,994 by FY 2012-13. Because of the entitlement nature of the Medicaid program, this causes rapid growth in the Department's appropriations at a time when the State's General Fund revenue growth has stalled or revenues have declined.

In the table on the following page, the Department illustrates the effect of an increase in expenditure due to an economic downturn. In the table, the Department uses caseload growth during FY 2002-03 to estimate how caseload and expenditure might increase in a single year during an economic downturn. While there have been more recent economic downturns, the Department selected a caseload statistic from FY 2002-03 because it was a period where rapid caseload growth was more directly related to economic conditions and generally unaffected by program changes. In contrast, in FY 2009-10 and FY 2010-11, there were other factors that were contributing to Medicaid caseload growth, including the implementation of HB 09-1293 "Concerning the Implementation of a Hospital Provider Fee…" which authorized new populations to become eligible for Medicaid.

[7] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

Summary of Medicaid and CHP+ Services Expenditure Projections Includes Financing Payments			
Item	**Adults**	**Children**	**Total**
Estimated FY 2019-20 Caseload	569,042	494,634	1,063,676
Caseload Groth during FY 2002-03	22.01%	17.15%	19.75%
Estimated FY 2020-21 Caseload with Economic Shock	694,287	579,464	1,273,751
Estimated FY 2020-21 Caseload from R-1 Request	582,421	502,194	1,084,615
Difference in Caseload Projections	111,866	77,270	189,136
FY 2020-21 Per Capita Costs	$4,212	$2,683	$3,588
Estimated Total Increase due to Economic Shock - Total Funds	**$471,208,844**	**$207,340,747**	**$678,549,591**

Rapid growth in caseload will strain the resources of the Department and strain the Department's provider network and its ability to provide services. For example, a large increase in caseload is likely to increase the number of calls to the Department's Member Contact Center, increasing wait times and reducing the likelihood that members will get their questions answered. Constraints on the State budget will prevent the Department from increasing staff to accommodate the needs of the new members; at various points in the past the State has implemented hiring freezes and furloughs which essentially require the Department to reduce staffing at the same time caseload is increasing.

When downturns occur, one of the principle ways to reduce Medicaid expenditure is through provider rate reductions. Frequently, in order to balance the budget, the Governor has proposed – and the General Assembly has approved – rate reductions to almost all provider groups. From FY 2009-10 to FY 2011-12, rates for most Medicaid providers were reduced by approximately 6.1%. While rate reductions directly reduce the Department's spending, they also reduce the amount of revenue that providers receive. This may make providers less willing to accept Medicaid patients.

Historically, Colorado has relied on increases in federal funds to offset the need for program and provider cuts during an economic downturn. For example: Beginning in 2009, the American Recovery and Reinvestment Act (ARRA) increased the federal medical assistance percentage for the Medicaid program. This has the effect of reducing the State's cost for Medicaid, thereby creating General Fund relief. In the last year of ARRA, FY 2010-11, Colorado received over $300 million in new federal funds for Medicaid that directly offset the need for General Fund and other State cash funds. Given that the federal budget for 2020 and beyond is currently projected to have annual deficits of over $1 trillion, it is unclear if the federal government would be able to provide this type of financial assistance in a future recession. Without additional federal assistance, more drastic program and provider cuts may be needed in a future downturn.

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

Reductions to other State departments can also affect the Medicaid program. For example, cuts to human services programs such as the Supplemental Nutritional Assistance Program (SNAP), child welfare programs, or the Office of Behavioral Health, can have long-term effects on people that cause their health care costs to increase. These effects further increase Medicaid expenditures. In addition, when recessions occur nationally, federal grant funding becomes less available, which can prevent backfilling of the loss of State funds, stifle innovation, and end critical programs which have the potential to reduce costs.

Economic Downturns Spur Innovation

Although economic downturns create significant challenges for the State's entitlement programs, they also create opportunities to find efficiencies and spur innovation. When faced with rate cuts, providers are more willing to accept alternative proposals that are designed to reduce funding without directly affecting rates. For example, during FY 2009-10, the Department collaborated with providers around the State to develop plans to reduce unnecessary and duplicative utilization across a wide variety of services. Further, the recession allowed the Department to implement critical utilization management policies, such as implementing prior authorization requirements for certain drugs, restricting payments to hospitals for readmissions, and other initiatives that may not have been considered without the pressure of restricted funding.

Scenario Evaluation: Department-Specific Contingency

Colorado's Medicaid program can be drastically affected by major changes in federal policy or unexpected changes in the Colorado health care landscape.

Changes in Federal Policy

Medicaid and CHP+ are programs that are funded jointly by the federal government and Colorado. As such, any change in federal policy for these programs can have a budgetary impact for the State. Most major policy changes require an act of Congress, and therefore there is uncertainty in what may occur in the next five years.

There is no clear consensus at the federal level about how Medicaid and CHP+ may change in the future. Possibilities that have been discussed at the federal level are discussed in the Agency Budget Drivers section of this document.

Changes in Colorado's Health Care Landscape

The Department does not provide medical services; rather, it administers a network of public and private providers who render services to members. Changes in the provider landscape can have a dramatic effect on the Department's ability to improve the health of its members. Examples might include:

- **Closure of a rural hospital.** In many areas of the state, there is only a single hospital within a reasonable travel distance. A hospital closure in a rural area could leave a large area of the State without access to hospital services. Some people may end up going without needed services, while the Department may end up paying more for transportation costs to bring people to other hospitals. Further, this may stretch the capacity of other nearby providers.

- **Closure of a Regional Accountable Entity.** The Department contracts with seven Regional Accountable Entities (RAEs) across the State to promote physical and behavioral health of their enrolled members. The RAEs administer the Department's capitated behavioral health benefit, while physical health services are reimbursed fee-for-service. As with any contracted arrangement, there is a risk of an early termination with a vendor. This can occur because of a vendor's financial difficulties, loss of appropriate licensure, or for breach of contract. If a RAE ceased to operate, members could experience challenges with accessing behavioral health services and/or coordinating care among different Medicaid providers and programs until the Department established an alternative arrangement. While the Department has plans to quickly address this scenario and minimize the risk to members, there could be negative consequences to member health, particularly those with complex health needs.

- **Provider shortages.** An ongoing concern is that there will not be enough providers available to provide services when members need them. There are already shortages of qualified providers in rural areas, particularly for skilled nursing services and home- and community-based services. A lack of qualified providers may cause people to forgo needed services or seek alternative, higher cost services. An example of this is the 2018 closure of Arapahoe House, a large Denver substance use disorder treatment provider. Their sudden closure left a significant number of people in a position where they needed to immediately find new providers; this, in turn, increased caseloads at other providers along the front range with virtually no notice and further exacerbated the effects of ongoing shortages of substance use disorder providers. While the Department continues to work on building provider capacity, these types of short-term effects can have long-term consequences on peoples' health and expenditure in public assistance programs.

Legality of the Colorado Health Care Affordability and Sustainability Enterprise

In recent years, there have been legal challenges to the Colorado Health Care Affordability and Sustainability Enterprise (CHASE). This program funds the costs of a large number of Medicaid members and additional payments for hospitals. Although none of the legal challenges thus far have been successful, if a court finds that CHASE violates the Colorado Constitution (namely, that the fees charged under the Enterprise are in violation of the Taxpayer Bill of Rights), Colorado would lack a funding source for these members, services, and payments. For FY 2020-21, the Department expects to collect approximately $1.0 billion in fees, which allows the Department to receive $2.6 billion in federal funds.

Emerging Trends

In addition to the primary drivers of expected budget growth, such as population growth, a rapidly aging population, and inflationary health care costs, there are several key trends that will continue to drive expenditure growth in the Department's programs. In all circumstances, the Department is exploring ways to control growing costs. Key examples of emerging trends include:

Prescription Drug Costs

The rapid rise of high cost drugs that treat rare conditions are likely to increase Medicaid expenditure, particularly in the short term. These drugs can be used to treat, and possibly cure, diseases that may cause life-long disability or premature death. At present, many of these drugs have high initial and ongoing costs, with treatment costing hundreds of thousands and, in some cases, millions of dollars per person per year. It is possible that the cost of these drugs is eventually offset by costs avoided through reduced hospitalizations, home health, home- and community-based services, institutionalizations, and other health care services. At this time, it is not known if the costs of these emerging treatments will exceed the expected cost of services without treatment. In the short-term it is likely that these drugs will increase Department expenditure as costs will be borne immediately and costs avoided will be measured over an individual's lifetime. The Department must cover any drug that received approval from the Federal Drug Administration and have a rebate agreement in place.

Rising Minimum Wages

As required by the Colorado Constitution, the State's minimum wage will increase every year. Many people who provide services in the Medicaid program, particularly people who provide personal care and homemaker services, are paid at or near the minimum wage. Medicaid rates will need to be sufficient to meet minimum wage rules.

Waiting Lists for People with Intellectual and Developmental Disabilities

The Department's Home-and-Community-Based Services program for adults with intellectual and developmental disabilities (the Developmental Disabilities Waiver) currently has a waiting list of over 3,000 people. These individuals qualify for the program but cannot access the services because of a lack of appropriations. While many of these people currently receive services through other programs, there is a large unmet demand for services – particularly residential services.

Furthermore, Colorado's growing population will generate additional demand for these services.

Higher Cost Community-Based Long-Term Services and Supports

Home-and-Community-Based Services are available to individuals who need assistance with activities of daily living,
such as getting dressed and bathing. These services are generally less expensive than institutionalization. In recent years, there has been increased enrollment in newer service delivery options which, while lower cost than nursing facilities, are more expensive than agency-based care models. There are two key examples of this:

- **Participant-Directed Programs.** Participant-directed services are home- and community-based services that help people of all ages, across all types of disabilities, maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them. Participant-Directed programs have the benefit of allowing individuals to receive access from a wider variety of providers than under agency-based care models, because there are fewer restrictions on who can be providers. In part because of this expanded provider network, it appears that people who use participant-directed programs use more services than people in traditional agency-based care models. On average, the Department spends more per person in these programs than in agency-based care programs. While the programs remain cost effective compared to nursing facilities, increased enrollment in these programs will continue to increase the need for additional appropriations in the future.

- **The Program of All-Inclusive Care for the Elderly (PACE).** PACE provides comprehensive medical and social services to certain frail individuals 55 years of age and older. This includes both community-based services and nursing facility services. PACE organizations are paid a pre-paid monthly premium to cover the expected cost of services. In the short-term, at least, enrollments in PACE increase State costs: When a person enrolls in PACE, the Department pays PACE organizations a rate that is higher than the Department would otherwise pay for an individual who needs home- and community-based services. This is because PACE rates are based on a blend of home- and community based service and nursing facility costs. This methodology exists because PACE organizations do not receive a rate increase when an individual requires nursing facility services when costs are expected to exceed payments. It is not known whether Medicaid programs fully recoup the upfront cost paid to PACE programs; the return on investment cannot be fully measured until after a person passes away. Enrollment in PACE continues to grow steadily.

Section 5: Anticipated Funding Decreases

There are three upcoming notable changes in federal financing for the Department's programs.

Reduction in the Federal Medical Assistance Percentage (FMAP) for Medicaid Expansion Adults

As part of the Affordable Care Act (ACA), the FMAP for expansion adults – those people newly eligible under the ACA's Medicaid expansion – will decline from 93% to 90% on January 1, 2020. This will cause an increase in cash fund appropriations from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE).

The Department has included a request for additional State funding as part of its November 1, 2019 budget request.

Reduction in the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program

The federal Children's Health Insurance Program (CHIP) provides low-income children and pregnant women with medical and dental coverage. Members are provided services through either the Child Health Plan Plus (CHP+) or through Health First Colorado, depending on the member's income level. On October 1, 2019, the FMAP for CHIP will be reduced from 88% to 76.5%. On October 1, 2020, the FMAP for CHIP program will be reduced from 76.5% to 65% and remain at that level. State CHIP costs are partially funded by money from the Tobacco Master Settlement, but the allocation to the CHIP program is insufficient to fully cover the State cost of the program at the lower FMAP rates. Additional sources of State funds will be needed to maintain the current CHIP program.

The Department has included a request for additional State funding as part of its November 1, 2019 budget request.

End of Dedicated Enhanced Funding for Health Information Technology

Through the Health Information Technology for Economic and Clinical Health Act (HITECH Act)-enacted under the American Recovery and Reinvestment Act of 2009-state Medicaid agencies have been able to leverage enhanced federal dollars for new projects related to the deployment and utilization of health information technology (HIT). Under the HITECH Act, the Centers for Medicare and Medicaid Services (CMS) funds the design and implementation of technology projects that support Medicaid operational needs. CMS funds 90% of the costs of designing and implementing the technology and the Department leverages a state appropriation to contribute the remaining 10%. However, the HITECH Act funding expires on September 30, 2021. To date, HITECH Act funding has been used to further the design and implementation of important Health IT statewide infrastructure, including connecting clinic and hospital Electronic Health Records to Colorado's Health Information Exchanges (Colorado Regional Health Network and Quality Health Network). HITECH Act funding has also been used to establish the Governor's Office of eHealth Innovation, eHealth Commission, and support the design and implementation of projects that are generated through Colorado's Health IT Roadmap.

With the HITECH Act and associated funding to states sunsetting on September 30, 2021, CMS has recognized the investment made– both at the federal level and state level–in these HIT projects. CMS encourages states to transition projects currently financed through the HITECH Act to other enhanced funding streams made available through Title XIX of the Social Security Act. To that end, in 2018, CMS

released four new State Medicaid Director letters designed to provide guidance on how HIT functions could continue to be funded with non-HITECH Act related funds. This will allow many of these projects to continue to be funded using 90% FFP or 75% FFP. Over the next year, the Department will work with CMS to determine the exact projects that can be maintained through alternate enhanced funding streams.

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