Long-Range Financial Plan FY 2021-22

November 1, 2021

COLORADO
Department of Health Care Policy & Financing

Section 1: Introduction

Mission and Vision

HCPF's vision for its members and Colorado citizens at large is that "Coloradans have integrated health care and enjoy physical, mental and social well-being." As a department, our mission is "Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado." HCPF modernized its mission this year, after engagement with stakeholders including the Member Experience Advisory Committee (MEAC, which includes Health First Colorado and CHP+ members), the Program Improvement Advisory Committee (PIAC, which includes providers, advocates, and various stakeholders), and HCPF employees. The new mission statement has three new points of emphasis: first, our commitment to health care equity; second, our increased focus on Medicaid cost control recognizing our increased membership, the programs impact on the state budget, and the importance of member benefit as well as provider reimbursement protection; third, our work supporting health care affordability for all Coloradans. These key concepts are reflected in our goals and work this past year and will inform our work in the coming year.

Overview of Wildly Important Goals & Measures for FY 2021-22

HCPF's "Wildly Important Goals" (WIGs) reflect the major goals of the Department, developed in collaboration with the Governor's Office. WIGs adhere to the "SMART" goal format, meaning that they are specific, measurable, achievable, relevant, and time-bound.

There are two types of WIGs referenced in this plan. The first are the Governor's WIGs to the Department. These two Governor's WIGs include: 1) Medicaid Pharmacy Cost Control and 2) Eligibility Technology Support. In addition, HCPF will be working in support of three WIGs that are the shared responsibility of the Health Cabinet. These are described below.

WIG 1: Medicaid Pharmacy Cost Control

"Increase savings on pharmacy costs by 83% through pharmacy cost control initiatives, from $12 million in FY 2020-21 to $22 million by June 30, 2022."

The fastest growing cost driver in health care is pharmaceuticals, and prescriptions for Medicaid members represent approximately 15% of retail pharmacy claims. HCPF is focused on decreasing Medicaid pharmacy expense by helping to implement effective policy like the Prescription Drug Affordability Board electronic prescribing tools that empower providers to choose the most cost-effective drugs for their

patients, and more effective provider reimbursement models including value-based payments.

To achieve this WIG, the Department is implementing its Maximum Allowable Cost (MAC) methodology for prescription drugs; an alternate payment methodology for clotting factor drugs, and the prescriber tool. We have confidence in the estimated $22 million savings target for FY 2021-22.

Successful completion of this goal will put downward pressure on the fastest growing cost driver in health care and drive savings are to HCPF's Medical Services Premiums budget line item. This WIG is for FY 2021-22 only and does not have projections into future years since the savings will no longer be novel to our budget.

Lead Measures

1. Value-based Purchasing of Specialty Drugs: Increase the number of value-based purchasing contracts with specialty drug manufacturers from 0 to 3 by June 30, 2022.
2. Implement Affordability Module Rx Tool: Implement and collect baseline data for the affordability module (SureScripts) of the Prescriber Tool to set future targets for pharmacy cost savings.
3. Clotting Factor Drug Cost: Integrate the clotting factor category of drugs into the MAC pricing structure for pharmacy cost control. The Dept estimates implementation by April 1, 2022 with annualized savings of approximately $4 million.

WIG 2: Eligibility Technology Support

"Increase the rate of automated eligibility renewals from 79% to 85% by June 30, 2022."

We have worked over the last few years to significantly improve the member service experience. This goal reflects that quest, through our continued focus on automation, which improves accuracy, speed and digital capabilities that support self-service empowerment. Self-service renewals also free up county and medical assistance eligibility workers to focus on complex cases, ensuring many of our most vulnerable members get high quality service. Our ability to automate eligibility renewals is limited whenever a member must be contacted to provide missing information. To address this, we are working with database partners who can provide eligibility staff automated access to employment and income information, thus eliminating the need to ask members for this information.

Through automation investments the renewal process will be streamlined and further enhanced by the implementation of a couple key projects. Throughout 2021, we are working with our CBMS system vendor to data-mine eligibility fields, searching for missing information, and then with county workers to populate those fields. To achieve this goal we will be implementing a near real-time interface to verify income

with the Federal Data Services Hub (FDSH) Work Number and through the Equifax vendor. This will significantly speed up the income verification process. In addition, we will be implementing an improved renewal process that will leverage interfaces and make a quicker determination on the front end of the process. This will mitigate members having to take action to ensure HCPF have an accurate, current eligibility determination. All projects have potential to increase the number of automated renewals. In FY 2022-23 HCPF targets the percentage of automated renewals to reach 90%, and for that percentage to remain steady in FY 2023-24. The ultimate plateau assumes flexibility for members who are best served by alternate renewal methods.

Lead Measures

1. Add system capability to verify employment and income automatically with external vendors such as Equifax and the Colorado Department of Labor by June 30, 2022.
2. Enhance the capacity to rapidly validate accuracy of current addresses by working with additional automated third-party data sources by June 30, 2022.

Shared Agency WIGs: Governor's Health Cabinet

In addition to the Governor's WIGs above, HCPF partnered with the Office of Saving People Money on Health Care, Colorado Departments of Human Services, Public Health & Environment, and Regulatory Agencies (CDHS, CDPHE, and DORA) to accomplish shared agency WIGs that the Health Cabinet, led by Lt. Governor Dianne Primavera, have prioritized. The Office of Saving People Money on Health Care will be managing and reporting the WIG data, but HCPF will support one of these outcome measures.

Health Cabinet WIG 1: Implement four lead measures to establish the foundation needed to deliver prescription drug cost savings to Coloradans by June 30, 2022.

> **HCPF Lead Measure:** Increase the number of eligible Medicaid-enrolled prescribers using the Prescriber Tool from 16% to 25% of eligible providers, from 4,000 providers to 6,115 providers out of 24,459 total, by June 30, 2022.

Health Cabinet WIG 2: Create the operational infrastructure to promote value in health care and lower costs in the employer-sponsored insurance market by implementing utilization of non-fee-for-service payment and reimbursement structures in Colorado by June 30, 2022.

> **HCPF Lead Measure:** Create a value based payments and quality metrics package that is applicable to Medicaid and aligns with the commercial market by June 30, 2022.

Health Cabinet WIG 3: Build the capacity of the behavioral health system in Colorado to increase access for consumers by executing on 6 lead measures by June 30, 2022.

HCPF Lead Measure: Add 1,233 newly enrolled behavioral health providers serving Coloradans in public programs by June 30, 2022, an increase of 13%.

Organizational Chart

Department operations and staff are organized into nine offices, each reporting to the Executive Director as described below.

Department Overview

Executive Director's Office

Kim Bimestefer was appointed Executive Director of the Department by Governor Jared Polis after her first appointment effective January 8, 2018. The Executive Director is responsible for setting the strategic direction of HCPF; creating alignment with other state agencies to achieve the health care agenda of the Governor; overseeing the operations and programs of the Department which are provided by both employees and contractors and ensuring HCPF operates in an efficient and effective manner; and leading HCPF to achieve its vision, mission, and annual goals. The office also leads collaborative efforts to drive down health care costs and prices to the benefit of Coloradans, their employers, Medicaid, CHP+, and the state. Lastly, this office oversees human resources and learning and development to support HCPF employees.

Cost Control & Quality Improvement Office

The Cost Control & Quality Improvement Office was established July 1, 2018, by the Medicaid Cost Containment law (SB18-266)[1]. This office manages the data repositories and tools, using these resources to produce directional analyzes such as utilization, unit cost, quality, and overall cost trends for Health First Colorado, CHP+, and other health care safety net programs administered by HCPF. The office oversees utilization

[1] https://leg.colorado.gov/sites/default/files/documents/2018A/bills/2018a_266_enr.pdf

review, population management, case and disease management, quality scorecard metrics, and cost management strategy, vendors, and program effectiveness, while sharing Regional Accountable Entity innovations and performance evaluation with the Health Policy Office The office also secures insights into cost trend drivers and evolving utilization patterns.

Finance Office

The Finance Office is responsible for the financial strategy, budgeting, accounting, external and internal audits, and risk management and procurement operations of HCPF. This includes presenting budgetary needs to Colorado executive and legislative authorities and forecasting program caseload and expenditures throughout the fiscal year. The office is also responsible for monitoring, developing, and implementing rates for payments to providers, including value-based payments and managed care rate setting.

Health Information Office

The Health Information Office (HIO) develops, implements, and maintains HCPF's claims payment system (Medicaid Management Information System, or MMIS) and HCPF's data management system (Business Intelligence Data Management System, or BIDM). The office also oversees Health Information Technology (HIT) projects and related Information Technology (IT) infrastructure. This office coordinates with the Governor's Office of Information Technology, the Office of eHealth Innovation (OeHI), and other stakeholders on HIT and IT projects that impact HCPF. In 2021, and in partnership with the Medicaid Operations Office, HIO assumed shared responsibility with OIT and the Colorado Department of Human Services (CDHS) for the management of Colorado Benefits Management System (CBMS), the state's eligibility system.

Health Programs Office

The Health Programs Office oversees Health First Colorado and CHP+ acute care, physical, and behavioral health programs. The office manages benefit policy development and oversight and is responsible for key functions including benefit coverage appeals, federal and state compliance activities, and the Accountable Care Collaborative.

Medicaid Operations Office

The Medicaid Operations Office oversees fraud, waste and abuse function and the Medicaid and CHP+ health plan operations performed by both Department employees and third-party contractors. In addition, this office establishes and monitors the operational performance standards for internal operations as well as for Department contractors. Operations includes claims payments, member and provider call centers, member enrollment, eligibility determinations made by contracted partners, and provider network management.

Office of Community Living
The Office of Community Living oversees Health First Colorado's long-term services and supports (LESS) programs and manages efforts to transform Colorado's LTSS system to ensure responsiveness, flexibility, accountability, and person-centered supports for all eligible persons.

Pharmacy Office
The Pharmacy Office oversees the prescription drug benefits provided to Health First Colorado and CHP+ members. The office is responsible for ensuring strong prescription drug policy and clinically appropriate and cost-effective use of medications. Focus areas include the Colorado Preferred Drug List Program; drug-utilization review including analysis and input from the Colorado Drug Utilization Review Board; value-based contracting; prescription drug affordability policy; reimbursement strategy; and contracting. The office also manages the point-of-sale pharmacy claims adjudication system (the Pharmacy Benefit Management System, or PBMS).

Policy, Communications and Administration Office
The Policy, Communications and Administration Office manages the legislative agenda, government affairs, communications and media relations, and legal affairs. This includes collaborating with our stakeholders in the General Assembly, our county human services administration, local public health and county commissioners, as well as our federally recognized tribes and urban American Indian communities.

Section 2: Evaluation of FY2020-21 Department Goals

There were two Wildly Important Goals (WIGs[2]) in HCPF's FY 2020-21 performance plan: 1) Access to Care and Customer Service, and 2) Medicaid Cost Control. Data from these measures is reported below and additional detail is available in the FY 2020-21 Department Performance Plan.[3]

HCPF achieved 100% of its annual WIGs and key measures in FY 2020-21.

WIG 1: Access to Care and Customer Service
The economic downturn caused an unprecedented number of Coloradans to lose their employer-sponsored health coverage. HCPF saw a 19% increase in Coloradans receiving services through Health First Colorado and CHP+. To deliver the support needed by Coloradans through the challenging time last year, we focused our WIGs on the areas most visible and meaningful to Coloradans, including enrollment support (call center response and application processing time), member call center, provider

[2] Learn more about Gov. Polis' health care goals and priorities at https://dashboard.colorado.gov/key-issues-performance/health
[3] https://operations.colorado.gov/performance-management/department-performance-plans/health-care-policy-financing

call center and payment turnaround time, provider recruitment and member access to providers, and connecting members who do not qualify for Health First Colorado or CHP+ to other coverage options through Connect for Health Colorado, the state's insurance marketplace.

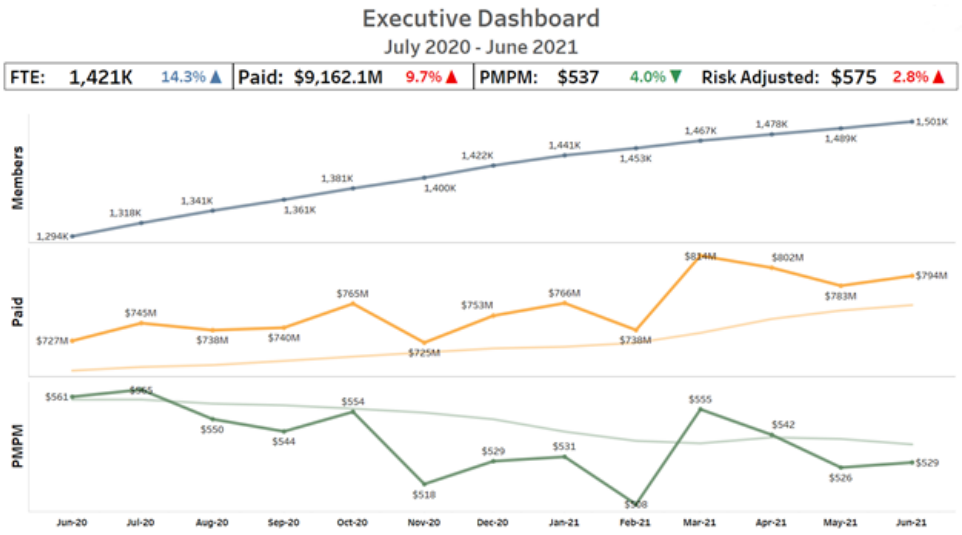
HCPF's successful completion of this goal ensured that Colorado's most vulnerable residents were able to get coverage in a timely manner, get their questions answered, and had access to providers to meet their needs. We also supported providers through our work on this goal by answering questions and paying claims in a timely manner.

WIG #1 Annual Measure	FY 20 YE	FY 21 YE	FY 21 Goal
Deliver health care coverage, service and access to Coloradans during this economic downturn. By June 30, 2021, out-perform average monthly targets as measured by the number of new Medicaid providers, member application processing times, call center speed-of-answer time, provider payment turnaround time, and timeliness of application referrals to Connect for Health Colorado.	N/A	100%	100%
Process 95% of eligibility applications within 45 days through June 30, 2021.	94.4%	98.1%	95%
Answer calls at the provider call center, member call center, and enrollment call center in an average of less than 150 seconds through June 30, 2021.	32 Seconds	55 Seconds	150 Seconds
Enroll 10,000 new Health First Colorado providers by June 30, 2021.	9,549	10,854	10,000[4]
Pay 100% of Medicaid medical and pharmacy claims in an average of less than seven days through June 30, 2021.	3.5 days	3.5 days	7 days
Refer 90% of applicants determined not eligible for Health First Colorado or CHP+ to Connect for Health Colorado within three days of authorization date through June 30, 2021.	N/A	99%	90%

[4] Starting point for FY21 goal is zero.

WIG 2: Medicaid Cost Control

Medicaid cost control continues to be a high priority in Colorado. HCPF's successful completion of this goal in FY 2020-21 represents effective stewardship of Colorado's financial resources while maintaining our commitment to member access to care and health outcomes. One of the leading indicators for this WIG was to complete the implementation of condition management and care support programs. Achieving this goal resulted in proactive engagement with our members who have complex, high cost health care needs. This helped improve their health outcomes and quality of life while simultaneously lowering the cost to the state.



Medicaid Trend. The July 2020 to June 2021 Medicaid trend, compared to the prior 12-month period, is DOWN 4.0% PMPM (Gov's WIG is PMPM trend increase ≤2%; includes claim payment runout). Risk-adjusted trend is up 2.8%. Paid trend is up 9.7%, which is low given membership is up 14.3% during the same period. ***We have significantly outperformed this Medicaid cost control goal***.

WIG #2 Annual Measure	FY 20 YE	FY 21 YE	FY 21 Goal
Responsibly manage health care costs to achieve an annual Medicaid trend[5] of no more than 2.0% by June 30, 2021.	11%	-4%	2%
Reduce Emergency Department visits per thousand members an average of 1.5% by June 30, 2021, by helping members maximize telemedicine and the right settings for care.	N/A	-15%	-1.5%
Complete implementation of the Maximum Allowable Cost (MAC) reimbursement model by April 1, 2021, to control specialty prescription drug costs.	N/A	100%	100%
Implement the diabetes, case management for members with complex health care needs, and maternity support programs across all Regional Accountable Entities (RAEs) by Dec. 31, 2020, to improve health and better control high cost claims.	N/A	100%	100%
Complete the study and policy design for telemedicine by Dec. 31, 2020, in preparation for implementation in the following fiscal year.	N/A	100%	100%

Section 3: Financial Structure

Department Budget Overview

The Department of Health Care Policy and Financing is comprised of seven divisions: (1) Executive Director's Office, (2) Medical Services Premiums, (3) Behavioral Health Community Programs, (4) Office of Community Living, (5) Indigent Care Program, (6) Other Medical Services, and (7) Department of Human Services Medicaid-Funded Programs. The Department's appropriations fund administration and services provided through public health programs including Medicaid, Children's Health Insurance Program and State Programs.

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$2,450,640,691	$523,715,016	$1,399,023,430	$93,709,522	$6,355,609,055	$10,822,697,714
FY 2020-21	$2,187,298,323	$635,500,848	$1,656,133,165	$45,994,354	$7,550,325,493	$12,075,252,183

[5] Trend will be defined as the growth from FY 2019-20 to FY 2020-21 in the total amount paid for Medicaid services, not including supplemental financing payments, divided by average monthly caseload.

Current Appropriation	$2,481,011,526	$865,704,200	$1,595,483,422	$87,674,424	$8,249,920,468	$13,279,794,040

Totals exclude capital construction.

Historical Appropriation by Long Bill Item

(1) Executive Director's Office

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$86,668,223	$0	$54,305,957	$4,514,382	$247,273,129	$392,761,691
FY 2020-21	$92,081,801	$0	$63,381,300	$4,352,565	$258,193,009	$418,008,675
Current Appropriation	$111,196,859	$0	$59,830,475	$4,144,561	$277,002,548	$452,174,443

(2) Medical Services Premiums

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$1,620,335,149	$523,323,333	$1,020,585,026	$88,970,140	$4,814,932,104	$8,068,145,752
FY 2020-21	$1,379,434,899	$635,104,923	$1,286,851,092	$41,444,689	$5,882,386,949	$9,225,222,552
Current Appropriation	$1,538,496,223	$865,284,199	$1,196,746,162	$83,318,813	$6,302,551,366	$9,986,396,763

Increase from FY 2020-21 to Current Appropriation is driven by projected increases in Medicaid caseload due to the COVID-19 pandemic and continuous coverage policy.

(3) Behavioral Health Community Programs

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$191,513,555	$0	$36,384,994	$0	$499,036,650	$726,935,199
FY 2020-21	$202,843,740	$0	$58,004,079	$0	$622,056,332	$696,526,243
Current Appropriation	$204,048,968	$0	$54,738,645	$0	$739,936,342	$998,723,955

4) Office of Community Living

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$318,433,010	$0	$7,054,129	$0	$339,681,664	$665,168,803
FY 2020-21	$286,328,411	$0	$16,526,567	$0	$393,671,265	$696,526,243
Current Appropriation	$340,224,884	$0	$9,255,237	$0	$484,759,913	$834,240,034

Increase from FY 2020-21 to Current Appropriation is primarily due to increases in enrollment onto the Developmental Disabilities waiver for reserved capacity reasons and from additional spots appropriated by the JBC, as well as moving funding for Single Entry Points from Medical Services Premiums to this long bill group.

5) Indigent Care Program

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$9,140,382	$391,683	$205,997,723	$0	$323,494,792	$539,024,580
FY 2020-21	$11,535,682	$395,925	$156,793,946	$0	$246,713,757	$415,439,310
Current Appropriation	$25,687,685	$420,001	$182,541,314	$0	$286,936,511	$495,585,511

Increase in General Fund from FY 2020-21 to Current Appropriation is driven by the depletion of the CHP+ Trust Fund and backfilling with General Fund..

6) Other Medical Services

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
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
FY 2019-20	$169,931,656	$0	$72,806,698	$225,000	$68,862,087	$311,825,441
FY 2020-21	$162,005,013	$0	$72,687,278	$0	$81,073,836	$315,963,227
Current Appropriation	$204,380,616	$0	$90,482,686	$0	$93,923,551	$388,997,903

Increase in General Fund from FY 2020-21 to Current Appropriation is driven by an increase in the average anticipated premium for Medicare Modernization Act with the expiration of the enhanced Federal Medical Assistance Percentage through the Families First Coronavirus Relief Act in January.

7) Department of Human Services Medicaid-Funded Programs

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
FY 2016-17	$52,337,261	$0	$1,888,903	$0	$55,110,762	$109,314,165
FY 2017-18	$54,819,328	$0	$1,888,903	$0	$57,234,023	$113,942,254
FY 2018-19	$58,882,351	$0	$1,888,903	$0	$61,271,256	$122,042,510
FY 2019-20	$54,618,716	$0	$1,888,903	$0	$62,328,629	$118,836,248
FY 2020-21	$53,068,777	$0	$1,888,903	$0	$66,230,345	$121,188,025
Current Appropriation	$56,976,291	$0	$1,888,903	$0	$64,810,237	$123,675,431

Capital Construction Information

	Controlled Maintenance	Capital Renewal & Recapitalization	Capital Expansion	IT Projects*	Total
FY 2016-17	$0	$0	$0	$0	$0
FY 2017-18	$0	$0	$0	$0	$0
FY 2018-19	$0	$0	$0	$6,605,000	$0
FY 2019-20	$0	$0	$0	$11,408,333	$0
FY 2020-21	$0	$0	$0	$4,500,000	$0

Current Appropriation	$0	$0	$0	$6,498,000	$0

**The funding is used to develop and implement the Health IT Roadmap, which coordinates investments and policies for health IT infrastructure and data sharing across the state. The funding is managed by the Office of eHealth Innovation (OeHI), within the Lt. Governor's Office, and the Department serves as OeHI's fiscal agent.*

Ongoing Debt Obligations

The Department does not have any ongoing debt obligations.

Section 4: Financial Forecast

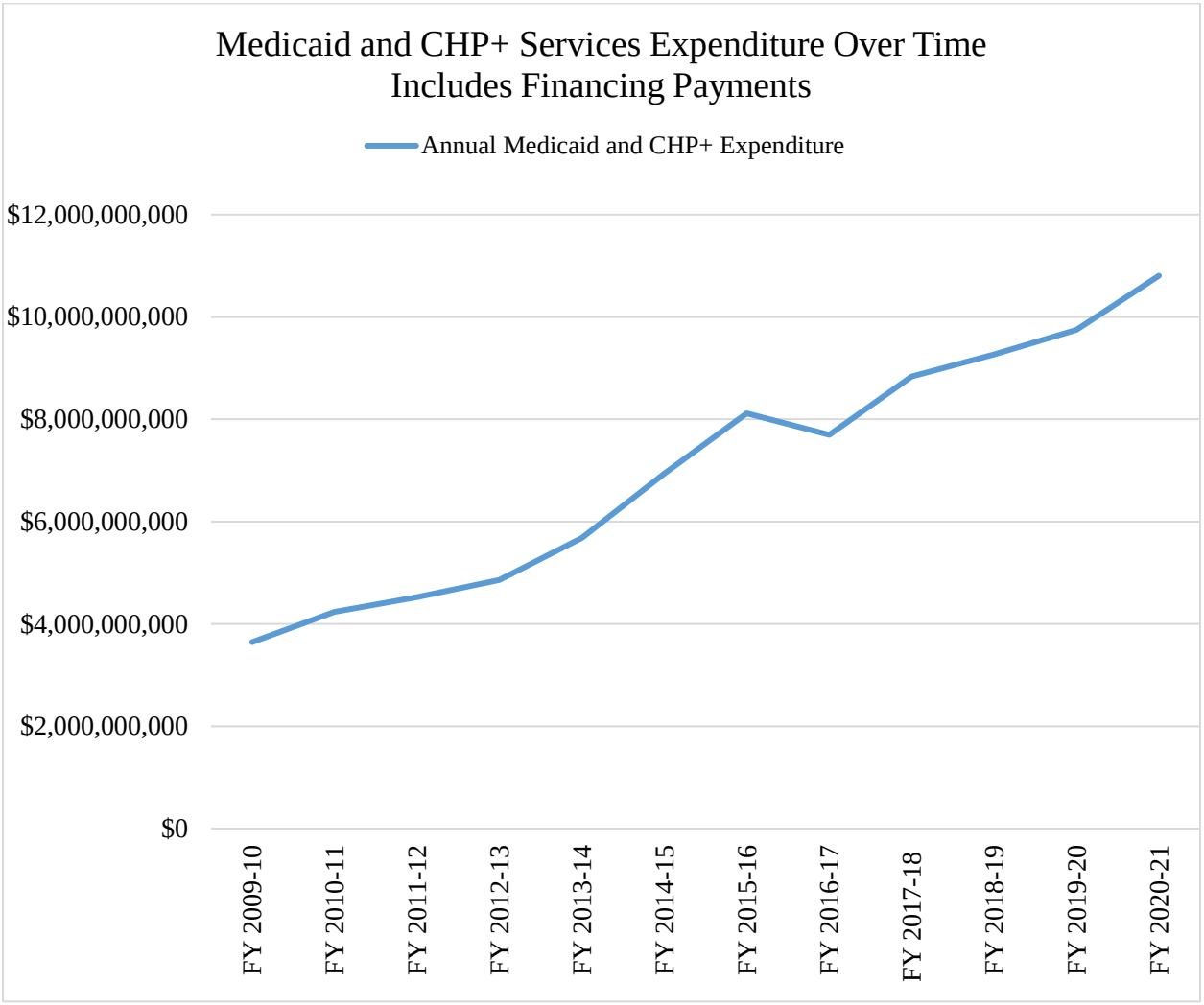
Department Baseline Forecast

FY 2021-22 – FY 2025-26 Timeframe

The following tables provide estimates of appropriations for FY 2022-23 through FY 2025-26. Estimates are derived based on expected increases to the budget from approved legislative or budget items from 2020 and prior and include estimates for increasing costs in the Medicaid and CHP+ programs based on the Department's November 2, 2021 budget requests R-1 through R-5.

	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Total
Current Appropriation	$2,481,011,526	$865,704,200	$1,595,483,422	$87,674,424	$8,249,920,468	$13,279,794,040
FY 2022-23*	$3,086,123,298	$865,704,200	$1,621,181,290	$92,018,785	$7,809,170,794	$13,474,198,367
FY 2023-24*	$3,334,901,608	$865,704,200	$1,808,399,731	$97,084,777	$7,927,335,400	$14,033,425,716
FY 2024-25*	$3,574,692,279	$865,704,200	$1,742,655,710	$102,443,576	$8,328,481,321	$14,613,977,086
FY 2025-26*	$3,829,468,227	$865,704,200	$1,665,029,485	$108,112,106	$8,753,740,967	$15,222,054,985

*Estimated Appropriation



Department Major Budget Drivers

COVID-19 - Changes in Economic Conditions

The novel coronavirus (COVID-19) pandemic that emerged in early 2020 continues to have an unprecedented impact on the health care sector, the economy and the most vulnerable Coloradans. A large majority of people enrolled in the Medicaid and Children's Health Insurance Program (CHIP)[6] qualify for the programs because their income is below specific thresholds. Colorado expanded eligibility criteria under federal law, and for Medicaid, adults and children must have income below 133% of the federal poverty level to qualify. For CHIP, children and pregnant women must have income below 250% of the federal poverty level to qualify.

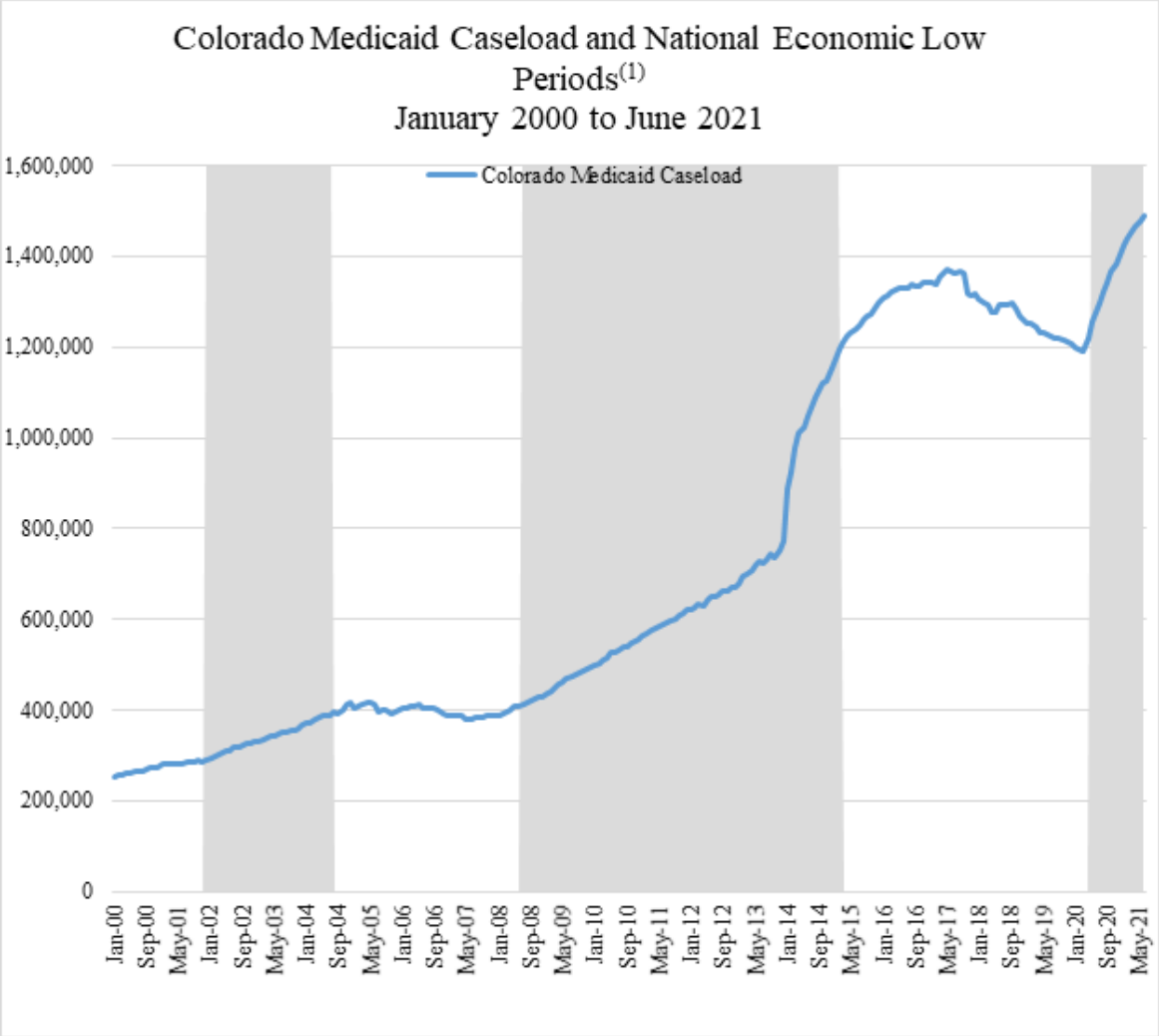
The economic downturn associated with the COVID-19 pandemic directly impacted the state budget through significant reductions to state tax income revenue, however, rapid revenue growth has occurred and now exceeds the TABOR cap. Although the economic recovery continues to strengthen, employment lags,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

During times of recession or other economic contraction, caseload increases. As unemployment rises and people lose their jobs, income, and health insurance, people may apply for coverage through the Department's programs. This drives costs for the State as people enroll in the Department's programs and begin to use services. This creates a double-edged problem for the State: Medicaid and CHIP costs are driven up by the influx of new caseload while the State collects lower General Fund revenues. Compounding the problem is the fact that Medicaid is an entitlement program, which means that the State cannot cap enrollment or turn away new enrollees. Further, federal law prohibits the State from reducing the amount, scope, or duration of services due to a lack of state funding. As a result, there are limited opportunities to reduce Medicaid growth during an economic downturn. In the case of the economic downturn associated with the COVID-19 pandemic, federal legislation helped some employers temporarily maintain their labor force, which likely blunted some of the initial enrollment surge. Federal legislation has also included a continuous coverage requirement, where no current Medicaid members may be disenrolled, which has contributed to overall rising Medicaid caseloads.

As the economy recovers, program caseload falls slowly. There are several key reasons for this. First, federal and state requirements for transitional programs allow people to stay enrolled for up to a year to prevent sharp drops in caseload as people return to work. Second, economic recoveries tend to affect people with lower income expectations more slowly. This means that while major economic indicators (such as unemployment, gross domestic product, and stock market indices) may show that the economy is improving, people with less education and people who are competing for low-wage

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

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.



(1) Shaded areas indicate when the unemployment rate was above the median average value from 1990 to 2020 indicating that unemployment was historically high and economy could be considered weak.

COVID-19 has changed utilization patterns due to people not seeking care, and the risk of spread and death in residential facilities, such as nursing homes, assisted living facilities and group homes. Although the reluctance to seek care was a short-term trend during the stay at home order and has lessened over

the last year, particularly with vaccines becoming more available and telemedicine more widely adopted, some members are still slow to return to their previous utilization patterns. Medicaid members are also less likely to be vaccinated than the general Colorado population, which could also be contributing to any reluctance to seek care. The Department is continuing to monitor utilization patterns.

Changes in Colorado's Demographics

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 310,000 people (5%) between 2020 and 2025[7]. Growth rates are even higher among older adults, with 13% growth of people between the ages of 65-74, and 30% growth of people aged 75 and older[8]. Colorado's population growth rates are expected to exceed national population growth by a significant margin in this time frame. Longer term projections from the State Demography Office's indicates that Colorado's population will reach about 8 million people by the year 2050. By 2050, they estimate that the population of people 65 and older will increase to just under 1,600,000 people. 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 affordability of health care in Colorado continues to be one of the most significant challenges facing the Department, the state, and the nation. With the economic downturn, all payers – self-funded employers and Medicaid alike – benefit from a solid affordability strategy. Specific to the Department, the increased need for HCPF programs and services combined with the state's budget restrictions makes the implementation of effective affordability policy more important than ever. As a trusted health care expert, and in partnership with other health care thought leaders, the Department is focused on research, analytics and reporting that identifies the drivers of rising health care costs and alternatives to address them. Leveraging insights from this effort serves to support not only Medicaid and CHIP members, but all Coloradans.

The Centers for Medicare and Medicaid Services (CMS) predict that national health spending is projected to grow at an average rate of 5.4% per year between 2019 and 2028, outstripping growth in the nation's Gross Domestic Product[9]. Prices for health care goods and services are projected to grow at a rate of 2.4% 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 7.6% 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.

[7] https://demography.dola.colorado.gov/births-deaths-migration/data/components-change/#components-of-change
[8] https://demography.dola.colorado.gov/population/population-totals-counties/#population-to-tals-for-colorado-counties

[9] https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.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. This could lead to provider consolidation, which may reduce access to care for Medicaid members. 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.

As the use of telemedicine increases, the Department is focused on promoting policies that increase access to care and outcomes as well as saving money where appropriate. Implementing changes to telemedicine in a thoughtful way could lead to budget savings over the long term as costs of delivering care via telehealth could be lower than in person care.

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

- **Prescription drug costs**: The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid, CHIP, and all health plans. In December 2019, the Department prepared a report titled "Reducing the Cost of Prescription Drugs."[10] While the Department continues to address key initiatives to help inform prescribers and update payment structures, high prescription drug costs are still a major factor in the affordability of health care. The report lays out a set of comprehensive changes that would favorably impact prescription drug costs and the out-of-pocket costs for families covered by commercial insurance, while achieving a meaningful reduction in the total cost of prescription drugs for Colorado's Medicaid and CHIP programs. Additionally, because the Department must cover any drug that receives approval from the Federal Drug Administration (FDA) and for which a rebate agreement is in place, the recent action of the FDA to lower the threshold of evidence for conditional drug approval may also increase prescription drug costs for the Department as more members utilize high-cost, conditionally approved drug therapies.
- **Hospital delivery system**: Colorado's hospital prices are some of the highest in the country. The prices for individual procedures, inpatient and outpatient care, vary widely from hospital to hospital. The report documenting COVID 19's impact on the Colorado hospitals' financing[11] published by the Department in August 2021 provided a thorough analysis of the changing price, costs and profits across the hospital industry in Colorado. The Department will continue to leverage the insights from this report, as well as analyzing the emerging insights from new laws on financial transparency and not-for-profit hospital community investments to drive improved hospital affordability policy to the betterment of Coloradans, their employers, the state and taxpayers.

[10] https://www.colorado.gov/pacific/sites/default/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20-%20December%2012%2C%202019.pdf
[11] https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Cost%20Price%20and%20Profit%20Review%20Full%20Report_withAppendices-0810ac.pdf
https://www.colorado.gov/pacific/hcpf/colorado-cost-shift-analysis

- **Population health and health outcomes:** The Department has developed data capture infrastructure and analytics to better understand care delivery, utilization, health outcomes and costs. The Department is able to leverage these insights to identify populations that would benefit from increased care supports and coordination. Concurrently, the Department has worked with its Regional Accountable Entity (RAE) partners to craft new programs to address these health improvement and affordability opportunities. The state's Behavioral Health Task Force, in which the Department actively participates, has developed a blueprint that includes bold changes that improve patient outcomes, experience, quality and access. The Department continues to be actively involved in the design and development of the Behavioral Health Authority. The Department recognizes that behavioral health reform will require significant investments of time and resources.

RAE Accountability: The Department is in the process of designing and negotiating the third stage of the Accountable Care Collaborative, known as ACC 3.0, with the Regional Accountable Entities (RAEs). The Department's ability to influence and improve member health care outcomes is dependent on its ability to work with these critical contractors to measure outcomes and implement policy interventions. Because the Department does not directly furnish care to members, RAE accountability is a critical strategy to improving health care outcomes and reducing costs.

Federal Policy Changes

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

Changes to Federal Medical Assistance Percentage Funding

There has been discussion on the federal level about both temporary and permanent changes to the federal medical assistance percentage (FMAP) that states receive for Medicaid expenditures. The Families First Coronavirus Response Act, (FFCRA) (Pub. L. 116-127), provided a temporary 6.2 percentage point increase in federal Medicaid matching funds to help states respond to the public health emergency. This did not apply to administrative costs. The estimated impact of the General Funds savings from the enhanced FMAP net the costs of the continuous coverage requirements from additional caseload is approximately $100 million per quarter.. States are required to provide continuous enrollment and not reduce benefits for the duration of the declared emergency in order to qualify for the higher match. The Public Health Emergency (PHE) was renewed on June 20, 2021. The FFCRA provides the temporary FMAP increase until the end of the quarter in which the PHE ends. The Federal government has signaled that the PHE will go through the entirety of CY 2021, although this is subject to change. The temporary nature of the PHE and impending expiration of the FMAP increase, poses the risk of a funding cliff. This could have implications for the state's General Fund. Similarly, The American Rescue Plan Act (ARPA), includes a provision to increase the federal matching rate (FMAP) for spending on Medicaid Home and Community Based Services (HCBS) by 10 percentage points from April 1, 2021 through March 31, 2022.

Medicaid Waivers and Executive Action

The Social Security Act allows the approval of "…experimental, pilot, or demonstration projects that are found by the Secretary [of Health and Human Services] to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.[7]"

The increasing availability of these waivers may provide options for Colorado to reform Medicaid programs beyond what was approved in the past. In addition to waivers, the federal government may change the Medicaid program via new regulations. This type of Executive Action could have significant effects on the operation and financing of the Medicaid program. Often, the changes that are proposed are extremely technical and complex but will likely have significant implications for provider payment rates and state financing of Medicaid by disrupting current arrangements and restricting the future use of such arrangements.

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

A public health care program may have the effect of shifting costs from the State to the federal government. This is not certain; for example, when Congress implemented a drug benefit in Medicare (Part D), they 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.

Scenario Evaluation: Economic Downturn

There are a range of caseload scenarios that could occur in the future that would impact Department costs. For example, there could be another wave of COVID-19 infections which causes unemployment to remain high due to a second stay-at-home order, and new enrollees grow more quickly than currently projected due to an increase in the number of people unemployed. Alternatively, there could be an economic rebound spurred by the availability of a vaccine or other factors, where Medicaid enrollment returns to pre-pandemic levels very quickly. The Department's November forecast assumes a moderate rebound, where the economy improves, but not back to pre-pandemic levels. In this scenario Medicaid enrollment continues to grow after the PHE ends.

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

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

Historically, economic downturns have led the General Assembly to reduce funding for state-only and cash-funded programs. The Department administers several non- Medicaid programs, such as the Primary Care Fund, the State-Only Supported Living Services Program, the Senior Dental program, and

the Old Age Pension Health and Medical program. In the past, the General Assembly has diverted money away from Department's State-only programs – and other programs around the state – to fund Medicaid programs.

Economic Downturns Spur Innovations

Although economic downturns create significant challenges for the State's entitlement programs, they also create opportunities to find efficiencies and spur innovation. The Department's strategy, starting from the beginning of the COVID-19 pandemic, was adjusted to recognize the emerging "new normal in healthcare,"[12] with a focus on sustaining and driving positive changes to the system. This includes policies that assure the right care is occurring at the right place, lowering pharmacy costs and hospital efficiency. For example, telemedicine visits have increased, and inappropriate emergency room visits have decreased as Coloradans avoid unnecessary interactions that increase the risk of COVID-19 transmission. By driving a new normal in health care, the Department can also leverage telemedicine services to reduce barriers to care like transportation, childcare, or inclement weather. Telemedicine can also be used to address traditional care access concerns for people with disabilities, older adults, or rural Coloradans, while also helping to overcome the stigma of accessing behavioral health care by enabling care from the privacy of one's own home. Additionally, the state, vendors and providers may experience benefits due to a broader work base due to employees working remotely which could provide efficiencies in the system.

Scenario Evaluation: Department-specific Contingency

Changes in Colorado's Health Care Landscape

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

Closure of a Rural Hospital

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

Provider Shortages and Consolidation

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

[12] https://www.colorado.gov/pacific/sites/default/files/HCPF%202020-2021%20Performance%20Plan.pdf

Emerging Trends

In addition to the primary drivers of expected budget growth, such as the economic downturn, 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:

Impacts from COVID-19

There are many impacts from the COVID-19 pandemic that will continue to impact Department costs. During the stay-at home and safer at home orders, Coloradans have avoided health care utilization, including emergency services. While there is a reduction in unnecessary care, the avoidance has also led to forgone care for people with chronic conditions. This includes forgone routine care, such as missed screenings, and forgone emergency care, such as a person who has a cardiac arrest at home but does not seek treatment. This can lead to decreased health outcomes and increased future costs. Additionally, the long-term health impacts for those who have had COVID-19 are still being studied, and appear to include long-term respiratory, cardiac, neurological issues, and other physical and behavioral health impacts. Additionally, the cost of treating the virus and cost and administration of vaccines will continue to strain the state's budget for years to come. The impacts of these varied factors are difficult to project with precision.

Behavioral Health

Implementing the recommendations from the Behavioral Health Task Force (BHTF) will have impacts to the state budget. The task force has evaluated and set the roadmap to improve the current system. The Department has worked in tandem with the Department of Human Services on a series of budget requests focused on implementing the BHTF blueprint, and maximizing Medicaid funding, which requires state funds to draw down federal funds. The residential and inpatient substance use disorder (SUD) treatment benefit authorized in HB 18-1136 "Residential and Inpatient SUD Treatment" is also underway. Depending upon provider capacity and demand for services, costs may be higher or lower than forecasted, impacting the need for state appropriations. Additionally, if more crisis support is provided in the community, costs that were previously the responsibility of the criminal justice system may be covered by Medicaid. Additionally, medium-to-long term effects on behavioral health due to the pandemic may increase utilization and treatment costs.

Among youth, the state is working with the provider community to improve access to providers that specialize in child and youth substance use and mental health services. The state has seen an increase in the number of youth who need high-level and complex mental health and SUD services. In response, the Department has been working with the Office of Behavioral Health to expand and support provider networks that can best serve children and youth with complex needs, including residential and hospital step-down facilities. While the American Rescue Plan Fund can help build out the infrastructure for these facilities and high-intensity services, there is potential that this is an area that will need ongoing attention. The Department looks forward to working with the provider community and Medicaid families, and with advocates calling for solutions in this area. The Department recently approved significant rate increases for residential and non-hospital inpatient care for children and youth, based on the level of clinical and specialized care required to serve this population. Tracking the rates for these services will be important in coming years, if the need for high intensity services is sustained or grows.

The Department has been working on this effort for many years with an increased focus since 2019 when the Behavioral Health Task Force Children's Subcommittee was formed.

Increased Costs

Rising health care costs will continue to require Department attention and innovation. This includes prescription drug costs and the high cost of specialty drugs, high cost Durable Medical Equipment (DME) including robotic arms and other expensive equipment. Additionally, with the increase in membership of older adults and people with disabilities, the higher cost of community-based long-term services and supports, including Consumer Directed Attendant Services and Supports (CDASS), In-Home Support Services (IHSS) and Program for All Inclusive Care for the Elderly will continue to put a strain on state budgets. Wage pressures, especially among HCBS direct care workers, will likely put upward pressure on Medicaid costs.

Section 5: Anticipated Funding Decreases

Major Expenses Anticipated

The temporary FMAP increases provided additional federal dollars that were instrumental to preserve and enhance Colorado's Medicaid program. While they helped the state weather substantial fiscal challenges posed by the pandemic, the temporary FMAP increases are expected to end and require state funds to backfill for reduced federal matching dollars.