DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2023-24 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, December 21, 2022

9:00 am – 5:00 pm

9:00-9:15 COMMISSION ON FAMILY MEDICINE

Presenters:

- Donna Marshall, COFM Board Member, Congressional District #1 Representative
- Richard "Levi" Sundermeyer, CAFMR Board Member, Program Director, HealthONE Family Medicine Residency
- Lynne Jones, Executive Director Commission of Family Medicine, Co Association of Family Medicine Residencies, CO Institute of Family Medicine
- Laurel Dang, 3rd year resident

9:15-9:30 INTRODUCTION & HEARING OVERVIEW

Presenter: Kim Bimestefer, Executive Director

9-30-9:35 COMMON QUESTIONS FOR DISCUSSION

Main Presenters:

- Kim Bimestefer, Executive Director

Supporting Presenters:

- Bettina Schneider, Chief Financial Officer

Topics:

- Common Questions for Discussion: Page 14, Questions 1-4 in the packet, Slide 16

9:35-9:45 COVID-19 PUBLIC HEALTH EMERGENCY

Main Presenters:

- Ralph Choate, Chief Operating Officer

Topics:

- Public Health Emergency Unwind: Page 20, HCPF Hearing Questions 1-9 in the packet, Slides 17-24

9:45-9:55 HOSPITALS

Main Presenters:

- Bettina Schneider, Chief Financial Officer

Topics:

- Hospitals: Page 30, Questions 10-11 in the packet, Slide 25

9:55-10:05 R9 BIRTHING EQUITY & DOULA SERVICES

Main Presenters:

- Adela Flores Brennan, Medicaid Director

Topics:

- R9 Birthing Equity & Doula Services: Page 31, Questions 12-15 in the packet, Slides 26-29

10:05-10:15 R6 VALUE BASED PAYMENTS & R8 COST & QUALITY INDICATORS

Main Presenters:

- Bettina Schneider, Chief Financial Officer

Topics:

- R6 Value Based Payments: Page 36, Questions 16-18 in the packet, Slide 30
- R8 Cost & Quality Indicators: Page 40, Question 19 in the packet, Slide 30

10:15-10:25 **BREAK**

10:25-11:00 PROVIDER RATES, PARTICIPATION & MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE

Main Presenters:

- Bettina Schneider, Chief Financial Officer
- Colin Laughlin, Deputy Office Director, Office of Community Living

Topics:

- Provider Rates, Participation & Medicaid Provider Rate Review Advisory Committee: Page 41, Questions 20-34 in the packet, Slides 31-33

11:00-11:05 PHARMACY

Main Presenters:

- Thomas Leahey, Pharmacy Office Director

Topics:

- Pharmacy: Page 56, Questions 35-37 in the packet, Slide 34

11:05-11:15 R14 – CONVERT CONTRATOR RESOURCES TO FTE

Main Presenters:

- Adela Flores Brennan, Medicaid Director

Topics:

- R14 – Convert Contractor Resources to FTE: Page 57, Questions 38-41 in the packet, Slides 35-37

11:15:-12:00 OTHER QUESTIONS – CHILD HEALTH PLAN PLUS (CHP+), CO-PAYS, RECOUPMENTS, AUDITS & FRAUD/WASTE/ABUSE

Main Presenters:

- Adela Flores Brennan, Medicaid Director
- Ralph Choate, Chief Operations Officer
- Bettina Schneider, Chief Financial Officer

Topics:

- Other Questions – CHP+, Co-pays, Recoupment, Audits & Fraud/Waste/Abuse: Page 60, Questions 42-48 in the packet, Slides 38-41

12:00-1:30 LUNCH BREAK

1:30-3:00 BEHAVIORAL HEALTH

Main Presenters:

- Kim Bimestefer, Executive Director
- Cristen Bates, Behavioral Health Initiatives & Coverage Office Director
- Charlotte Crist, Cost Quality & Improvement Office Director

Topics:

- Behavioral Health Delivery System & Provider Network: Page 67, Questions 49-53 in the packet, Slides 42-57
- Behavioral Health Provider Rates & HB 22-1268 Update: Page 78, Questions 54-58 in the packet, Slides 58-59
- R10 – Children & Youth with Complex Needs: Page 84, Questions 59-61 in the packet, Slides 60-61
- Crisis Services, Universal Contract & BHA Coordination: Page 87, Questions 62-64 in the packet, Slides 62-63
- R12 – Behavioral Health Claims System: Page 89, Questions 65-67 in the packet, Slide 64
- Certified Community Behavioral Health Clinics (CCBHC) Grant: Page 91, Questions 68-69, Slides 65-68

3:00-3:15 BREAK

3:15-4:45 OFFICE OF COMMUNITY LIVING

Main Presenters:

- Kim Bimestefer, Executive Director
- Bonnie Silva, Office of Community Living Director
- Charlotte Crist, Cost Control and Quality Improvement Office Director
- Colin Laughlin, Office of Community Living Deputy Office Director

Topics:

- Community-Based Program Growth: Page 93, Questions 70-71 in the packet, Slides 69-75
- Private Duty Nursing (PDN): Page 95, Questions 72-74 in the packet, Slides 76-79
- Program for All Inclusive Care for the Elderly (PACE): Page 100, Question 75 in the packet, Slides 80-82
- Participant Direction: Page 101, Questions 76-79 in the packet, Slides 83-84
- Nursing Facilities: Page 106. Question 80 in the packet, Slides 85-88
- Case Management Redesign: Page 107, Questions 81-94 in the packet, Slides 89-95
- Developmental Disabilities (DD) Waitlist: Page 117, Question 95 in the packet, Slides 96-100

4:45 **CONCLUDING REMARKS**

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Colorado Commission on Family Medicine
Report to the Joint Budget Committee, December 2022
Training Family Physicians for the State's Health Care Needs since 1977

Presenters:

- ***Donna Marshall, RN***
  Congressional District 1 Representative
- ***Richard "Levi" Sundermeyer, MD***
  Program Director, Colorado Association of Family Medicine Residencies (CAFMR) Board Member
- ***Laurel Dang, MD***
  Family Medicine Resident, Swedish Program
- ***Lynne Jones***
  Executive Director, Colorado Commission on Family Medicine, CO Association of Family Medicine Residencies (COFM/CAFMR)

Key Contributions to Colorado of the Commission on Family Medicine

- Family Medicine Resident Physicians (FMRP) touch over 2/3rds of Colorado counties during their training.
- FMRP providing direct patient care to over 108,000 individual patients annually, ~70% of whom are uninsured or Medicaid/Medicare beneficiaries.
- Physicians who train in Colorado tend to remain in the state (60+%).
- COFM is a unique collaborative vs. competitive model of recruiting new physicians to the state.

***Our vision*:** to promote high quality health care for all Coloradans by enhancing access to primary care, including rural and underserved communities, through the training of exceptional family physicians.

Our mission: to convene key leaders and stakeholders who support family medicine training to:

- Cultivate and develop a highly qualified family physician workforce in Colorado to appropriately meet the needs of the population, including rural and underserved communities, through recruitment, education, advocacy, and resource sharing.
- Evaluate and inform community, state, and national policy impacting delivery of advanced primary care and positive health outcomes for Coloradans.
- Be a powerful voice to elevate health care delivery for all Coloradans.

Access to primary care across Colorado

- Since its inception, COFM's mission to assure access to primary care in rural and other underserved communities has driven its actions and efforts.
- All FMRP clinics serve as safety net like clinics, caring for our most vulnerable and hard to reach.
- Four rural training tracks and over a dozen rural rotations feed FMRPs to communities and counties with the least access to primary care. Recent graduates now practice in Meeker, Pagosa Springs, Granby, La Junta, Alamosa, Brush, Fruita and others.
- All residency programs have relationships with the federal qualified and community health centers in their communities and have also supplied those systems with physicians (Sunrise, Pueblo Community Health, STRIDE, Clinica, Peak Vista, Marillac, and others).

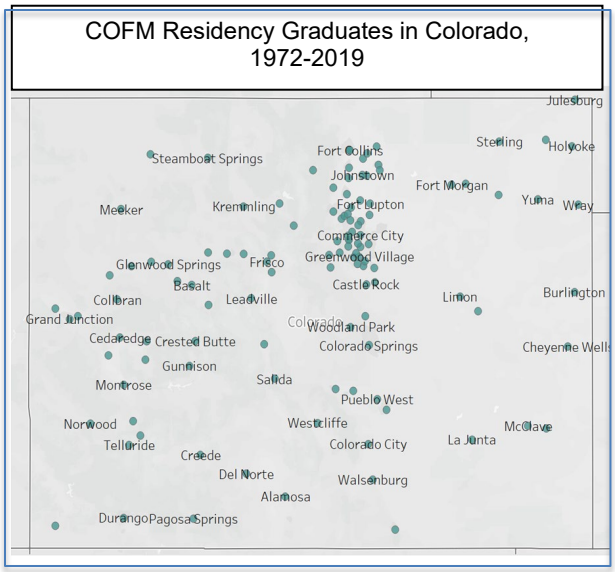
COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Addressing health disparities and inequities

-77,700 of the 108,000 individual patients treated are uninsured, or Medicaid/Medicare beneficiaries.
-8 of the 10 programs offer COVID-19 vaccines.
-7 of the 10 programs host or partner to provide MAT/Opioid clinics and treatment.
-All 10 programs participate in a myriad of community service projects and programs.
-Most engage with schools and other educational institutions to teach and share career experiences with students aspiring to heath careers.

Addressing workforce and pipeline in Colorado



Generating a physician workforce that is representative of the community served is unquestionably a marathon, not a sprint. For the residency programs, this means:

- Intentional recruitment of medical students from historical institutions of color, students typically underrepresented in medicine, and those with a likelihood of practicing in a rural or underserved environment.
- Adapting, screening, interviewing, and selection methods to be responsive to cultural differences.
- Recognizing the challenge of the national match program for resident placement.
- Addressing recruitment from the community/K-12 level through medical school from both a local and a system perspective.
- Interaction with local educational institutions and para- and allied- professional training entities.
- Advocating for policy and regulation changes to reduce barriers to health career pathways.
- Partnering with residency program host institutions to expand outreach efforts.

Below is the chart of the racial/ethnic breakdown of Colorado family medicine residents over the last several years. The average percentage of residents of color in the past 3 years is about double the average percentage of 2013-2015. Progress is slow and the programs are dedicated to generating a more diverse resident pool in the future.

Year	% Resident Grads Practicing in Urban Underserved Areas of Colorado	% Resident Grads Practicing inRural Colorado
2021	21%	21%
2020	22%	15%
2019	20%	24%
2018	22%	13%
2017	22%	22%
2016	27%	21%
2015	29%	18%
2014	29%	20%
2013	24%	3%
2012	22%	8%

Resident graduates remaining to practice in Colorado as well as those choosing rural and underserved practice settings. Forty-six percent of family medicine residents remained in Colorado for this fiscal year.

Colorado continues to increase the average number of physicians practicing in rural with time. From 2012 -2014, prior to the establishment of the rural training tracks, an average of about 10% practiced in rural area where in the past 3 years it is approximately 17%. Underserved community practice average around 20% over time.

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

VALUE OF FAMILY MEDICINE RESIDENCY PROGRAMS TO COLORADO

Shortage of primary care physicians

- 2020 County Health Rankings identify 17 counties with a shortage of primary care physicians (PCPs) in Colorado. Of those, half have only one or two PCPs, leaving little room for transition of the physician(s) from the county, which according to HRSA Area Health resources Files, has already occurred in several counties.
- In addition, 10 of the 17 have an uninsured population of 10+%.
- Finally of those 17 counties, 13 are directly served through the family medicine residency physicians in primary programs, rural rotations, and/or rural training track programs. All told, Colorado family medicine resident physicians touch patients in over 2/3rds of Colorado counties.

Colorado's family medicine residencies help fill the gap

- There are 10 family medicine residency programs in Colorado.
- Programs are independent of one another but collaborate through the Commission on Family Medicine (COFM).
- Historically from 2010 through 2021 about 20% of family medicine resident physicians come from Colorado medical schools (University of Colorado and Rocky Vista University) and 60% stay to practice in Colorado.
- Over 40% of graduates who stay in the state practice in rural or underserved areas.
- The residency clinics are part of Colorado's health care safety net. In 2022:
    - Over 108,000 Coloradans received health care in family medicine clinics.
    - 72% of patients were Medicaid (46%) or Medicare (17%) or uninsured (9%).

Strategies to encourage family medicine residents to practice in rural Colorado

- COFM requires a one-month rural rotation for all family medicine resident physicians.
- COFM supports rural training tracks (RTTs) in Alamosa, Fort Morgan, Sterling, and Wray. Residents live and train in the rural community in years 2 & 3 of residency.
- COFM collaborates with rural training programs at CU Medical School and Rocky Vista University to create a training pipeline for graduates.
- COFM works with several state partners to enhance access to care including the Rural Health Center, CDPHE Primary Care Office, CO Academy of Family Physicians, and the Colorado Hospital Association, among others.

Funding the Family Medicine Residency

- Expenses for training family physicians are paid by the patient revenue, federal Medicare GME funds, the sponsoring hospitals, health systems and the Colorado General Assembly.
- The Colorado General Assembly provides funds to expand the number of family physicians being trained and place them in areas of highest need: rural and underserved areas.
- State funds are matched by federal Medicaid dollars, effectively doubling the investment.

Family medicine training in Colorado

- Dual mission of training physicians and exemplary, direct care.
- Residents complete 3 years of training prior to going into practice.
- Our programs are sought after for our commitment to full scope, broad spectrum practice.
- Colorado requires one-month rural experience in addition to standard requirements.
- Residency Clinics serve as safety net care access (72% Medicare, Medicaid and uninsured).

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Support through State funding is increasing our number of primary care physicians

Benefit of Additional Training Positions from the Programs:

…In Fort Collins we were able to grow our residency to meet the primary care needs of an additional 1,000 patients in a safety net clinic (70% Medicaid) in addition to providing better coverage for our complex and busy inpatient services.

- Between 2018 and 2021, the number of family physicians graduating annually from our residency programs increased from 68 to 85 residents.
- An average, over time, of 60% of residents stay in the state.
- Almost half on average stay in Colorado practicing in rural or urban underserved communities.
- Rural training programs (2014 fund start) add 6 graduates annually.
- Additional training positions (2015) add 5 graduates annually
- One training position (2017) added to the UC FM residency.
- Funds to expand residency training are long-term investments requiring sustained support.

Retention of graduates

- 85 graduates in 2022.
- 46% of this year's graduates stayed in Colorado.
- 42% of those in Colorado practice in rural/underserved area.
- Since 1972 (1st graduating classes of FPs), 60% of graduates are still practicing in CO.

Timeline of increasing the number of residents in family medicine programs:

CO Residency Program Base Support	2017/18	2018/19	2019/20	2020/21	2021/22
Total # of Residents*	221	252	247	265	**258**
Total # of Graduates*	67	83	82	81	**85**
Cost per Resident**	$367,579	$342,711	$359,387	$366,346	**368,911**
State Support per Resident***	$15,113	$13,254	$13,523	$18,758	**$12,946**
% Support from State***	4.30%	4.10%	3.7%	3.6%	**3.5%**

Total Number of Residents/Graduates: The table above does not include resident physicians training at Denver Health (DH), a training track of the UC Family Medicine Residency Program that does not qualify for State/COFM funding. The DH track includes 15 residents, bringing the total of family medicine residents training in Colorado to 273, 85 of whom are expected to graduate in June of 2023.

**To calculate the cost to train a family medicine resident, we obtain financial data from each residency program. The information reported by the programs includes the costs to support the educational components of residency training and clinical costs to operate a full-scope family medicine practice, inclusive of the costs of clinical and non-clinical staff, overhead, operations, etc. These costs are included because the clinical setting is central to training a family physician. The calculation of expenses is not standardized across programs. Some sponsoring hospitals allocate all operating costs to the residency. Other hospitals, however, do not include in their residency operating budgets such items as rent, utilities, IT services, security services, and human resources.

***State support per resident is calculated by dividing the *base funding* from the state by the number of residents in training. During FY 2021/22, the residencies reported spending $95,178,952 for training 258 residents (DH residents are not included in this calculation). The % support from the state represents the proportion of the residencies' total expenses that is paid by *base funding*.

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Benefits of the Commission

The Commission fosters collaboration among the independent programs:

- Improves quality of all the programs.
- Allows for efficiencies in programming and recruiting medical students.
- Ensures residents train in advanced primary care settings, preparing graduates for future practice models.
- Increases the placement of graduates in rural and underserved locations.

Value of Statewide Collaborative

Greeley resident physicians find great value in the CAFMR chief resident workshop sessions and really enjoy the collaborative recruiting opportunities with the other family medicine residency programs in Colorado.

A colleague once shared that cardiac specialists and surgeons may hold patients' lives in the balance when they present in their practice and should be compensated for that. However, chances are that the patient was referred there by their family physician or primary care provider with a stomachache, or trouble breathing, or chest pain, or any other array of symptoms that could be attributed to any number of conditions or illnesses and that family physician sorted them out to make the appropriate referral.

Challenges facing family medicine physician training

The Colorado Health Institute puts it well in their 2017 report *"Primary Care Workforce: A Study of Regional Disparities"* – "Investing in the workforce pipeline and creating local training opportunities will be important. It is not realistic to expect patients to commute great distances for care…Colorado's current workforce generally reflects the fee-for-service payment system, which creates incentives to provide as many medical services as possible and reimburses nonprimary care clinicians at higher rates than their primary care counterparts."

Delivering exceptional family medicine physicians to our most under-resourced areas is not without its challenges. Family medicine physicians do not choose family medicine because it is the most lucrative medical discipline. These family physicians love the interaction they have with patients, their families, and their communities, they strive to make a difference in their lives. Nevertheless, they have historically and continue to be one of the lowest paid of the medical specialties.

Other challenges also impact the discipline

- Less Colorado family medicine residents are choosing to remain in Colorado due to:
  - Opportunities for spouses/significant others due to low unemployment rate.
  - Cost of housing in Colorado.
  - Full scope practice opportunities (in rural and underserved communities).
  - Colorado Medicaid/Medicare reimbursement rates are lower than nationally.
- Less medical students choosing family medicine as a specialty due to continued fallout from the pandemic and economic reasons (other specialties garner much higher salaries).
- Medical student interviews for residency continue to be virtual vs. in person inhibiting a medical student's opportunity to get a full picture of what 3 years of residency will be like.
- There have been changes in the scope of practice for graduating family physicians with more opportunities for full scope practice being limited and the trend of larger hospital systems to hire for urgent care/hospitalist roles vs. full scope, outpatient primary care.

Rural Training Tracks

"The Colorado rural training track programs have provided an invaluable education and increased access to primary care to the rural populations. These physicians not only increase access to general primary care, but also can provide maternal care and preventative care screenings within the communities they serve and are more likely to work in rural communities after residency." -Rural Training Track Hospital Administrator

The resident physicians who are trained in Colorado and whose programs participate with the Commission on Family Medicine continue to choose practice in rural and underserved areas with physician graduates in rural practice up 75% prior to establishment of the Rural Training Track (RTT) program. An additional 20+% choose to practice in underserved urban communities where Medicaid members and people without insurance are more likely to reside.

Colorado proudly hosts 4 rural training tracks:

☆Wray (one of oldest in country) ☆Alamosa ☆Fort Morgan ☆Sterling

- The state generously supported start-up and development of these RTTs; they graduated their first residents in 2019.
- Sustained state funding is necessary to augment what the host communities and institutions provide to support this training.
- This model has proven successes in increasing family medicine presence in rural communities.
- Wray supports 1 resident, and the others support 2 residents per training year for years 2 and 3; year 1 is spent in urban "host program".
- Including Wray, the programs will graduate 7 family physicians per year.
- RTTs are an example of state funds being used to train family physicians where we need them.

Background Information

Over the years, the legislature has requested that COFM develop programs and activities to support access to best practice primary care for the residents of Colorado. The General Assembly allocates funds annually to support the training of family physicians. Beginning in 2013, additional state funds have enabled the residency programs to expand the number of family physicians being trained and to place them in areas of highest need: rural and underserved communities.

State funding is federally matched 50-50 ($4,520,084 - matched by Medicaid) to train family physicians (allocated to the Commission on Family Medicine) and falls into three categories:

This state funding support is crucial to the sustainability of the quality and comprehensive scope of the residency programs in Colorado. The chart on the next page is a break out of how those funds are allocated.

Base Funding ($1,670,084)	Rural Training Track ($1,500,000)	Added Resident Positions ($1,350,000)
• Distributed from HCPF to programs • Supplements Medicare GME and other funding sources & patient revenue to defray expense of resident training • Add what Base Funding pays for from below	• Initiated in SFY 2014-15 • Tracks established in Alamosa, Fort Morgan, Sterling • 6 graduates/year • Rural trained residents highly likely to practice in rural areas (approximately 60%) • Rural training requires sustained support and investment for training and retention • Rural "pipeline" is established through medical student recruitment from University of Colorado and Rocky Vista University and other medical schools across the country • Pipeline work expansion work through state efforts	• Initiated in SFY 2015-16 • 5 programs added additional position each • Programs successfully graduated first cohort of 5 residents in 2017-18 • The program has successfully graduated 5 resident cohorts each year since 2017-18 • Residents commit to 3 years of practice in rural/underserved communities in exchange for loan repayment support • Loan repayment recipients currently practice in: Adams, Arapahoe, Archuleta, Boulder, Chaffee, Denver, El Paso, Larimer, Morgan, Pueblo & Weld counties • Working with CHSC to distribute awards and diversify workforce pool

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Value of Resident Physicians to Rural Colorado

Benefits of the Commission's work to rural Colorado are multiple and difficult to quantify. Close to ¾ of the Commission's funding impacts rural primary care practice either directly or indirectly through training and practice with our rural training tracks (RTT) and rural rotation sites.; the broad spectrum training the resident physicians receive; the recruitment efforts on behalf of our rural communities as well as all of our programs, the cross organization training they receive with federally qualified health centers, public health, behavioral health, in-hospital and in-clinic care delivery, schools, and with homeless, indigent, and undocumented patients.

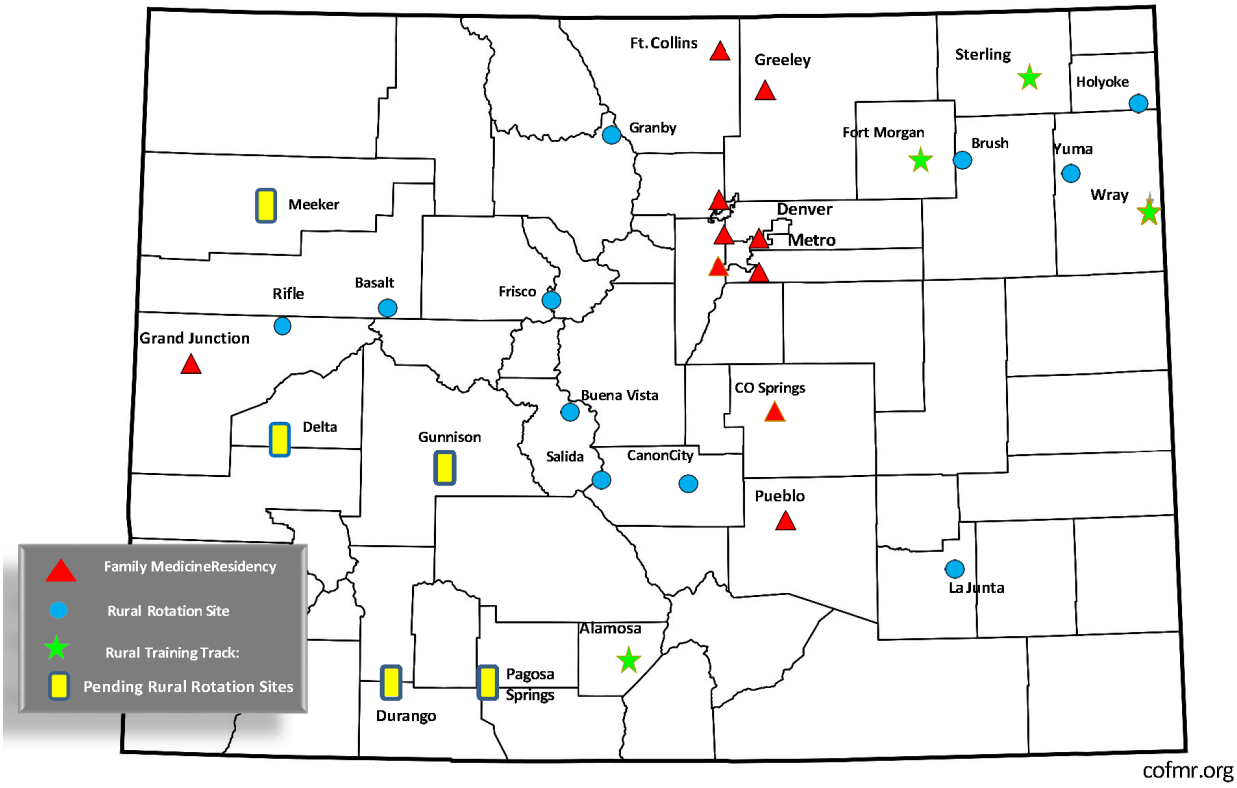
Our Rural Training Tracks: Our residents and faculty practice at a sole community rural hospital handling level 3 trauma, obstetrics, inpatient, geriatric, psychology, and other routine procedures.

Our Rural Rotation Clinics:
These rural physicians value the residents in their practice as a means to introduce them to rural practice and to keep up on current trends in their field.

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Colorado Family Medicine Training Sites



RTT resident physicians see:

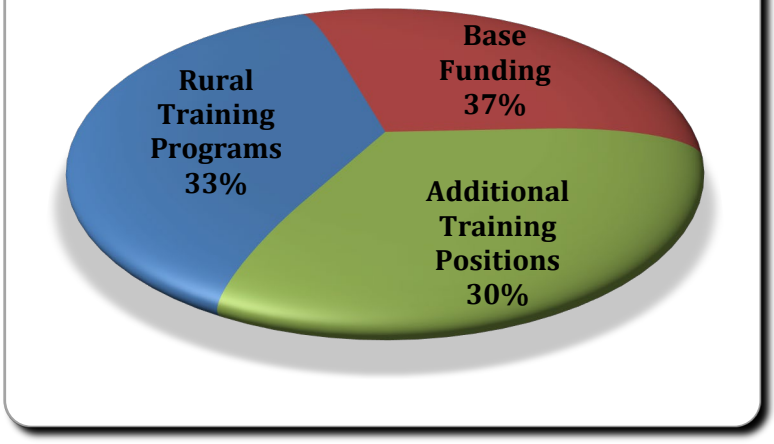
- 50-60% Medicaid members
- 10-25% Medicare members
- 3-24% uninsured community members

Seventy resident physicians (on avg.) complete one-month rural rotations and a range from 150-300 visits, many with underserved patient populations each year

Annually, rural track, community-based resident physicians provide:

- Direct care to 10,000+ patients
- About 21,000 patient visits
- Multiple community projects & services

2021-2022 COFM Funding*



*State funds ($4,520,084) are matched by Medicaid funds ($4,520,084)

COMMON QUESTIONS FOR DISCUSSION

1. **Please describe the implementation plan for new programs added to the Department from one-time stimulus funds (such as the CARES Act, ARPA, and one-time General Fund), as well as any challenges or delays to program implementation.**

RESPONSE

Coronavirus Aid, Relief, and Economic Security Act (CARES)

- **Telehealth Services:** The Department received $5,068,381 in FY 2020-21 from the CARES subfund through SB 20-212, Reimbursement for Telehealth Services. This bill expanded Medicaid reimbursement for telehealth services, which was necessary to protect the safety of both members and providers, while still providing access to services during the pandemic. The Department fully spent the funding in the first half of FY 2020-21.
- **Residential Care Strike Team Staffing:** The Department spent $45,820 in FY 2020-21 for FTE to support the Governor's cross-agency taskforce. This taskforce was created to develop and implement strategies to mitigate the spread of the illness and save lives in residential congregate settings that serve older adults and people with disabilities. The Department used the funding to staff a project manager and workforce lead for the taskforce.
- **Vaccine Outreach:** The Department received $14,337,696 to implement targeted vaccine outreach for two high-priority population groups: 1) homebound members and 2) populations impacted by health disparities. The Department made funds available to the Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and case management agencies to ensure resources were available to vaccinate these populations. One hundred percent of homebound members who wanted to receive a vaccine, received their vaccine and minimized the health disparity gap between racial groups within the Medicaid population (achieving our <3% vaccination disparity target between people of color and white people). The Department fully refinanced these funds with the Federal Emergency Management Agency (FEMA) Disaster Relief Fund by the end of FY 2021-22.

Families First Coronavirus Relief Act (FFCRA)

- **Enhanced Federal Medical Assistance Percentage (FMAP):** FFCRA provided a 6.2 percentage point increase to the standard FMAP for Medicaid services. The federal match rate increased from 50% to 56.2% for most Medicaid services. The enhanced federal match will continue until the end of the public health emergency based on current law. The Department is required to comply with several requirements to be eligible for the 6.2 percentage point increase, including maintaining coverage for members throughout the public health emergency, even if they no longer qualify for the program. The Department has received $1.372 billion through the FFCRA FMAP bump through October of 2022, annualizing to over $1.5 billion through December 2022.

This has helped the state balance its budget during the pandemic as it has resulted in a reduction to General Fund of that amount.

American Rescue Plan Act (ARPA)

- **Home and Community-Based Services (HCBS) Enhanced Federal Match:** Section 9817 increased the federal medical assistance percentage (FMAP) for Medicaid HCBS spending by 10 percentage points from April 1, 2021, through March 31, 2022. The bill specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen'' Medicaid HCBS. The Department submitted a spending plan to implement this provision and received approval from the Centers for Medicare and Medicaid Services (CMS) and the JBC in September 2021. The Department projects saving $318 million in state funds from the enhanced federal match and spending $529 million through the spending plan, which includes the $318 million in freed-up state funds and matching federal funds for eligible projects.

  The Department's spending plan includes eight (8) priority categories. Each category represents a critical area of need for members, their families and the provider network. Across these categories, there are 63 distinct initiatives. The projects encompass a range of work activities, from current efforts that can be strengthened and supercharged with these funds, to large, transformative work that will ensure Colorado's HCBS system is a national model for excellence in health outcomes, access, member satisfaction and affordability. At the heart of each is the Department's guiding principle: to ensure access to high-quality services in the community of choice for all members. As of November 2022, all 63 initiatives have launched and are moving forward as planned. The Department provides quarterly updates on the implementation of the spending plan to both the JBC and CMS, all of which can be found on the Department's external website. These reports provide detail on the progress of each initiative, as well as the spending and forecasted spending.[1]

- **100% FMAP to Urban Indian Health Organizations:** Section 9815 provides a 100% federal match for services provided in an Urban Indian Health Organization for eight quarters. The Department has received $176,375 through October 2022 in additional federal funds through this provision and a corresponding reduction of that amount to state funds. The enhanced federal match is accounted for in the Department's R-1, Medical Services Premiums. The Department received approval of R-16 in the FY 2021-22 budget, Urban Indian Health Organizations State-Only Payments, which was then established in statute through HB 22-1190, Supplemental State Payment to Urban Indian Organizations. This bill allowed the Department to use the freed up General Fund to make state-only payments to Denver Indian Health and Family Services, which is the only Urban Indian Health Organization in the state. The Department paid out the full appropriation from that bill of $118,850 in FY 2021-22 and FY 2022-23.

[1] https://hcpf.colorado.gov/arpa

- **100% FMAP for COVID-19 Vaccine Administration:** Section 9811 provides a 100% federal match for expenditure billed for COVID-19 vaccine administration for Medicaid and CHP+. The Department has received $15.89 million through October 2022 in additional federal funds through this provision and a corresponding reduction of that amount to state funds. The enhanced federal match is accounted for in the Department's R-1, Medical Services Premiums.
- **Increased Allotment for Disproportionate Share Hospital Payments:** Section 9814 increases the federal allotment for payments to hospitals that serve a disproportionate share of low-income patients to account for the 6.2 percentage point FMAP increase authorized under the Families First Coronavirus Relief Act. Department projects have drawn down an additional $36.95 million through the increased allotment through September 2022. This is being used to offset General Fund per SB 21-213, Use of Increased Medicaid Match.
- **Behavioral Health Recovery Act (SB 21-137):** SB 21-137, Behavioral Health Recovery Act, appropriated $250,000 in the State and Local Fiscal Recovery Fund to support training health care & behavioral health care professionals in substance use screening, brief intervention, & referral to treatment (SBIRT). SBIRT is a comprehensive, integrated best practice for early identification, intervention and treatment of people with or at risk of substance use. These funds were fully expended in Q4 of FY 2021-22. These funds supported the completion of 12 trainings in Q4 with a total of 107 attendees.
- **Planning Grant to Provide Community-Based Mobile Crisis Services:** The Department received $818,278 in a direct grant from CMS under Section 9813 to plan how to expand the Department's crisis response services to meet new federal guidelines provided in the same section. This planning grant is supporting the Department to determine how to implement these changes in coordination with the Behavioral Health Administration (BHA) to provide qualifying community-based mobile crisis intervention services within the state's crisis system. Services that meet these new federal standards will qualify for an enhanced 85% federal match if implemented. To date, the Department has conducted extensive stakeholder engagement to inform benefit design, with a focus on rural and frontier areas. The Department is moving to weekly technical assistance meetings to continue to develop competencies and expand capacity for this new benefit. The Department is working with the BHA and providers on a needs assessment and readiness review. Grants will then be made available to support providers to prepare to provide the new service, set to be in place July 2023.
- **Sunset Limit on Maximum Rebate Amount for Single Source Drugs and Innovator Multiple Source Drugs:** Section 9816 eliminates the current cap on rebates that manufacturers pay to the state for certain prescription drugs. This provision goes into effect Dec. 31, 2023. This would likely result in higher rebates overall to the state, which would offset overall cost of care for Medicaid members.
- **12-Month Postpartum Coverage for Medicaid and CHP+:** SB 21-194, Maternal Health Providers, expands eligibility for members who were eligible for pregnancy-related and postpartum services from 60 days postpartum to 12 months postpartum. Section 9812 of ARPA provides a state option to expand coverage in this way through the Department's State Plan Agreement with CMS. The Department has submitted State Plan Amendments for both Medicaid and CHP+ and is awaiting

CMS approval. There is no additional or enhanced funding through ARPA to implement the provision.

- **Medicaid Member Immunization Effort:** The Department was allocated $278,886 from the Public Health/Administrative fund allocated to the Governor's Office to hire two term-limited FTE through FY 2022-23 to increase the number of Medicaid members fully immunized for COVID-19 and other critical vaccines. These FTE will leverage Medicaid and statewide data to develop localized strategies to increase member vaccination rates. The two FTE have been hired and approximately $40,000 has been expended through September 2022.
- **Funding for Administrative Staff for the ARPA-Related Work:** The Department was allocated $80,000 from the Public Health/Administrative fund allocated to the Governor's Office to begin work on standing up the administrative infrastructure for ARPA-related projects. The funding was used to support staff time dedicated to engaging stakeholders, developing budgets, drafting and finalizing the spending plan, and preparing presentations for the ARPA HCBS Spending Plan. Because of the extensive work accomplished over the summer and fall of 2021, both CMS and the JBC approved the Spending Plan on Sept. 21, 2021.
- **Rural Health Care Provider Expanded Access:** SB 22-200, Rural Provider Stimulus Grant Program, appropriated $9.6 million to provide grants to qualified rural health care providers based on financial need and the ability to expand health care access. The grant program is intended to improve health care affordability and access in rural communities. Qualified uses for the grant funds include: projects that improve health care affordability by modernizing the information technology infrastructure of rural providers, such as investments in shared data analytics platforms and technologies like telehealth and e-consults, and projects that expand access to health care in rural communities, such as projects extending hours for primary and behavioral health care and creating new or expanded access sites including surgery, chemotherapy and advanced imaging. The intended outcomes of these grants are to ensure and improve Coloradans' access to quality health care and to drive financial sustainability for hospitals and clinics in rural areas of Colorado. As of Nov. 2022, the SB 22-200 advisory committee held six meetings and made recommendations defining eligible rural hospitals, permitted uses of funds, timelines and reporting requirements, and program rules. The request for application for the grants is targeted to be released in March or April 2023, with fund disbursement beginning in July 2023.
- **Health Care Practice Transformation and Integration:** HB 22-1302, Health Care Practice Transformation, appropriated $34.7 million to support the creation of the primary care and behavioral health statewide integration grant program. This program will provide grants to physical and behavioral health care providers for implementation of evidence-based clinical integration care models. Grants may be used to train staff, invest in IT upgrades to support integration, expand telehealth, support change management and re-processing workflows, and community engagement. Depending on the hospital's revenue, cost sharing is required as a component of participation and receipt of grant funds. Funding will be prioritized to applicants that serve populations that experience disparities in health care access and outcomes. Additionally, these funds will support the implementation of universal contracting, which will

represent a major step forward in behavioral health provider accountability, especially for safety net providers like community mental health centers. The intended outcome of these grants is to ensure and improve Coloradans' access to quality behavioral health care. As of October 2022, the universal contract work is underway and is scheduled to be implemented by July 2023. The grants' steering committee is in development, which will provide input into grant application requirements, feedback and direction on data collection standards and review, and engage with community partners. The Department anticipates that grants will be awarded by July 2023.

Challenges or Delays to Program Implementation

The Department is monitoring all of our stimulus funded efforts very closely and at this time does not have any significant concerns about being able to meet spending deadlines. As challenges have emerged with particular initiatives, we have been able to manage them quickly to ensure that they are back on track for successful implementation.

2. **Please identify how many rules you have promulgated in the past year (FY 2021-22). With respect to these rules, have you done any cost-benefit analyses pursuant to Section 24-4-103 (2.5), C.R.S., regulatory analyses pursuant to Section 24-4-103 (4.5), C.R.S., or any other similar analysis? Have you conducted a cost-benefit analysis of the Department's rules as a whole? If so, please provide an overview of each analysis.**

RESPONSE

From October 2021 to October 2022, the Department promulgated 74 rules. The Department does cost-benefit and regulatory analyses for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analyses are included in the rule-making document packet that accompanies each rule proposed by the Department and can be found on the Department's website. The cost-benefit analysis includes the following components:

- Description of persons who will bear costs of the proposed rule and persons who will benefit from the proposed rule;
- Discussion of the probable costs, to the Department or any other agency, of implementation and enforcement, and any anticipated effect on state revenue;
- Comparison of the probable costs/benefits of the proposed rule to the probable costs/benefits of inaction; and
- Determination of whether there are less costly or less intrusive methods for achieving the purpose of the proposed rule.

The Department makes the rule-making document packet available to the public when the public notice of proposed rule-making is published and it is also included in the public record after the Medical Services Board adopts the rule.

With respect to these rules, a separate cost-benefit analysis was requested for one of the rules. Section 24-4-103(2.5), C.R.S., states that anyone may request a cost-benefit analysis within five days of the publication of notice of proposed rule-making in the Colorado Register.

The response to the cost-benefit analysis request was structured like the analysis performed on every rule described above. The analysis included the reason for the rule or amendment, the anticipated economic benefits of the rule or amendment, the anticipated costs of the rule or amendment, any adverse effects on the economy and at least two alternatives to the proposed rule or amendment.

The Department performed a regulatory analysis of all 74 rules pursuant to section 24-4-103(4.5), C.R.S. The regulatory analysis performed on each rule is compliant with statute and is available to the public for review five days prior to the rule-making hearing on the Department's public website. The Department has not conducted a cost-benefit analysis of the rules as a whole.

Each year the Department is required to submit a Regulatory Report to the General Assembly and the Secretary of State. This report documents all rules promulgated by the Department and is available here.

3. **[Rankin] For how many temporary FTE has the department been appropriated funding in each of the following fiscal years: FY 2019-20, FY 2020-21, FY 2021-22, and FY 2022-23? For how many of the temporary FTE was the appropriation made in the Long Bill? In other legislation? Please indicate the amount of funding that was appropriated. What is the department's strategy related to ensuring the short term nature of these positions? Does the department intend to make the positions permanent in the future?**

RESPONSE

The Department is unable to provide temporary FTE counts. Temporary FTE are not included in the statutory definition of FTE pursuant to Section 24-75-112(1)(d)(II), C.R.S. which states that FTE does not include contractual, temporary, or permanent season positions. The department has provided as part of the Nov. 1 request the Schedule 14A and 14B which provides actual expenditures. For the upcoming years, the department manages the dollar appropriation which has been affirmed by two Supreme Court cases (Colorado GA vs Owens and Anderson v Lamm).

4. **[Zenzinger] Please provide a description, calculation, and the assumptions for the fiscal impact of implementing the provisions of the Partnership Agreement, including but not limited to changes in annual leave accrual, holiday pay, and paid family and medical leave. If your department includes employees who are exempt from the Partnership Agreement, please indicate whether or not you intend to implement similar benefit changes as those required for covered employees. Please provide a breakdown of the fiscal impact of implementing the provisions of the Partnership Agreement for: a) employees who are subject to the Agreement, and b) employees who are exempt from the Agreement.**

RESPONSE

The cost to departments for employees using the paid family medical leave was requested and approved last year (DPA FY 2022-23 R-02). For FY 2023-24 the cost is part of the POTS appropriation called Temporary Employees Related to Authorized Leave. The adjustment to annual leave and the additional holiday, as noted in the fiscal note for the bill (S.B. 22-139) were expected to be minimal and if necessary, will be addressed through the annual budget process. The Governor's Nov. 1, 2022, budget included funding for the economic articles of the Partnership Agreement, including funding for paid family medical leave. The department is working with OSPB and DPA to submit a January budget amendment if necessary to seek additional adjustments related to the Partnership Agreement. In addition, OSPB will provide the JBC with a breakdown of the fiscal impact of implementing the Partnership Agreement by department.

DEPARTMENT DISCUSSION QUESTIONS

COVID- 19 PUBLIC HEALTH EMERGENCY

1. ***[Sen. Bridges]*** **Describe the Department's plan to review eligibility at the end of the public health emergency, including the timing and process for redeterminations and the support for counties. How does the Department plan to ensure that individuals won't lose eligibility erroneously.**

RESPONSE

The federal government has given states guidance on how to resume normal operations including redetermining eligibility for all members currently enrolled in Health First Colorado and CHP+. States have up to 12 months (14 months including noticing) to re-evaluate eligibility for everyone who is enrolled.

Colorado has opted to take the entire time allowed. This approach leverages the current annual renewal cycle for each member to reduce member confusion, leverages existing renewal processes for eligibility workers and takes the full allowable time to complete renewals. This approach has three key operational goals in mind 1) focus on member continuity of coverage so those eligible remain enrolled 2) improve the member experience with smoother transitions in coverage for those no longer eligible and 3) minimize impacts to eligibility workers and state staff.

In order to minimize erroneous terminations, the Department has implemented various system changes, outreach, and operational methods to connect with members. For example, if a member's renewal is due in May 2023, the renewal process will start approximately 70 days prior to May 2023. The eligibility system will check to see if we can automatically renew coverage based on interfaces and if they qualify, the member will receive a Notice of Action approximately around the middle of March 2023. These eligibility system changes to increase automation have driven the automatic approval rate to approximately 34% for all members renewing. This means there is no member or eligibility worker

activity needed for these approvals. For members who have met eligibility criteria and remained eligible, the automatic approval rate has been higher, recently averaging 66% of those members renewing.

If the Department is not able to renew based on interfaces, the Department will send the household a renewal packet in March 2023. The signature page and any necessary changes will be due May 5, giving members at least 30 days to respond. The Department has contracted with a vendor for proactive address validation to ensure the packet goes the correct address. In addition, the Department has partnered with advocates and stakeholders for an Update Your Address campaign to get the correct address and are encouraging members to sign up for electronic notices, so they do not have to wait for a mailed letter. For members who have opted into electronic noticing, the Department will also send text messages and/or emails to members who receive a renewal packet, reminding them to review, sign, and send back the packet. The Regional Accountable Entities (RAEs) will receive data on members who need to send their renewal packet and conduct direct outreach to members to remind them to take action on their renewals.

In addition, the Department has collaborated closely with the counties to prepare them for the upcoming end of PHE workload. The Department received funding to support counties with additional staffing and there have been several business process improvement sessions, ongoing engagement to get county thoughts and ideas on plans, and a robust oversight and accountability program. This has been instrumental with meeting our goals of member continuity of coverage if eligible, improving member experience, and minimizing impacts to eligibility workers.

2. ***[Rep. Sirota]*** **Discuss how the Department is planning for this dis-enrollment process. Specifically, how is the Department ensuring that individuals who are still eligible do not lose coverage?**

RESPONSE

In order to minimize erroneous terminations, the Department has implemented various system changes, outreach, and operational methods to connect with members. For example, assuming the PHE ends in April 2023, if a member's renewal is due in May 2023, the renewal process will start approximately 70 days prior to May 2023. The eligibility system will check to see if the Department can automatically renew coverage based on electronic interfaces. If they qualify, the member will receive a Notice of Action around the middle of March 2023. These eligibility system changes to increase automation have driven automatic approval rate to approximately 34% of all members renewing. Therefore, no member or eligibility worker activity is needed for these approvals. For members who have met eligibility criteria and remained eligible, the automatic approval rate has been higher, recently averaging 66% of those members renewing.

If the Department is not able to renew based on interfaces, the Department will send the household a renewal packet in March 2023. The signature page and any necessary changes will be due May 5, giving members at least 30 days to respond. The Department has contracted with a vendor for proactive address validation to ensure renewal packets go to the correct addresses. In addition, the Department has partnered with advocates and stakeholders for an "Update Your Address" campaign to get the correct address and are encouraging members to sign up for electronic notices, so they do not have to

wait for a mailed letter. The Department will also send text messages and/or emails to members who receive a renewal packet, reminding them to review, sign, and send back the packet. The Regional Accountable Entities (RAEs) will receive data on members who need to send their renewal packet and conduct direct outreach to members to remind them to take action on their renewals.

In addition, the Department has collaborated closely with the counties to prepare them for the upcoming end of PHE workload. The Department received funding to support counties with additional staffing specific to processing renewals, and there have been several business process improvement sessions, ongoing engagement to get county input on plans, and a robust oversight and accountability program. This has been instrumental with meeting the Department goals of member continuity of coverage if eligible, improving member experience, and minimizing impacts to eligibility workers.

3. ***[Sen. Kirkmeyer]*** **Describe the redetermination process. Specifically, what type of notice will the Department or counties be providing to individuals that will lose Medicaid coverage?**

RESPONSE

Every Medicaid and CHP+ household has a redetermination (renewal) date set 12 months from the month they applied for coverage (and every year thereafter). The renewal process starts approximately 70 calendar days prior to the member's renewal month. For example, renewals due in April 2023 will be started February 12. The first step in the renewal process is to determine if a member can be automatically renewed based on information we have for them from other data sources. This means that some members will not receive a renewal packet, but rather receive a "notice of action" letter that lets them know they are still eligible for coverage. The majority of these members do not need to take further action to keep their coverage. In some cases, members may also receive a letter requesting them to check if their income information is correct or make updates.

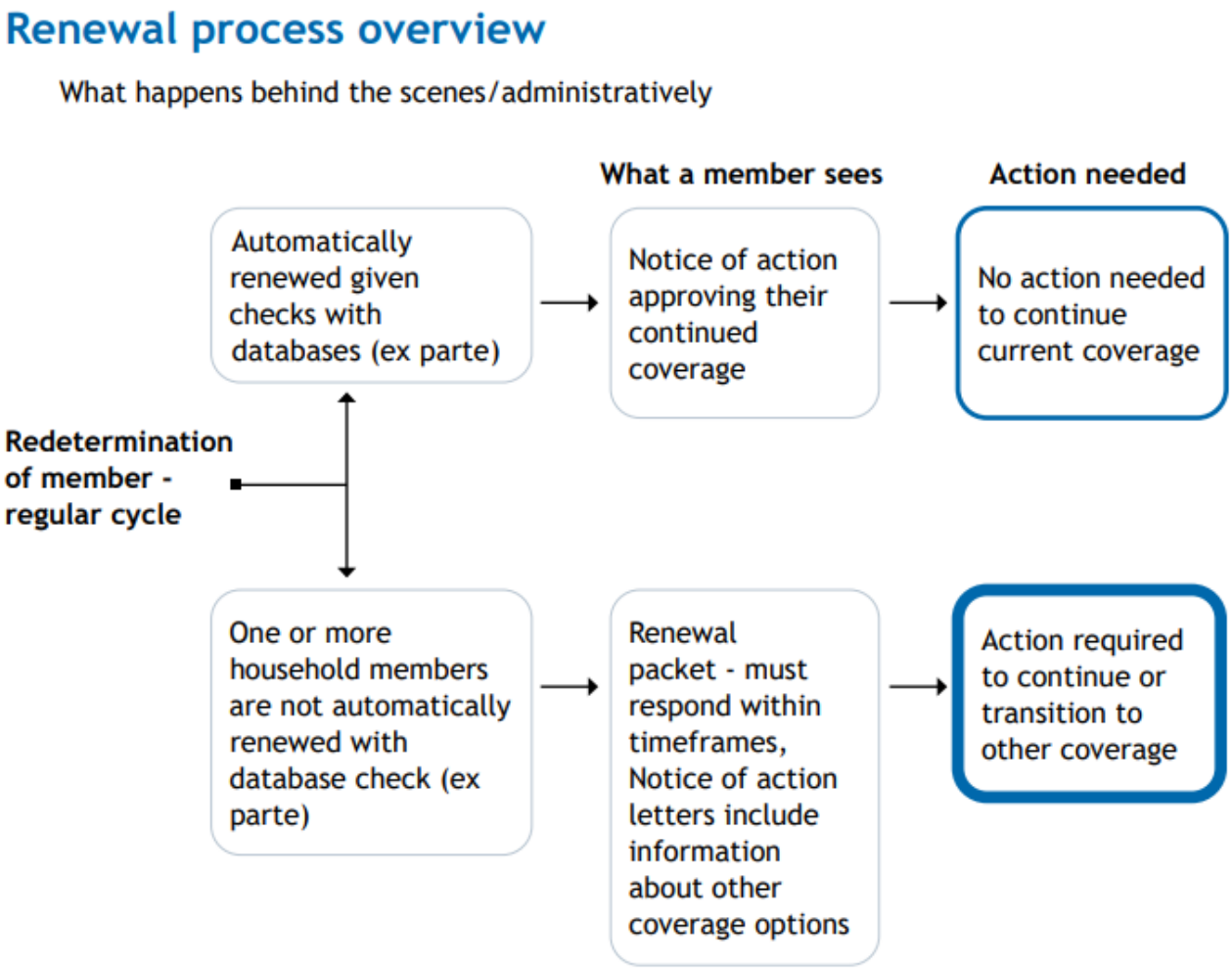
If the Department is not able to verify a member's eligibility with existing data, they will have to go through the next step in the renewal process to see if they still qualify for coverage. These members will receive a renewal packet asking them to see if anything about their situation has changed, and will request verification to determine whether they are still eligible to receive Medical Assistance. The information we have for members is pre-populated in the packet to make it easier to verify or update as needed. The renewal packet was also reformatted to make it easier to read and add a signature requirement.

The renewal packet can be completed electronically through PEAK, the Health First Colorado mobile app or by mail. Important things to know about the renewal packet:

- Members will receive a renewal packet approximately 70 calendar days before their renewal deadline to allow time for completion.
- The renewal packet is sent out for the entire household, so it will include verification information for each person in the household who is a Health First Colorado or CHP+ member.

- The renewal packet must be reviewed fully, including providing updates if applicable. All renewals must be signed where indicated, and sent back in by the deadline specified in the packet, even if there are no changes.

After a renewal is received, the Department can determine if the member still qualifies for coverage. If they no longer qualify or failed to provide the information needed to complete the renewal, a notice of action letter providing the termination reason is sent with appeal information. This letter will also provide information regarding financial assistance and purchasing a health plan through Connect for Health Colorado. Below is an overview chart of the renewal process for members:



4. ***[Rep. Bird]*** **Please provide information about the demographics of the individuals who will be dis-enrolled. Include any information about whether those who will be dis-enrolled are likely to have other health care coverage.**

RESPONSE

At the end of the COVID-19 public health emergency (PHE), once the federally required continuous coverage protection is no longer in place, states will be required to return to normal operations. If a member is found to be no longer eligible through the annual renewal process, they will be disenrolled. Some members will be automatically renewed based on the information we have on file for them at the time of their renewal. Other members not automatically renewed will need to take action by verifying information and signing their renewals in order for eligibility to be determined.

Predicting who will be disenrolled at the end of the PHE is challenging. Eligibility renewals will be conducted on every member over the course of the year based on their annual renewal date. Until a full renewal determination is completed, the Department does not know who will be disenrolled, as member circumstances may change. In order to make an accurate eligibility determination, the renewal must use current, not outdated, information. Therefore, at this time, the Department cannot provide exact data about the demographics of the individuals who will be disenrolled at the end of the PHE.

The Department has some demographic information on members who have, at some point during the PHE, been found to be ineligible. This is known as the continuous coverage population. It would be inexact to extrapolate data from the continuous coverage population across the entire Medicaid and CHP+ population, but this data may give us some preliminary insight into whom might no longer be eligible once their renewal is completed. A summary of demographics on this continuous coverage population is below.

There are just under 800,000 people who are part of the continuous coverage population associated with the PHE. Of those, 96% were eligible for Medicaid and 4% for CHP+. The continuous coverage population generally mirrors the overall Medicaid and CHP+ combined populations. For example, 38% of the continuous coverage population is age 0-20 vs 40% of the total population, 30% of the continuous coverage population and the total population are ages 21-39, and 23% of both are ages 40-64. The male/female percentages for both the continuous coverage population and total populations are 47% / 53%. Approximately one third of each population identifies as being Hispanic/Latino.

There are a few differences between the continuous coverage population compared with the total Medicaid and CHP+ population. They are more likely to be White/Caucasian, have other insurance and have higher incomes. There are five percent more White/Caucasian members in the continuous coverage population than are reflected in the total population (41% vs 36%) whereas approximately 1% fewer of Hispanic/Latino (31% vs. 30%) and Black/African American (6% vs. 7%) members are in continuous coverage. Members who have other health care coverage, with non-Medicare third party liability, are more likely to be in the continuous coverage population than in the total population (16% vs. 12%). That pattern is also true of members with Medicare coverage (12% vs. 9%). Members with higher incomes, measured by the federal poverty levels or FPLs, are more likely to be in the continuous coverage population than those with lower incomes.

When it is time to renew, members must take action unless they are automatically renewed. The Department is working with stakeholders to ensure that when renewals are due, members know how to take action and get help as needed. Members who are in the continuous coverage population with lower incomes (0-133% FPL) are more likely to have been identified due to not returning verification or

not completing the renewal process. Conversely, members with higher incomes are more likely to have been identified due to having incomes that are over the allowable limits. Members who do not meet the income requirements are likely to be disenrolled. Members who have not provided verifications will be given the opportunity to respond to requests before an eligibility determination is made.

Looking at historical churn patterns may give insight into whom will be disenrolled at the end of the PHE. The Department conducted a Medicaid churn study analyzing data from Jan. 1, 2018, through Dec. 31, 2019, the two years preceding the federal public health emergency. During that time, 43% of members maintained their eligibility, 21% disenrolled, 16% became eligible, and 20% were eligible at some point during the two years but were not continuously enrolled ("cyclers"). Low-income adults and low-income children dominated the churn because they comprise most of the population. Young adults (age 18-39) were least likely to maintain coverage, and most likely to leave or cycle off and on. Not meeting income eligibility was the primary reason adults were disenrolled from Medicaid.

5. ***[Sen. Zenzinger]*** **As people are disenrolled from Medicaid, will there be increased societal costs elsewhere, including costs for other public benefits?**

RESPONSE

The Department estimates that more than 300,000 individuals will lose Medicaid eligibility through the redetermination process after the PHE. Employers not currently covering these individuals may have increased benefits costs once those individuals fully transition to employer-sponsored coverage; individuals and families may have to afford premium contributions, deductibles and high co-pays compared to Medicaid under their new coverage options.

Colorado's approach to redetermining eligibility after the public health emergency is meant to mitigate losses in health coverage and ensure smoother transitions in health coverage for those no longer eligible for Health First Colorado or CHP+. Further, given the length of the COVID-19 PHE and improvements to Colorado's economy since the onset of the pandemic, the Department anticipates that many of those who are no longer eligible due to increases in their income may already have other coverage through their employer, and others may benefit from subsidized coverage offered through the Connect for Health Colorado marketplace.

To the extent that people lose eligibility for Medicaid due to income and do not enroll in employer sponsored coverage or coverage through Connect for Health Colorado, there may be costs to the delivery system associated with uncompensated care.

The Department has been collaborating with other state agencies, counties, local public health, providers, health plans, advocates, Connect for Health Colorado, and many other community partners in planning for the end of the PHE. Until the full renewal process is complete and other public benefit programs have resumed their normal operations after the end of the PHE, it is difficult to assess if there will be increased societal costs elsewhere or costs for other public benefits. Often, people who are enrolled in Medicaid are income eligible for other public benefits and may already be accessing or have accessed those benefits already. People who are found ineligible for Medicaid after the PHE due to

being over income levels may not qualify for other public benefits. However, because the eligibility requirements for public benefits differ significantly by program, it would be difficult to generalize.

6. ***[Rep. Bird]*** **Discuss the potential unmet need that is likely to occur for those individuals who become ineligible for Medicaid following the end of the public health emergency.**

RESPONSE

During the COVID-19 public health emergency (PHE), individuals who enroll in Health First Colorado and the Child Health Plan Plus (CHP+) remain on the program even if their circumstances change, due to the federal continuous coverage requirement. When the federal PHE ends, states will resume normal operations including evaluating eligibility for medical assistance programs.

The federal government has given states guidance on how to resume normal operations. States have up to 12 months (14 months including noticing) to re-evaluate eligibility for everyone who is enrolled. Colorado has chosen an approach that leverages the current annual renewal cycle for each member to reduce member confusion, leverage the existing processes and take the full allowable time to complete renewals. This approach has three key operational goals in mind 1) focus on member continuity of coverage so those eligible remain enrolled 2) improve the member experience with smoother transitions in coverage for those no longer eligible and 3) minimize impacts to eligibility workers and state staff.

It is difficult to assess any unmet need until the full redetermination process is complete, though we have estimated that more than 300,000 Coloradans may lose Medicaid eligibility at the end of the PHE (over the 12-14-month redetermination period). Given the length of the public health emergency and improvements in Colorado's economy since the initial onset of COVID-19 that caused job losses and loss of employer sponsored health coverage, many of those who are no longer eligible may have found employment and other health coverage through an employer sponsored plan. The Department's approach to resuming normal operations at the end of the public health emergency, including close collaboration with Connect for Health Colorado, Regional Accountable Entities, CHP+ health plans, providers and many other partners, is meant to mitigate an increase in the uninsured rate, coverage gaps and unmet health coverage needs. Individuals who are no longer eligible for Health First Colorado or CHP+ will receive information about their options on the Connect for Health Colorado health insurance marketplace. The Department is working closely with Connect for Health Colorado to ensure individuals who are over income are connected with assisters who can help them find other coverage and access to financial subsidies. Still, the HCPF structure of no premium, no deductibles and low co-pays (no co-pays except for unnecessary ER visits, if the Governor's budget is approved) is far more affordable compared to the typical employer sponsored or individual commercial coverage alternative.

7. ***[Rep. Bird]*** **If this process is likely to result in a large number of individuals losing health care coverage, what actions should the General Assembly consider taking to ensure that this process does not result in a public health crisis?**

RESPONSE

The uninsured rate in Colorado before the ACA went into effect was over 15%. The ACA, which included provisions like coverage up to age 26, Medicaid expansion, the creation of marketplace exchanges and related subsidies – combined to reduce the uninsured rate in Colorado to about 6.5%. Through the public health emergency, the uninsured rate has remained flat, at about 6.6%, largely due to Medicaid's continuous coverage provision. Our shared goal among providers, advocates, Connect for Health Colorado, the Department and other stakeholders is to maintain Colorado's uninsured rate.

The 12-month (14 months with noticing) process to review eligibility for all Health First Colorado and Child Health Plan *Plus* (CHP+) members after the end of the public health emergency will be a return to normal eligibility operations as required by federal law. The Department's approach to the eligibility reviews focuses on ensuring those who remain eligible for Health First Colorado and CHP+ stay covered, by connecting those who are no longer eligible with health coverage options and related subsidies on the Connect for Health Colorado marketplace. The Department anticipates some of those currently enrolled may already have employer sponsored coverage. According to the most recent data from the Colorado Department of Labor & Employment, Colorado's private sector has grown by 449,500 jobs, compared to declines of 358,800 in early 2020, translating to a job recovery rate of 125.3%. [2]

The Department anticipates an uptick in eligibility decision appeals from members after the end of the public health emergency and a need for additional resources to address those appeals in a timely manner, as identified initially in FY 2020-21 S-10/BA-19, Public Health Emergency End Resources. Given the constant change in end dates for the PHE, the Department will work through the regular budget process to address specific needs for these resources.

8. ***[Rep. Sirota]*** **In a normal year (when there isn't a federal public health emergency), who churns on and off of Medicaid and CHP+ and why? Are there particular populations that are more vulnerable to, or impacted by, churn? What information is the Department and other agencies and organizations gathering about the impact of allowing people to maintain eligibility for Medicaid during the federal public health emergency? How is the policy impacting health outcomes and other public benefits?**

RESPONSE

The Department conducted a Medicaid churn study analyzing data from Jan. 1, 2018, through Dec. 31, 2019, the two years preceding the federal public health emergency. During that time, 43% of members maintained their eligibility, 21% disenrolled, 16% became eligible, and 20% were eligible at some point during the two years but were not continuously enrolled ("cyclers"). Low-income adults and low-income children dominated the churn because they comprise most of the population. Young adults (ages 18-39) were least likely to maintain coverage and most likely to leave or cycle off and on. Not meeting income eligibility was the primary reason adults were disenrolled from Medicaid. A large percentage (43%) of pregnant adults cycled off and on Medicaid. The guaranteed 12 months of postpartum coverage will reduce churn in this population. Children and the elderly (65+), as a percentage of their total

[2] Colorado Department of Labor and Employment, "Colorado Employment Situation – October 2022" Press Release issued November 18, 2022 available at colmigateway.com

populations, were least likely to experience churn. Adults with disabilities had one of the lowest churn rates, with 71% maintaining coverage throughout the period, and only 12% disenrolling and not returning, the primary reasons being death or failure to pay premium/fee. The Department has waived Buy-in premiums throughout the PHE and will continue to do so throughout the unwind period. The study focused primarily on Medicaid, however, transition of children between Medicaid and CHP+ was observed.

National data suggests that while children are some of the least likely to experience churn, eliminating churn among the 0-6 populations may have the highest opportunity to improve care and decrease costs[3]. The Department's CY 2018-2019 churn study found that 12% of infants (age 0-1) and 19% of preschool children (age 2-5) lost Medicaid eligibility during that timeframe. Another 15% and 19%, respectively, cycled on and off Medicaid. The study categorized 6-year-old members with other elementary age members (age 6-11), 20% of whom lost eligibility and 18% of whom cycled on and off Medicaid during the two-year period. Some of the children who lost eligibility or cycled on and off eligibility transitioned to the Child Health Plan *Plus* program. While the study did not break out the Medicaid and CHP+ transitions by age groups, overall 25% of low-income children who lost Medicaid eligibility were enrolled in CHP+ the next month. An even greater percentage of low-income children who cycled off Medicaid, 43%, were enrolled in CHP+ the following month. Federal regulations dictate the transitions between the two programs with a higher federal match provided for CHP+ members.

Because children 0-6 are less likely to cycle on and off Medicaid and cost less than the average population, retaining these members on Medicaid rosters can prove cost-effective. For example, continuous coverage can help ensure better utilization of well-child visits and earlier diagnosis of health care conditions, preventing acute crises that result in repeated emergency room visits. Early intervention and school-based services for behavioral health conditions can provide immediate, low-cost interventions that reduce the likelihood of costlier, lifelong conditions. Continuous access to care can also decrease health disparities. Research has shown that churn results in higher administrative burden and health care costs due to the lack of access to timely or preventive care. These national studies are promising and worth exploring further. To date, the Department has not done an analysis on the potential impact of this policy in Colorado to the state budget or to the provider community.

During the PHE, the Department provided uninterrupted coverage. This reduced the administrative burden related to Medicaid churn, allowing county workers to focus on helping people with other programs and benefits (e.g., food assistance, cash assistance). The Department does not, however, have the data needed to estimate reduced administrative costs since the county workers still needed to work on many of the CBMS cases to determine eligibility for the DHS programs.

The Department has been tracking medical trends throughout the public health emergency. A few of the trends the Department has observed include reduced emergency department and transportation utilization, accelerated adoption of telemedicine, and avoidance of congregate settings in long-term care. These trends were more pronounced earlier in the pandemic when concern over contracting COVID-19 was greater. Mitigating factors, however, make it difficult to interpret outcomes and

[3] https://cohcpf-my.sharepoint.com/:w:/g/personal/saupso_hcpf_co_gov/ES4jHVrnO5hMh-N0LoK7RnsBtJaLX8vTnRhEO4lZd06Akw?e=vpXGgN

confidently state whether those trends will continue after the public health emergency. Many more people had continuous coverage than usual, which could have resulted in more timely and consistent care. It was, however, often more difficult to access care over much of the past two years. For example, due to concerns about overwhelming the health care system, many people either chose to defer or were unable to schedule elective procedures. Some parents may have delayed routine immunizations and well-child appointments to avoid being in medical offices where they may have a higher risk of being exposed to COVID-19.

9. ***[Sen. Kirkmeyer]*** **What is the Department doing to ensure that counties have the resources necessary to administer the program over the 12-month period following the end of the federal public health emergency?**

RESPONSE

The Department has taken multiple steps to ensure that counties have the necessary resources for the end of the public health emergency (PHE) and the processes and tools in place to manage the workload throughout the PHE unwinding period. The FY 2022-23 BA-6 request provided over $15.2 million in one-time funding to counties to hire eligibility technicians, customer service staff, and their resources to ensure the new staff have the necessary technology and training to manage the PHE unwinding workload. Because that one-time funding ends in June 2023, the Department will work through the regular budget process to ensure the continuity of those resources, including the most recent likely extension of the PHE into April of 2023.

In addition to the many automations implemented, as noted in the previous question, HCPF has also implemented an array of processes and tools to support counties through the PHE unwind including:

- Providing county grant funding to help offset county share for FY 2022-23 PHE funding
- Adding the Overflow Processing Center, which is state-contracted county staff that assists counties with processing cases
- Creating performance management tools, including the Medical Assistance Performance (MAP) Dashboard, to monitor progress and performance
- Educating counties through Continuous Learning Sessions on tools like the MAP Dashboards and pending data to monitor their work and performance
- Making telephonic signatures an option for redeterminations, easing the administrative burden for both members and counties

As the timing of the PHE continues to evolve, we are staying in contact with our county partners, contract resources, and constituencies to ensure we remain synchronous in our planning.

HOSPITALS

10. **P37 *[Rep. Bird]* What is the Department doing to ensure that rural and safety net hospitals can maintain sufficient staffing after the public health emergency ends?**

RESPONSE

The Department provides financial support targeting rural and safety net hospitals specifically through its supplemental payment and grant programs:

- The Hospital Transformation Program, which ties provider fee-funded hospital payments to quality-based initiatives, includes dedicated rural support funding of $12 million for each of five years for a total of $60 million for 23 critical access hospitals with the lowest patient revenues or reserves. This rural support funding can be used for organizational readiness including staffing, amongst other purposes. The Department has paid $24 million from this source to date.

- Senate Bill 22-200 created the Rural Provider Access and Affordability Stimulus Grant Program to provide $9.6 million in funding for projects to improve health care affordability and access in rural communities. This funding will be awarded beginning in July 2023 and will drive financial sustainability for rural hospitals by helping them better meet the needs of their communities and keep care local.

- Safety net and rural hospitals receive a greater return on investment through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) provider fee funded payments. In FY 2021-22 hospitals in frontier counties (fewer than 6 people per square mile) realized a 517% return on their provider fees and hospitals in other rural counties realized a 166% return on their provider fees while urban hospitals realized a 28% return on their provider fees. Denver Health, the state's largest safety net hospital, realized a 205% return on its provider fees.

In addition, the Department provides the maximum allowable Disproportionate Share Hospital (DSH) payments to safety net and critical access hospitals. With the focus on rural hospitals in the CHASE provider fee and DSH payments along with their base Medicaid payments, the vast majority of rural and critical access hospitals are reimbursed at least their cost of providing care for Medicaid members.

11. **P38 *[Rep. Bird]* Discuss what the Department is doing to limit the administrative burdens on rural and safety net hospitals to receive reimbursements.**

RESPONSE

To reduce administrative burden for hospitals receiving supplemental Medicaid reimbursement, such as those funded through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) hospital provider fee, the Department uses existing data sources like the hospitals' Medicare Cost Reports whenever possible, aligns with other reporting requirements, requests only information necessary to meet federal requirements, and engages in stakeholder input and feedback when creating data request forms and processes.

R9 BIRTHING EQUITY & DOULA SERVICES

12. ***[Rep. Sirota]*** **Describe the stakeholder process used prior to submitting R9 Birthing equity. Why was this solution selected for improving birth equity rather than other strategies, like direct entry midwives?**

RESPONSE

The Department submitted a Health Equity Plan in June of 2022. This included four priorities: COVID-19 vaccination rates, maternity, behavioral health and preventive care. The doula benefit focuses on reducing disparities, improving health outcomes and reducing costs for all Medicaid members with an emphasis on Black, Indigenous, People of Color (BIPOC) pregnant people.

The Department initiated its stakeholder work through monthly meetings with the Maternity Advisory Committee (MAC)—a member-led group primarily composed of BIPOC members who have given birth as Medicaid members. Early and emphatic discussion illustrated a need to provide more community-based support to our members. Doulas fit this need well since commonly reported themes include: how particularly challenging the postpartum period can be without someone providing emotional, physical and educational support—all within a doula's scope; and, how important it is to have providers who look like you and/or share lived experiences with you—a strong marker of community-based doula training programs that would be made possible with the training funds included in the request of $100,000.

The budget preparation and review process are confidential until the Governor officially submits the budget to the Legislature on Nov. 1. As a result, the Department began the next phase of stakeholder work with other state and national partners (including New Jersey, Oregon, Nevada and California, as well as the National Academy for State Health Policy). In those discussions, we learned that stakeholder work is critical to the success of a doula benefit; therefore, the Department requested funding to seek community input on the design of the benefit. R-09 includes a request for $150,000 for community engagement work including contracting with one or more community-based organizations that are able to center community voices and take an equitable approach to engagement. While the Department was poised to begin stakeholder engagement after the Governor's Budget was made public on Nov. 1, stakeholders shared that they would prefer the Department wait until January 2023. This will provide stakeholders additional time to appropriately prepare the birthworker[4] community to be empowered,

[4] While doula is the more well-known term, it comes from the Greek word for slave, so there is growing interest in the stakeholder community to move towards the term "birthworker." When discussing engaging the community,

informed and well-resourced for upcoming policy discussions. The next phase of Colorado-based stakeholder engagement will begin in earnest in 2023 with the Department working closely with community partners to create crucial and robust opportunities for participation from doulas, members, hospitals, doctors, midwives, licensed practitioners and other key informants—with a focus on equitable inclusion of BIPOC members and birthworkers.

Finally, the Department's choice to pursue reimbursement of doulas through the budget request process does not preclude the Department from simultaneously considering other strategies to improve maternal and perinatal health for Medicaid members, including reimbursement of direct entry midwives (DEMs). The Department recognizes that clinical and nonclinical community services together, provided by midwives and doulas, improve health care access and outcomes and reduce rates of maternal illness and death. For example, a recent analysis of Medicaid births showed individuals who had both a midwife and a doula had the highest rates of postpartum visits[5].

The Department is committed to having a transparent conversation with the community about its midwifery strategy. A meeting has already been scheduled for January 2023, when the Department will meet with midwifery advocates and leadership from the Department of Regulatory Agencies (DORA), which manages the current registration of DEMs. The initial goal is to determine how the state could potentially pursue the addition of this provider through regulation or statutory changes across HCPF and DORA and increase all parties' understanding of the historical barriers to Medicaid reimbursement for DEMs with the end goal of continuing improvements to birth equity across Colorado.

13. ***[Rep. Sirota]*** **Please speak to the evidence supporting the efficacy of doula services.**

RESPONSE

There is a robust body of literature that shows doulas are an evidence-based intervention for anyone who is pregnant, with especially inspiring implications for reducing disparities. Research[6] supports the use of doulas to:

- Reduce Cesarean-section rates and associated costs
- Increase breastfeeding rates
- Reduce preterm birth rates
- Reduce low birth weight rates
- Reduce rate of birth complications
- Improve adoption of infant safety precautions (e.g., car seat usage and back sleeping)
- Improve patient satisfaction

---

the Department will use birthworker, and the Department will solicit feedback on what terminology should be codified in future policy making to describe this workforce.

[5] Elevance Health Public Policy Institute (2022). Addressing Maternal Health Disparities: Doula Access in Medicaid. Retrieved Nov. 23, 2022, from https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/54/EH_Doula_R4.pdf

[6] See Appendix A for a list of references cited to support all research summarized in P-12

- Reduce rates of perinatal mood and anxiety disorders
- Reduce ER and hospital visits in the perinatal period
- Improve APGAR Scores (a test of five measures to evaluate an infant's health at birth)
- Shorten labor duration

For increasing birth equity, research shows subpopulations who have been disproportionately impacted by gaps in the health care system can realize enhanced improvements. Some highlights of this research include:

For pregnant people with Opioid Use Disorders, doulas can create a positive experience that improves parenting behaviors, resulting in more family reunifications, reductions in child maltreatment, health advocacy, resource assistance, and recovery support (McConnell et al., 2022; Parick and Gannon, 2021)

Pregnant people who had doula-supported births had near-universal breastfeeding initiation (97.9%), compared with 80.8% of the general Medicaid population. Among Black pregnant people, 92.7% of those with doula support initiated breastfeeding, compared with 70.3% of the general Medicaid population [Kozhimannil et al., 2013(a)].

In the 2018 Listening to Mothers in California survey, 1,977 pregnant people were interviewed, and doula support was associated with highly respectful care, particularly for low-income and certain racial/ethnic groups in California. By race/ethnicity, the association was largest for non-Hispanic Black pregnant people and Asian/Pacific Islander pregnant people (Mallick et al., 2022).

The Everyday Miracles program in Minneapolis targeting pregnant people with Medicaid showed lower Cesarean-section and preterm birth rates than the national Medicaid population [Kozhimannil et al., 2013(b)].

Elevance Health, a national insurer working with Medicaid agencies as a managed care entity (including in two regions in Colorado), did an analysis of three states in which Elevance-affiliated Medicaid plans reimburse for doulas. The analysis compared Medicaid members in states receiving doula services to those who did not. While the racial composition for the doula group had a higher rate of black pregnant people, the doula group still had a lower rate of preterm and low birth weight deliveries. This suggests that doulas have a protective factor against racial inequity, even among Medicaid members (Elevance Public Health Policy Institute, 2022). This study additionally showed that Medicaid members with doulas had fewer inpatient hospital admissions during pregnancy, were more likely to attend their postpartum visits, had lower rates of postpartum depression and anxiety, and have lower overall costs than Medicaid members without doulas.

While not an exhaustive list of references or research points, this research illustrates the importance of a state investment in doulas. With nine states already reimbursing doulas and another seven states with Medicaid reimbursement implementations in progress, Colorado will join a cadre of emerging leaders in birth equity by supporting this evidence-based intervention.

14. ***[Rep. Sirota]*** **Why does the Department believe it will have more success than other states in implementing a new doula benefit and attracting providers?**

RESPONSE

While there has been slow uptake in early adopter states, the evidence about the positive impact of doulas on health equity support the Department's request to add doulas as a Medicaid benefit in order to create access for Health First Colorado members and ensure doulas are not only available to wealthier pregnant people who can pay out of pocket. Additionally, despite some early challenges, no state has abandoned their doula programs. Instead, they, like Colorado, recognize the incredible value of a doula and have thoughtfully revisited and revised their stakeholder work, community outreach and subsidized trainings to create functioning doula benefits.

The Department has been thoughtful in its proposed design of the new doula benefit, working with those other states and national partners to glean best practices and lessons learned (e.g., New Jersey, Oregon, Nevada and California as well as the National Academy for State Health Policy). The following chart depicts various hurdles we've heard from other states and our proposed solution to help Colorado be successful in this endeavor:

Issue	**Background**	**CO Solution**
Low reimbursement rates	Several states did not reach their doula enrollment goals because of doulas reporting that the reimbursement rates were insufficient.	Colorado proposes a reimbursement rate of $1,500/per pregnancy. This matches the highest Medicaid reimbursements across the country. Oregon formerly provided a lower rate of $350 and only covered 204 births in four years. As a result, Oregon has recently increased its rate to $1,500. This is consistent with Rhode Island's program, which plans to provide a rate of $1,500 when the service is implemented in July.
Stakeholder engagement	Some states struggled with getting the right doulas and members to the table to reflect the diversity of doulas and their clientele. Some doulas felt left out of the conversation and did not feel that the benefit design reflected their wants/needs as providers, especially those in the BIPOC community. Full community support is essential to ensuring the benefit is reflective of the needs of the doula community.	The Department built the request with many details to be determined with stakeholder feedback, which is why the Department requests $150,000 in this request to hire a vendor to support a community–based, equity driven stakeholder process. Input from doulas, obstetric providers, members and advocates will help inform critical model components including: 1) how many visits should be covered and distributed across the prenatal and postpartum period; 2) how to spend the $100,000 in training funds to build community capacity; 3) appropriate trainings and certifications; and 4) how to increase member knowledge.

Allowable trainings and certifications for doulas	Some states are not inclusive of different trainings or licenses that reflect the different routes to becoming a doula. For example, while there is a national certifying organization, DONA International, community-based organizations can deliver high quality doula trainings that are responsive to unique community needs.	The Department will use the stakeholder engagement process and funds to: 1) build a list of approved trainings that maximizes community involvement and equity; 2) design a process to attest to the rigor of new, emerging trainings that may not be on an approved list; and 3) iteratively update the approved trainings list.
Doula participation to reflect community served	Some states have encountered issues with recruiting BIPOC and low-income doulas into the workforce because of the cost of training/enrollment. States found that the training required to become a doula was financially prohibitive.	To encourage participation, the Department requests $100,000 in training funds to subsidize doula training programs. This will increase capacity and avoid the issues experienced by Oregon and Minnesota, particularly in underserved communities and communities of color. The Department is also working with its member-led Maternity Advisory Committee to identify and support appropriate pathways to becoming a doula, as members on that workgroup have pursued their certification.
Doula challenges with enrolling and billing Medicaid	Since doulas historically were not reimbursed by payers, states report that doulas need more education and support to become integrated into Medicaid billing systems.	The training dollars will also be used to train and provide ongoing support for doulas to enroll in and bill Medicaid. The distribution and design of dollars between the training funds (new doulas v. enrolling and billing support) will be determined with stakeholder engagement.
Member knowledge	States reported that many members did not know how a doula could support them or where to find them in their communities.	The Department requested an additional $30,000 annually for member outreach. The "Listening to Mother's" survey found that 36% of Medicaid or CHP+ members had never heard of doulas, but with help from stakeholders and our RAEs, the funds here can be leveraged to educate our members.

Finally, while the Department focused on lessons learned from other states to build its model, the Department also heard early successes. This includes how some later adopter states are already reporting successes from designing models based off lessons learned from the early adopters. For example, as of September 2022, New York state's doula pilot program had served 830 people, and a

survey sent to pilot participants found 97% of respondents said having a doula improved or somewhat improved their childbirth experience. In New Jersey, the community doula benefit began in January 2021. As of August 2022, 56 community doulas were enrolled, four doula agencies had formed and enrolled, 57 Medicaid members had received community doula services, and 41 babies had been born with the support of a community doula.

15. ***[Sen. Kirkmeyer]*** **How does the proposed doula benefit interact with nurse family partnership programs? Is it duplicative?**

RESPONSE:

Colorado has a strong history of providing a broad array of home visitation services that complement each other. The Nurse Home Visitor Program (also known as Nurse Family Partnership, or NFP) provides valuable nurse services to first time parents. The doula benefit complements the Nurse Home Visitor Program while improving health outcomes and equity for many of our members who: 1) may not be eligible for NFP; 2) would like a support person present at their birth; and 3) may only want or be able to commit to a shorter intervention model. The key differences between Nurse Family Partnership (NFP) and the doula benefit can be delineated as follows:

	NFP	Doula Benefit
Population Served	First-time parent on Medicaid	All pregnant or postpartum Medicaid members
Care Provided	Prenatal through 2 years postpartum nurse visits at the home (frequency varies according to period of pregnancy or child development). Does not include presence at birth to support.	Prenatal, birth support, and postpartum support, usually through the first several weeks. *Note: Colorado model will include stakeholder work to determine how far into postpartum visits may go.* Doula is present at and supports during birth.
Providers of Care	Registered Nurses	Support persons trained specifically in perinatal and postnatal care

As demonstrated in the chart, NFP and the doula benefit would serve slightly different populations, with different models of care and different providers. Because of these differences, the addition of a doula benefit is not projected to undermine the sustainability or duplicate the efforts of other established home visiting models—including NFP.

Finally, while NFP serves as many members as possible, there are limits to its capacity. Workforce shortages have created sites that cannot meet patient demand. As a result, some sites have waiting lists and others implemented additional criteria to stratify need. A doula benefit will be aligned with the larger system to ensure members are matched with the program that best serves their needs and allows each program to focus on the sub-populations that can most benefit from the program's unique model.

R6 VALUE BASED PAYMENTS & R8 COST & QUALITY INDICATORS

16. ***[Sen. Zenzinger and Sen. Bridges]*** **Provide background information related to R6, including why the Department chose to move in this direction, and whether this initiative is achieving the intended objectives.**

RESPONSE

The General Assembly has authorized the Department to establish alternative payment and delivery models within the Medicaid program. HB 17-1353, Implement Medicaid Delivery & Payment initiatives, defined the Accountable Care Collaborative (ACC) in statute and authorized the Department to implement performance-based payments for Medicaid providers. As a result, the Department has enrolled nearly all members in a regional organization that helps connect members to the care they need. The Department is also developing new payment methodologies that move away from traditional fee-for-service payments and towards payment structures that provide payments based on the provider's performance.

CMS is encouraging state Medicaid programs to have 50% of all payments through value-based payments by 2025. As well, the industry – including HCPF – is moving away from paying for volume and moving towards paying providers for value. Value based payments are a way for the Department to reward providers for better patient outcomes, closing disparities, and improving affordability. The Department is committed to achieving this goal and supporting members and providers with value-based payments.

The Department is proposing to increase reimbursement to primary care medical providers (PCMPs) because a strong foundation of primary care is essential to increasing quality and affordability in Medicaid. Even before the COVID-19 pandemic the state of primary care in the United States was in decline. According to the National Academy of Sciences, visits to primary care doctors nationally were declining and the workforce development pipeline was shrinking as doctors elected to specialize in more lucrative health care fields. The Department's FY 2023-24 R-6, Value Based Payments, was targeted to address these issues and provide tools to improve primary care. The initiatives in R-6 are relatively new in the U.S. health care system and Colorado will be a leader in primary care support nationwide. Because these PCMPs will have inexperience with these initiatives they will need more support in managing the data tools associated with the APM to achieve the transformative potential and be effective in the long term. APM 2 expansion is a Governor's Office FY 2022-23 Wildly Important Goal (WIG).[7] This WIG supports the expansion payment reform efforts in Colorado to meet CMS's goal of 50% of all Medicaid payments made through value-based payment arrangements by 2025.

The Department requests funding to establish a peer-to-peer based learning network at the RAE level designed to coach, mentor and assist clinicians. This support includes organizing enrolled practices into a large community of practice so that best ideas and innovations from exemplary practices are brought to the surface and spread across the networks. By helping PCMPs with practice transformation and support, the Department can increase well-child visits and reduce avoidable spending related to chronic

[7] https://dashboard.colorado.gov/governors-dashboard/health-care-policy-financing

conditions by reducing avoidable admissions and improving quality. Providers who join the partial capitation voluntarily will have the ability to invest in nonbillable services and nontraditional staff which have been shown to improve the care received by people with chronic conditions.

APM 2 is in its first year of operation. Robust program evaluation, which requires sufficient program data, will be conducted as a priority of program operation after the first year's performance data is collected within the limitations of claims runout. However, based on our ongoing stakeholder engagement, initial feedback from existing participants is favorable and demonstrates alignment with key goals of the APM 2 program. This includes stability in provider revenues, as well as flexibility in payments not tied directly to utilization.

17. ***[Sen. Bridges]*** **What will be expected of providers to meet the quality indicators to secure the incentives?**

RESPONSE

Primary care medical providers (PCMPs) are expected to provide high quality care to earn incentives, as demonstrated through the quality model. The Department collects administrative data from PCMPs and other providers to track this information, and PCMPs also submit additional data to support this process. This existing quality model will be utilized and simplified by aligning the measure set with Centers for Medicare and Medicaid Services Adult and Child Core Measure Sets, which also align with measures in the Medicaid Health Equity Plan as well as Multi-Payer Collaborative. The Department performs an annual stakeholder engagement process to update the quality model.

The Department plans to give the full rate increase to PCMPs who elect to earn at least 25% of their revenue as a partial capitation payment in FY 2023-24. This percentage would increase over time to the requirement that 50% of a PCMP's revenue is earned as a partial capitation payment. PCMPs who elect to earn lower than the targeted percentage of their revenue as a partial capitation payment will still be eligible for a reduced rate increase proportional to the amount of partial capitation they select. To make it easier for PCMPs to get the rate increase, the Department plans to automatically enroll all PCMPs into the APM 2 program. PCMPs who do not wish to participate and receive the rate increase can notify their Regional Accountable Entity (RAE) and be disenrolled from the program before the automatic enrollment occurs or any time they choose not to participate.

PCMPs will continue critical work through process improvement resulting in improved chronic condition management and reduced avoidable hospitalizations with the additional reimbursement provided by R-6. Based on feedback from PCMPs, the Department is also requesting funds to establish peer-to-peer learning collaboratives for participating PCMPs. These collaboratives will be established within the RAEs to allow PCMPs to share common experiences and provide peer-to-peer assistance as they transition to the APM 2 program. These voluntary initiatives will provide support to PCMPs as they manage quality indicators and improve health outcomes.

18. ***[Sen. Bridges and Sen. Zenzinger]*** **How is the Department handling the attribution issues since implementing value based care? Will the Alternative Payment Methodology proposed in R6 succeed if attribution isn't accurate?**

RESPONSE

The Alternative Payment Methodology (APM) proposed in R-6 requires accurate attribution to be successful. The Department handles attribution issues as they arise and when effective solutions become possible. The Department has taken a variety of actions to improve the functionality of the attribution methodology since implementation of the Accountable Care Collaborative (ACC) Phase II and the rollout of the first APM. These actions include policy changes and system updates with our partners to streamline attribution, mitigate provider confusion, and enhance member engagement. These changes include:

- Completed system update to enhance geographic attribution methodology with geo-mapping technology to connect member to the nearest appropriate provider;
- Enhanced system functionality to allow Regional Accountable Entities (RAEs) to customize primary care medical provider (PCMP) data, indicating which types of members (ages, genders) they accept for enrollment;
- Removed an obsolete method for assigning members on the same case to the same PCMP;
- Updated the reattribution methodology to reassign members under 2 years old more frequently (monthly) to expedite connection to medical homes for newborns;
- Updated the reattribution methodology to better align with APM 2 payment methodology by identifying geographically attributed members who subsequently developed a relationship with their assigned provider; and
- Modified ACC enrollment/disenrollment rules to ensure members are not inappropriately assigned to PCMPs.

It is important to distinguish issues with accurate attribution from “leakage,” or nonfidelity, of a member to their attributed PCMP. Leakage happens in two directions: 1) leakage away from a PCMP, and 2) leakage towards a PCMP. Leakage will always occur in an open system that does not lock members in to receiving care from specific providers. The purpose of this type of system is to allow members choice in where they receive their health care and is required by federal regulations except in certain circumstances, such as inappropriate utilization patterns like prescriber shopping.

Leakage towards a PCMP is when a provider treats a member that is not attributed to them. The APM proposed in R-6 accounts for this leakage by supplementing the provider’s APM payment with traditional fee-for-service revenue. If a member’s utilization pattern or individual choice results in a reattribution of that patient to the PCMP, they would then be included in the APM 2 payment for that PCMP. This allows the APM proposed in R-6 to accurately pay for attributed members, while accounting for any additional utilization by nonattributed members.

Conversely, leakage away from a PCMP is when a member receives care from a PCMP who is not their attributed PCMP. This type of leakage makes it difficult for a provider to guide a member's health care and manage progress towards specific health outcomes. To address this type of leakage in the APM, the Department has excluded members that are geographically attributed to a PCMP from the APM payment and quality metric calculations. The Department also updated the attribution methodology to look for members who were originally geographically attributed to a certain PCMP, but subsequently developed a claims history with a different PCMP, to change their attribution to that PCMP. This enables the PCMP to then get the APM payment for this member.

19. ***[Sen. Kirkmeyer]*** **For FY 2022-23's R8 County administration oversight, please provide more information about last year's request and the ongoing impacts to the Department's appropriations.**

RESPONSE

The FY 2022-23 R-8 County Administration, Oversight and Accountability budget request had several components to it. Below is a description and update for the components that the JBC approved.

County Administration Funding Shortfall
The Department was approved $12,398,333 total funds, including $1,551,224 General Fund, in FY 2022-23 and ongoing to increase the standard county administration allocation that covers county costs for Medical Assistance administration. The Department requested this funding to help reduce the shortfall in state funding that the counties cover at the end of each fiscal year. Since FY 2015-16, counties collectively have had to invest an average of $4.5 million annually of local funds to cover the state funding shortfall. Based on county expenditures in FY 2022-23 thus far, the Department anticipates the state shortfall to be less than the $4.5 million historical average, with a smaller state shortfall for the current fiscal year.

County Incentive Program Increase
The Department was appropriated $2,479,667 total funds, all of which is General Fund, and 1.0 FTE to increase the county incentive program, provide local share offset to counties meeting their benchmarks, and provide increased oversight. This was appropriated in FY 2022-23 and ongoing. The County Incentives Program is critical in helping counties minimize the actual local share paid if counties meet and/or exceed benchmarks and deliverables. The Department reviews whether counties have met their performance benchmarks at the end of each fiscal year and provides performance incentive payments at that time to help offset local share paid out. The Department is in the process of hiring the approved position.

Management Evaluation Reviews
The Department was appropriated 1.0 FTE to perform Management Evaluation reviews of all counties and eligibility sites to reduce the amount of time taken to conduct a review from a three-year cycle to closer to a two-year cycle. The ME Review Program conducts a 360-degree review of the county department or eligibility site's operations to ensure compliance with Medical Assistance Program requirements. The Department is in the process of hiring this position, which will be tasked with addressing ME Review and performance findings once reviews occur. The Department anticipates it may

be several review cycles before the two-year cycle goal is met; current reviews are taking longer than expected due to the high number of findings across sites thus far.

Quality Assurance
The Department was appropriated 1.0 FTE to increase the amount of Quality Assurance reviews conducted monthly for all counties and eligibility sites. The Eligibility Quality Assurance (EQA) Program produces an error rate for all sites, which allows the Department to identify low accuracy rates and target improvements to those specific sites. The EQA Program acts as a leading indicator that helps the Department determine error trends and rates prior to federal or external reviews that result in audit findings. This position has been hired.

Audits and Findings
The Department was appropriated 2.0 FTE to support the Department's Eligibility Site Accountability and Oversight Program. These positions provide support to the Eligibility Policy and Systems teams as the Department addresses eligibility issues discovered through the Oversight and Accountability Program. Work by these positions includes providing policy guidance, issuing memos, monitoring eligibility systems functionality, and leading CBMS and PEAK system enhancements and modifications. One position has been filled and the Department is in the process of hiring the second position.

Caseload Reduction
The Department's request included projected savings due to the additional oversight and monitoring resources, which will help counties better identify erroneous enrollment into the program and prevent avoidable costs by assuring only those truly eligible are enrolled in the Medical Assistance Program. The Department's appropriations include a reduction of $16,453,273 total funds, including $3,818,331 General Fund in FY 2022-23 and a reduction of $32,906,546 total funds, including $7,636,662 General Fund in FY 2023-24 and ongoing. The Department assumed in the request that the public health emergency (PHE) and the continuous coverage requirement would end in FY 2021-22. The PHE has since been extended through January 2023, so the Department has not been able to realize anticipated savings. The Department will update the projected savings as needed to reflect the shift in timing through its forecasts for Medicaid and CHP+ expenditure.

PROVIDER RATES, PARTICIPATION & MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE

20. ***[Sen. Zenzinger]*** **Why is the Department choosing between across-the-board rate increases and targeted increases?**

RESPONSE

The Department prioritized both targeted and across-the-board rate increases to address the critical needs currently facing the most vulnerable Medicaid providers while keeping within the constraints of the limited funding available in the state's budget.

- Over half of the funding (59%) requested in R-7, Provider Rate Adjustments, is for increases to the nursing home and home and community-based service providers that serve older adults and

people with disabilities, which are disproportionately facing solvency issues and workforce challenges such that they are at risk of not having adequate staffing to provide necessary care. The proposed increase for nursing facilities is higher for those nursing facilities with the highest Medicaid patient mix and utilization, which are more likely to be facing financial hardship. The Department is also requesting targeted increases for home and community-based services to support the financial stability of direct care worker agencies and workers and to maintain an adequate provider network to support the needs of a growing population. Additionally, further increases are requested for group home settings and transportation services for people with intellectual and developmental disabilities, as the Department's analysis shows significant potential for access to care issues without higher levels of investment.

- The Department prioritized rebalancing rates in alignment with the 2022 Medicaid Provider Rate Review Recommendation Report, which made up 22% of the requested funding in R-7. Rebalancing rates promotes more equitable rates across services with intentional increases for the lowest rates on the fee schedule while addressing rates that are above Medicare or other state Medicaid programs. This is a more targeted approach to services that need it most, rather than the blunt approach of an across-the-board increase. It would cost an additional $26.5 million total funds, including $8.0 million General Fund, to increase the rates that were identified as being well below the benchmark rates without requesting corresponding reductions to those rates that were identified as currently above the benchmark.
- The Department requested an incentive payment for rural hospitals to leverage the advances of the Office of eHealth Innovation's (OeHI) rural connectivity program. This proposal makes up 2% of the requested funding in R-7 and is necessary to ensure rural providers can remain connected to the Health Information Exchange (HIE), which is critical to improving quality, equity and affordability, and for keeping pace with health care delivery in rural and frontier communities. Without these investments, health disparities in rural and frontier communities will continue to grow.
- The Department prioritized the remaining funding in R-7 (17%) for a 0.5% across-the-board rate increase and to eliminate most member co-pays. Both initiatives will result in an increase in funding to providers. The elimination of co-pays (with the exception of co-pays charged for inappropriate emergency room use, which is at the request of front range and rural hospitals) is both a means of addressing health disparities for low-income Coloradans **and** a provider rate increase, since many of the co-pays cannot be collected from low-income Coloradans. This indirect provider rate increase is projected to increase payments to providers by $8.7 million total funds across the board, impacting pharmacies, physicians, rural hospitals, rural clinics and more. Further, the elimination of co-pays reduces provider administration expenses, creating further financial value for providers.
- In addition to the increases requested through R-7, the Department requested to increase rates for primary care medical providers who are participating in the Alternative Payment Methodology 2 program up to Medicare rates, which would be a 16% rate increase.

21. ***[Rep. Bird]*** **If the General Assembly were to raise the across-the-board rate increase for HCPF above the proposed 0.5 percent, what would be the impact on the number of providers participating in Medicaid? Would there be savings related to avoided higher intensity services?**

RESPONSE

Any impact on the number of providers participating in Medicaid would depend on the size of the rate increase. The General Assembly has appropriated significant targeted increases to specific providers in the past, which have generally been in response to recognized rate shortfalls. The Department has not observed a direct link between prior rate increases and changes in provider participation in Medicaid. Nevertheless, increasing Medicaid rates to more closely match Medicare rates is likely to encourage provider participation and enhance access to care. Historical across-the-board rate increases are shown below.

- FY 2019-20: 1.0% increase
- FY 2020-21: 1.0% decrease
- FY 2021-22: 2.5% increase
- FY 2022-23: 2.0% increase
- FY 2023-24: 0.5% increase (requested)

The increase in the size of the Medicaid population (now representing 1 in 4 Coloradans) also makes provider participation in the Medicaid program more attractive. Through the public health emergency, Medicaid has been able to grow its provider participation as providers desire to continue to serve the 460,000 Coloradans who moved onto Medicaid, largely from commercial insurance due to the COVID-19-induced economic downturn and the related loss of employer-sponsored coverage.

As a result, the Department is more focused on targeted rate increases, increases to primary care and leveraging all avenues to provide appropriate care in that setting, while implementing thoughtful win-win strategies like the elimination of co-pays to create indirect across the board increases for providers.

It is also unclear if there would be savings related to avoided higher intensity services, or on what timeframe savings would occur. Further, the ability to avoid higher intensity services would vary significantly based on the types of services where the General Assembly appropriated funding for additional rate increases. For example, some higher intensity services are the result of a person being unable to receive appropriate care in a primary care setting; if appropriated rate increases increased the number and availability of primary care doctors, some higher intensity services may be avoided – which is another reason why the primary care increase requested is important. Concurrent improvements in preventive care, which is also provided in the primary care setting, is also a focused objective of the Department. Prevention and early identification of illness and disease progression is one of the most effective ways to reduce the need for higher intensity services.

Similarly, rate increases for certain home and community-based services (HCBS) will help address workforce challenges, allowing more members to receive services or increase the number of services

that a person receives. This, in turn, may postpone or prevent the need for a person to move into a higher-cost, higher intensity nursing facility; at the same time, some members and their families may want nursing facility services regardless of the availability of HCBS. The extent to which savings may occur – in primary care, HCBS, or other service areas - would depend on the size of the rate increase and whether that rate increase is large enough to induce more providers to provide services to Medicaid members.

22. ***[Rep. Bird]*** **The Department notes that there are a number of factors that affect providers' willingness to participate in the Medicaid program. However, it is also possible that if reimbursement rates are adequate, many of these other factors would not be as significant. Please discuss this dynamic.**

RESPONSE

Yes, the level of Medicaid reimbursements directly impacts provider willingness to see Medicaid members, as does Medicaid reimbursement compared to the respective average commercial reimbursement.

The historical rate setting practice of the Department has been to give across the board rate increases and larger targeted increases for rates that are identified as significantly lower than benchmark rates, providers most greatly impacted by the workforce crisis, and access to care issues. The number of enrolled providers and services rendered by providers have been steadily increasing, with more than 60,000 individual providers in Colorado now enrolled in Medicaid.

Participation varies by specialty area. The Department is studying the percent of enrolled providers who are not actually seeing Medicaid patients, their specialty and who they are owned by (i.e.: major hospital systems) to determine solutions to address this issue.

23. ***[Sen. Bridges]*** **Is the Department concerned about losing providers based on reimbursement rates?**

RESPONSE

The Department recognizes that the Medicaid rates across provider group have historically been lower in most cases compared to Medicare and commercial insurance plans. A critical part of the annual Medicaid rate review process is to evaluate rates compared to other benchmarks to identify the rates that are the lowest, which could be creating barriers for provider participation and ultimately leading to low access to care. The Department is requesting to increase rates identified during this year's process that are significantly below the benchmarks. This is a more targeted approach to services that need it most rather than the blunt approach of an across-the-board increase. The Department will continue to utilize the rate review process to help maintain provider participation in the Medicaid program. The Department, in collaboration with the JBC and in response to broad provider support, is reducing the amount of time between MPRRAC targeted increase opportunities for each provider specialty type;

MPRRAC analysis frequency will change from every five years to every three years going forward, improving the ability of the JBC to increase targeted provider reimbursements.

The Department has specific concerns about the financial stability of providers that serve older adults and people with disabilities, which are disproportionately facing solvency challenges, workforce challenges, and related staffing sufficient to provide necessary care. To address these concerns, the Department is requesting targeted rate increases for nursing facilities and home and community-based waiver services. The increase for nursing facilities will be higher for those facilities with the highest Medicaid utilization, which are more likely to be facing financial hardship. The increase for home and community-based services will support the financial stability of direct care workers and help maintain an adequate provider network.

The elimination of co-pays is an indirect means of providing an across-the-board increase to almost all Medicaid providers – pharmacies, physicians, rural clinics and more – while also reducing their administrative expenses in serving Medicaid patients. If the provider chooses not to invest in the administrative expense to collect or "chase down" the member co-pay or cannot collect the co-pay from the member, the provider's total reimbursement is reduced by that co-pay amount. The value of this co-pay elimination to providers will vary, but some examples are below:

- Primary care visit for an established patient (procedure code 99211) has a reimbursement rate of about $18.74. Eliminating the $2.00 co-pay would increase reimbursement by 10.7% for those visits for which the co-pay is not collected.
- Radiology exam for the foot (procedure code 73620) has a reimbursement rate of $9.12. Eliminating the $1 co-pay would increase reimbursement by about 11.0% for those visits for which the co-pay is not collected.

24. *[Sen. Zenzinger]* Over the last few years the Department has rebalanced the rates for specific codes to be closer to Medicare for many providers. How did we end up with so many rates above Medicare? Were the rates for some codes above Medicare because Medicare does not meet cost? How have the rate rebalances impacted the providers choosing to participate in Medicaid and client access to care?

RESPONSE

There are several reasons that Medicaid rates may end up higher than Medicare rates. For example:

- Medicare may lower rates to recognize more efficient provider processes.
- Medicare rates do not change but an across-the-board rate change raises Colorado Medicaid rates.
- The Department requests to rebalance rates to between 80% and 100% of Medicare rates but only the increase to 80% (not the decrease to 100%) of Medicare rates is approved by the General Assembly. This is often because the reductions are not received well by those impacted providers, especially in times of increasing inflation.

There is no automatic mechanism to adjust Colorado Medicaid rates to Medicare rates. The process is through MPRRAC, and we are modernizing that process from a review of all rates every five years to a review every three years to meet the demands of providers, the JBC and our elected officials.

Overall, provider participation in Medicaid has been increasing; the Department is not aware of any instances where the rate rebalancing approved by the General Assembly has led to decreases in provider participation or adversely affected access to care.

25. ***[Sen. Zenzinger]*** **The JBC has heard concerns that Medicaid home care and durable medical equipment rates are not adequate, leading to cases when providers cannot care for Medicaid patients. Please discuss the adequacy of these two rates.**

RESPONSE

Based on the Medicaid Provider Rate Review analysis in 2020, private duty nursing services reimbursements were found to pay at an average of 98.15% of their state benchmarks and were determined to be sufficient to allow for member access and provider retention. Long-Term Home Health Services were also reviewed during the 2020 report and were found to have paid at an average of 101.72% of their state benchmarks and were determined to be sufficient for member access and provider retention. More information can be found in the 2020 Medicaid Provider Rate Review Analysis Report.

Based on the Medicaid Provider Rate Review analysis in 2021, home care services (personal care and homemaker services) provided on Colorado's Home and Community Based Service (HCBS) waivers were found to pay between 84-129% of their state benchmarks and were determined sufficient. More information can be found in the 2021 Medicaid Provider Rate Review Analysis Report as well as Appendix C. The Department has invested a total of $445,011,108 in budget changes, including $424,203,977 in rate increases and $20,807,131 in other policy changes, from FY 2018-19 through FY 2022-23 for HCBS waiver services through the American Rescue Plan Act and investments made through the Joint Budget Committee. In FY 2023-24, the Department is requesting $81,704,890 in new funding for many HCBS waiver services.

In the 2019 Medicaid Rate Review, it was determined durable medical equipment rates not subject to the upper payment limit were reimbursed at 104% on average of their Medicare benchmarks. Additionally, durable medical equipment rates below 80% of their Medicare benchmarks were increased to 80% of Medicare as of July 1, 2022. Durable medical equipment rates subject to the upper payment limit are required by federal law to pay no more than 100% of their Medicare benchmark.

26. ***[Sen. Zenzinger]*** **Please provide an update on the Medicaid Provider Rate Review Advisory Committee (MPRRAC) process and the status of the Department's implementation of recent legislative changes in S.B. 22-236.**

RESPONSE

At the MPRRAC meeting on June 17, 2022, the Department initiated implementation by informing the current MPRRAC members about SB 22-236 and upcoming changes to the Advisory Committee's membership and review cycle. This information was reiterated at the September and November MPRRAC meetings. The first part of SB 22-236 implementation reduces the membership of the MPRRAC from 24 members to seven and became effective on Dec. 1, 2022. The Department provided recommendations for potential members to the appropriate appointing bodies as required in the bill; appointments must be made by Jan. 1, 2023.

In July 2023, the five-year rate review cycle will be replaced with a three-year cycle, with the first report due November 2023. By September 2023, the Department is required to establish a schedule for the three-year cycle. Department staff are working to determine which rates to review and what analysis is feasible. The Department's FY 2023-24 R-11, Compliance, includes a request for 3.0 FTE to support the additional workload due to the accelerated review cycle. These FTE were identified in the fiscal note for SB 22-236 as necessary to review provider rates within the expedited time frame.

27. ***[Sen. Kirkmeyer]*** **Provide a list of providers that will get only a 0.5% rate increase, vs those getting a targeted rate. Department wide, not just in OCL.**

RESPONSE

Services Receiving a Targeted Rate Adjustment

- Physician Services
    - Cardiology
    - Cognitive Capabilities Assessment
    - Gastroenterology
    - Ear, Nose and Throat
    - Health Education
    - Ophthalmology
    - Primary Care/Evaluation and Management
    - Radiology
    - Respiratory
    - Vaccines and Immunizations
    - Vascular
    - Women's Health and Family Planning
    - Other Physician Services
- Dialysis and Nephrology
    - Facility-Based Payments
    - Professional Procedure Codes (Non-Facility)
- Laboratory and Pathology
- Eyeglasses and Vision
- Injections and Misc. J-Codes

- Rural Hospital Providers
- Nursing Facilities
- HCBS Services
    - Adult Day Services
    - Alternative Care Facility Services
    - Consumer Directed Attendant Support Services (CDASS)
        - Homemaker
        - Health Maintenance
        - Personal Care
    - Day Habilitation Services
        - Specialized Habilitation
        - Supported Community Connections
    - Homemaker Services
    - In-Home Support Services
        - Homemaker
        - Health Maintenance
        - Personal Care
    - Mentorship Services
    - Nonmedical Transportation Services
        - Mobility Van
        - Wheelchair Van
        - Nonmedical Transportation General
    - Personal Care Services
        - Relative
        - Nonrelative
    - Prevocational Services
    - Residential Habilitation Services
        - Foster Home
        - Group Home
        - Group Residential Support Services
        - In-Home Resiliency and Support Services (IRSS)
        - IRSS Host Home
    - Respite Care Services
        - ACF Respite
        - Unskilled Respite
        - CNA Respite
        - Skilled RN/LPN Respite
        - Camp (Group, Overnight)
        - Individual Respite (In Family Home)
        - Individual Day Respite
    - Supported Employment Services

        - Job Coaching
        - Job Development
    - Supported Living Program Services
    - Transitional Living Program Services

Services Receiving the Across-the-Board 0.5% Rate Increase

- Accountable Care Collaborative Administrative Per Member Per Month (PMPM)
- Anesthesia
- Ambulatory Surgical Centers (ASCs)
- Behavioral Health Fee-for-Service
- County Administration
- Dental Services
- Durable Medical Equipment (codes not subject to the Upper Payment Limit)
- Emergency Medical Transportation
- Private Duty Nursing
- Home Health Services
- Inpatient Hospitals
- Outpatient Hospitals
- Maternity Services (Surgery and Other Maternity Services)
- Nonemergent Medical Transportation
- Pediatric Behavioral Therapy
- Pediatric Personal Care
- Prenatal Plus Program
- Prosthetics, Orthotics and Disposable Supplies
- Substance Abuse Counseling
- Psychiatric Residential Treatment Facilities
- Residential Child Care Facilities
- Surgeries
    - Cardiovascular System
    - Digestive System
    - Eye & Auditory
    - Integumentary System
    - Musculoskeletal System
    - Respiratory System
    - Other Surgeries
- HCBS Services
    - Art and Play Therapy
    - Music Therapy
    - Massage Therapy

- Palliative/Supportive Care
    - Care Coordination
    - Pain and Symptom Management
- Therapeutic Services
    - Bereavement Counseling
    - Therapeutic Life Limiting Illness Support
- Intensive Support Services
- Hippo Therapy
- Movement Therapy
- Behavioral Services
- Dental Services
- Specialized Medical Equipment and Supplies
- Assistive Technology
- Home Delivered Meals
- Recreational Facility Fees/Passes
- Community Transition Services
    - Coordinator
    - Items Purchased
    - Vehicle Modifications
    - Vision
- Adaptive Therapeutic Recreational Equipment and Fees
- Substance Abuse Counseling
- Case Management
- State Supported Living Services
- State Supported Living Services Case Management
- Family Support Services
- Preventive Dental Hygiene

28. ***[Sen. Zenzinger]*** **Describe why the Department did not consider targeting the proposed increase to the following provider services:**
    - **Massage, Movement, and Music therapies**
    - **Speech services (speech language pathology)**
    - **Behavioral Services**

    Members are also hearing that the targeted increases to the following services may not be enough, and that providers are unable to offer services. Discuss how these rates were selected and what more needs to be done for these providers:
    - **Day habilitation**
    - **Supported employment**
    - **Homemaker and personal care**
    - **Respite**

RESPONSE

Every year, the Department must make difficult decisions about how to prioritize rate adjustments and which services should receive targeted rate increases. The historical rate setting practice of the Department has been to give across the board rate increases and then additional targeted increases for rates that are identified as significantly lower than benchmark rates, providers most greatly impacted by the workforce crisis, and to address potential access to care issues.

The Department understands that all service providers have struggled in the current economic climate, and it considers all of them as part of its annual analysis of which specific ones should receive a targeted rate increase. To develop its request this year, the Department conducted an analysis to determine which services had the greatest need for rate adjustments. To achieve the largest impact, the Department has requested targeted increases for home and community-based services to support the financial stability of direct care worker agencies and workers and to maintain an adequate provider network to support the needs of a growing population requiring long-term services and supports. This includes services such as day habilitation, supported employment, homemaker, personal care, and respite. Each service will receive a targeted increase to allow the provider the ability to increase their direct care workers' wages to $15.75/hour. Additionally, since 2018 these services have received average increases of 30%, 21%, 36%, 38%, and 29% respectively.

While massage, movement, music, speech, and behavioral therapy service providers have undoubtedly been impacted by the current economic climate, the Department's data shows they do not have the same level of reported solvency or access to care issues. Additionally, massage therapy in the Children with Life Limiting Illness and Spinal Cord Injury waivers received a 34.5% targeted rate increase effective July 2022. These important providers are included in the across-the-board increase.

Over half of the funding (59%) requested in R-7, Provider Rate Adjustments, is for increases to the nursing home and home and community-based services providers that serve older adults and people with disabilities, which are disproportionately facing solvency issues and workforce challenges such that

they are at risk of not having adequate staffing to provide necessary care. The data shows that without significant investment in the services prioritized by the Department, there will be provider solvency and access to care issues.

29. ***[Sen. Zenzinger]*** **With significant labor shortages for Home- and Community-Based Services, why didn't the Department request a targeted rate increase for community integration services? How do we address individuals who need their services provided one-on-one but are only able to get services in a group setting due to rates that are below minimum wage?**

RESPONSE

In the FY 2023-24 budget, the Department has prioritized significant targeted rate increases for home and community-based services, with additional increases for both nonmedical transportation and group home services as part of its R-7 request. The nonmedical transportation services are specifically intended to increase access for members seeking community integration. The targeted rate increase for group home services will support the continued availability of this community residential option – helping to avoid institutional level of care. The request also includes increases that are, in part, aimed at increasing the compensation rate from $15.00 an hour to $15.75 an hour (statewide) as well as cover the amount of the Denver minimum wage increase in full.

These increases do include day habilitation services, in which the Supported Community Connector (SCC) benefit resides. The current rate for individual SCC is $28.84 an hour, and wage data reported by providers shows an average of $18.75 per hour for SCC providers, well above minimum wage.

30. ***[Sen. Zenzinger]*** **How is the Department addressing wage compression and administrative and financial burdens forced on providers who are required to be certified or licensed by the Department of Regulatory Agencies in long term care?**

RESPONSE

The Department has identified staffing shortages and increasing labor costs as a major challenge facing long-term care providers. To combat this crisis, the Department has undertaken substantial efforts aimed at removing administrative burdens, creating efficiencies, providing financial resources, and otherwise supporting essential workers.

The Department collaborated with the Colorado Community College System (CCCS) to establish the Care Forward Colorado program. This program is aimed at revitalizing Colorado's health care workforce with zero-cost training programs for many certified and/or licensed positions within the health care system. Another component of the program, being led by the Colorado Department of Public Health & Environment (CDPHE), funds certification for new professionals and re-engagement efforts to recruit back individuals who had previously left health care-related jobs. The Department is providing support and data to CDPHE to assist in this effort.

The Department has also worked closely with our partners at the Department of Regulatory Agencies (DORA) to ensure a smooth transition for Temporary Nurse Aides (TNAs) who may have been operating under the initial period of the public health emergency and will continue to do so until the federal government determines that a temporary license is no longer necessary. Through this partnership, the Department collaborated with DORA to expand testing site locations to enhance accessibility and availability for these workers. The Department also helped many members of this workforce connect with provider agencies to not only address employment needs but also help them receive their long-term certification as a Certified Nurse Aide.

Department data indicates that cost burdens associated with temporary labor obtained from staffing agencies is increasing at a disproportionately high rate as compared to other labor costs. While the Department can identify the cost incurred by the long-term care provider, it does not currently have insight into how much of that cost is passed on to the temporary staff in the form of wages. Providers utilizing staffing agencies have additionally reported administrative burden related to re-verifying active licenses or certifications of workers obtained through temporary staffing agencies. As directed by SB 22-210, License Supplemental Health-care Staffing Agencies, the Department, in conjunction with CDPHE, has collected information on staffing agencies operating in Colorado for the purposes of licensing and financial reporting with the Department of Labor and Employment (CDLE). Beginning October 2023, staffing agencies will be required to submit financial reporting which will document how revenue is being used as it relates to wages, administrative overhead, and profit taking on the part of the staffing agency. The bill also clarifies that the staffing agency will be responsible for ensuring ongoing licensure for temporary staff to ease the current administrative burden incurred by the long-term care provider.

Finally, the Department increased the rate for home health services provided by a Licensed Practical Nurse, Registered Nurse, Physical Therapist, Speech Language Pathologist, and Occupational Therapist by 12.19%-12.23% in the last two fiscal years. The Department also increased the rate for private duty nursing provided by a Licensed Practical Nurse and Registered Nurse by 15.53% and 10.68%, respectively, in the last two fiscal years. The Department has also invested a total of $445,011,108 in budget changes including $424,203,977 in rate increases, and $20,807,131 in other policy changes from FY 2018-19 through FY 2022-23 for home and community-based services, which would allow many agencies to address issues of compression for the suite of services they offer.

The Department will continue to examine the appropriateness of its rates and how to create efficiencies for its members, direct care workers and providers. It will also continue to work closely with DORA, CDPHE, CDLE and others to support this critical Colorado workforce.

31. *[Sen. Zenzinger]* The JBC has heard concerns that the rate is inadequate for Certified Nurse Aide Extended Unit in long term home health. Please explain why the rate drops from over $38 for the first hour to $23 for continuous hours of service after the first hour and whether this rate structure and these rates are reasonable.

RESPONSE

As noted, there are two different types of certified nurse aide services, basic and extended. The first unit of Basic Certified Nurse Aid home health care can be billed for up to one hour of service delivery. The extended rate can be billed for service delivery up to 30 minutes per unit with a minimum of 15 minutes per extended unit. The difference between the rates has been a long-standing practice and was reviewed in the 2020 Medicaid Provider Rate Review; the rates were determined sufficient based on the data metrics. For more information about the analysis of this service, please see Appendix B of the 2020 Medicaid Provider Rate Review Analysis Report. These rates will be reviewed by the MPRRAC again before the end of 2025.

32. ***[Sen. Zenzinger]*** **The Department requested Denver minimum wage adjustments for nursing homes and personal care and homemaker services for FY 2023-24. Please explain what the Denver minimum wage adjustment is intended to cover. Does it address wage-related costs for the agencies (worker's comp, liability insurance, professional liability insurance, FICA, the new FAMLI benefit collection, etc.), and if not why not?**

RESPONSE

The Department requested to increase rates for most home and community-based waiver services to reflect the Denver minimum wage increase to $17.29 per hour in the FY 2023-24 R-7, Provider Rate Adjustments, including personal care and homemaker services. These increases are intended to address wages of direct care workers in the city and county of Denver. The Department has provided the flexibility for provider agencies to use this funding to support administrative costs as long as the base wage requirement is met. This flexibility has proven to be beneficial as Department data shows direct care workers' average pay is $17.59/hour following increases from last year. The Department anticipates that number to go up if R-7 is approved this year. Finally, wage-related costs for agencies are included in the rate methodology for all services.

Nursing Facilities will be required to meet the Denver Minimum Wage and new base wage requirements as determined by the Department. The Department is requesting funding for higher payments to nursing facilities as part of R-7 to help address the cost pressures that they are currently facing. Further, the increase in the Denver minimum wage will be considered in the calculations for the wage enhancement supplemental payment available to nursing facilities, as established in section 25.5-6-201(37), C.R.S. This is the only provider type to have this consideration under the local minimum wage statute.

33. ***[Sen. Zenzinger]*** **The Denver minimum wage will increase January 1, but the reimbursement won't happen until July. Will the Department be submitting a supplemental request to cover costs in FY 2022-23? Please comment on the lag.**

RESPONSE

The budget preparation and review process are confidential until the Governor officially submits supplemental and budget amendment requests to the Legislature on Jan. 3, 2023.

The Department's request to implement the base wage increases in FY 2023-24 is based on the timing required to secure federal approval for the rate changes. The Department must submit requests to change the rates for the Home and Community Based Services (HCBS) waivers to the Centers for Medicare & Medicaid Services (CMS) through waiver amendments. This process often takes a minimum of six months and must be completed before the Department can implement increases to the rates. The Department acknowledges that this will create a lag from when the minimum wage is effective to when the rate increase will be implemented and that the current nature of HB 19-1210, Local Government Minimum Wage, creates hardships for Medicaid providers. The Department will continue to work with local governments to increase understanding around the timing impact of increasing the minimum wage on direct care services.

34. *[Sen. Kirkmeyer]* For the targeted rate adjustment, does paying a higher rate for Denver have an adverse impact other counties. Please discuss this at length.

RESPONSE

House Bill 19-1210, Local Government Minimum Wage, permitted municipalities to establish a local minimum wage. The City and County of Denver established its own minimum wage effective Jan. 1, 2020, with subsequent increases annually based on the Consumer Price Index. This has created an unfunded mandate since its inception, as the Department had to increase Denver County rates to ensure they were sufficient for providers to adhere to the minimum wage requirement. In 2020, the Joint Budget Committee approved funding for increases for some Denver providers through HB 20-1360, the FY 2020-21 long bill.

The home and community-based services (HCBS) direct care worker base wage increase to $15.00 per hour statewide was implemented effective Jan. 1, 2022, through American Rescue Plan Act (ARPA) funding approved by the Joint Budget Committee in 2021. The Department's request to implement a base wage increase in FY 2023-24 to $15.75 per hour will provide additional funding for HCBS providers across the state.

The Department's targeted rate increase would ensure that providers in Denver can pay the minimum wage of $17.29. The Department does not have documentation or data on the impact of Denver's minimum wage on other counties at this time. While the Department has not seen a decrease in service utilization in other counties, and members continue to receive the necessary services from service providers, the Department does have concerns regarding the differences in the Denver minimum wage and how that impacts wage compression, provider migration, and access to care issues, which are exacerbated by the higher rates paid by other industries like retail, hospitality, and other health care organizations like hospitals. The proposed targeted rate increase is a critical step to ensure providers will be able to continue to provide services and retain/recruit workers.

PHARMACY

35. ***[Rep. Sirota]*** **What are the non-pharmacy costs to the state associated with the prior authorization criteria for non-preferred agents/medications (hospital visits and provider costs) compared to the pharmacy costs for eventual approval of non-preferred agents/medications?**

RESPONSE

The Department does not have data which indicate that the coverage requirements for nonpreferred drugs are causing increased nonpharmacy costs. The claims data show that preferred drugs are prescribed about 96% of the time. The Department has also implemented a number of ways to ensure that prescribers can efficiently request prior authorizations if they believe a nonpreferred drug is the better alternative. If a prior authorization request is submitted for a nonpreferred drug, a response is provided within 24 hours or less. The Department also dramatically streamlined the prior authorization process for providers by implementing the prescriber tool in 2021. This tool allows providers to view the preferred drug list and submit electronic prior authorization requests directly from their Electronic Health Record (EHR) systems. Prior authorizations submitted electronically will often receive a response within minutes if not seconds. If a prior authorization is requested via phone, a response is typically provided while the caller is still on the line. In the event there are delays with providers submitting a prior authorization request, pharmacies may dispense a 72-hour supply of a medication in emergency situations.

36. ***[Rep. Sirota]*** **How many prior authorization exception requests does Medicaid receive for non-preferred medications on Department's preferred drug list (PDL)? How many are approved/denied initially? Of those, how many are subsequently overturned on appeal?**

RESPONSE

For FY 2021-22, Medicaid paid for about 8.2 million prescriptions. During that time frame, 48,731 prior authorization requests were submitted for nonpreferred medications. Of that total, 31,982 (about 66%) were approved and 16,749 (about 34%) were denied. Those denials include prior authorization requests which were denied for technical reasons (e.g., missing patient name) as well as clinical denials (i.e., the patient did not meet the clinical criteria for coverage of the nonpreferred drug). In about 12,000 cases, the Department's pharmacy benefit manager helped prescribers find an appropriate drug for their patient in lieu of a prior authorization request. During the same fiscal year, 63 appeals were filed for prior authorization denials with none overturned pursuant to the administrative hearing process.

37. ***[Rep. Bird]*** **Please provide information about any cost savings within Medicaid that result from the use of specialty drugs.**

RESPONSE

Specialty drugs cover over 40 therapeutic categories and special disease states with over 500 drugs, so it is difficult to accurately estimate the cost savings that may result from use of the specialty drugs identified in the JBC staff briefing. At the same time, less than two percent of the drugs prescribed to Medicaid members to treat their conditions (largely specialty drugs) are so expensive they are consuming about 50% of Medicaid's prescription drug spend. Some of these drugs have clearly proven their ability to significantly reduce associated Medicaid medical spend, like drug therapies that cure Hepatitis C.

That said, there is insufficient data on the long-term effectiveness for these drugs, even for the drugs which have been approved for one-time use. Assuming these drugs replace all prior drug therapies for the applicable health conditions, the Department estimates the total cost of these specialty drugs would be offset by about 4.8% on average for that year (i.e., 4.8% of the $27.5 million). Assuming Medicaid patients no longer needed any other Medicaid services due to these new treatments (e.g., if a drug provided a lifetime cure), the Department estimates the total cost of these specialty drugs could be offset by up to an additional 8.4% on average for that year.

The Department is increasing its focus on creating value-based contracts with manufacturers to hold them more accountable to their clinical promises, which relate directly to their impact on patient health and disease progression. This is especially important as the newly emerging gene therapies are coming to market with prices in the millions of dollars for a single treatment.

Specialty drugs will have an increasing impact on the Department's prescription drug expense and reflect the greatest vulnerability in the Department's budget. The Department is very closely monitoring utilization of these drugs, related specialty drugs in the pipeline, their costs, offsets from existing treatments, and changes in the utilization of other services due to emerging specialty drug patient impact.

R14 - CONVERT CONTRACTOR RESOURCES TO FTE

38. ***[Sen. Zenzinger]*** **Please provide an update on the Department's progress in filling the FTE that have been added over the last couple of years.**

RESPONSE

Over the last three fiscal years, HCPF has been funded 155.6 new FTE through appropriations from the General Assembly. The Department has made great progress over the last several months in filling funded FTE. This was accomplished by increasing the Department's HR staff to exclusively support recruitment of our ARPA funded positions, as well as implementing new processes and project management systems to increase our time to fill rate. Currently, of the 155.6 FTE that have been appropriated over the last three fiscal years, 133.2 positions are filled, and 13.5 positions are being actively recruited.

39. ***[Rep. Bird]*** **Describe how confident the Department is that they can fill the requested positions. Is state compensation competitive?**

RESPONSE

The Department is confident that its new recruitment and hiring processes will allow it to hire and onboard new employees more effectively and efficiently. However, there is an opportunity to be more competitive with compensation, especially within the analyst series, which includes financial and IT professional roles. The Department is revising its compensation policies and procedures to ensure that compensation is more competitive with the current job market. Based on existing historical survey data, the most frequent reason for leaving employment is for better pay with other employers.

40. *[Sen. Bridges]* Regarding *R14 Convert contractors to FTE*, what will these individuals be doing? Does this request relate to notifications, including those related to the dis-enrollment process?

RESPONSE

The requested FTE would form a dedicated stakeholder engagement and facilitation unit that could be leveraged on new Department initiatives and ongoing programs that require stakeholder engagement. By "stakeholder engagement" the Department means public meetings with consumers, advocates, members, providers and other Department stakeholders to solicit and process feedback about Department policies, processes and practices. This request does not relate to notifications, or to the renewal or disenrollment processes that will occur as the Department unwinds the PHE. Department staff have already solicited stakeholder feedback on the content and structure of the notices for the PHE unwind.

The requested FTE would be hired for their expertise in facilitation, stakeholder engagement and change management. Permanently reducing contractor funding for stakeholder engagement activities to hire state FTE to perform the work would be a more efficient and effective use of state resources. Using dedicated FTE for stakeholder engagement would develop institutional knowledge and best practices that are not at risk of being lost between vendor transitions; reduce redundant overhead work such as conducting solicitations, negotiating contract terms, reviewing vendor work, processing invoices, and implementing corrective action plans, and identify opportunities for cross-Department collaboration due to centralized oversight of stakeholder engagement activities. Ultimately, this request would generate a more robust and cohesive capacity for stakeholder engagement that would enable greater success in implementing legislative and executive priorities, enhance member engagement in program development, and better inform and prepare external partners for major policy changes.

The unit's work would support policy and program development, but the unit itself would not be directly responsible for any Medicaid policies or programs or for providing research or expertise outside of stakeholder engagement and facilitation. Examples of the unit's duties would include:

- Working collaboratively with subject matter experts and program staff to develop and execute external stakeholder engagement strategies for the Department's large-scale initiatives.
- Facilitating high-profile engagement activities.

- Leveraging conflict resolution and mediation strategies to prevent and deescalate high-conflict situations that occur in the context of public meetings.
- Developing standard operating procedures and best practices for use throughout the Department.
- Training other Department staff in facilitation, engagement and change management best practices.
- Identifying and educating staff about the latest technologies and tools that can be employed, particularly for the facilitation of virtual meetings, to improve engagement and further improve accessibility.
- Engaging stakeholders on current Department priorities such as Medicaid value-based payments including the development of APMs for primary care and maternity care, Phase III of the Accountable Care Collaborative (ACC), supplemental payment programs to providers like nursing facilities and the University of Colorado School of Medicine (CUSOM), and the Colorado Prior Authorization Review (PAR) Program.
- Engaging stakeholders on future Department priorities and new initiatives.

41. *[Sen. Kirkmeyer]* Would approval of *R14 Convert contractors to FTE* set up an internal conflict by substituting employees for contractors?

RESPONSE

The FTE requested in FY 2023-24 R-14, Convert Contractors to FTE, will not set up an internal conflict by substituting employees for contractors. When the Department uses contractors for stakeholder engagement, those contractors are following the Department's guidelines for stakeholder engagement and are acting as Department staff augmentation. Contractors do not work with stakeholders without direct oversight by the Department's current subject matter experts, as contractors do not independently have the knowledge or experience to perform the work without direct Department staff support. The Department requests to convert contractor funding to state FTE to achieve more efficient and effective stakeholder engagement for Department programs.

The complex nature of Department programs and policies requires high-quality collaboration and engagement with diverse stakeholders including Medicaid and Child Health Plan *Plus* (CHP+) members, medical providers, legislators and community groups. The diversity of stakeholders and projects requires a wide variety of engagement techniques including communication and outreach to external partners, facilitated meetings and workgroups, conflict resolution and mediation, and the development of policy and process documents based on stakeholder feedback to provide insights and recommendations for Department programs. These valuable efforts are greatly benefited by the guidance of skilled professionals trained in facilitation, stakeholder engagement and change management. Ultimately, robust stakeholder engagement supports the effective implementation of new programs and initiatives, builds community trust, improves the Department's relationships with the community and external partners, and supports greater equity in the implementation and execution of Department priorities.

This request would allow the Department to form a more cohesive and effective stakeholder engagement strategy that would increase the Department's capacity to meaningfully engage with external partners and increase the rate and success of new initiatives.

OTHER QUESTIONS – CHILD HEALTH PLAN PLUS (CHP+), CO-PAYS, RECOUPMENTS, AUDITS & FRAUD/WASTE/ABUSE

42. ***[Rep. Bird]*** **What are the differences between CHP+ and Medicaid? Why have a separate CHP+ program instead of an extended Medicaid program?**

RESPONSE

The key differences between Medicaid and the Children's Health Insurance Program are their income eligibility limits, their federal reimbursement structures and their benefits. Medicaid is a program that covers eligible adults and children, generally up to 138% of the poverty level (FPL). It was created under Title XIX of the Social Security Act and provides a robust set of benefits to members. It is a state-federal program that generally draws a 50% standard match from the federal government in Colorado. There is no cap on Medicaid enrollment. If a person is found eligible, they are entitled to be covered.

The Children's Health Insurance Program (CHIP) is known as the Child Health Plan *Plus* (CHP+) in Colorado and covers children and pregnant people up to 260% of the FPL who make too much to qualify for Medicaid, but not enough to secure commercial coverage. CHIP was created under Title XXI of the Social Security Act in 1997. The benefits in CHIP are benchmarked to commercial coverage and under federal law, states are permitted to create waiting lists and cost sharing like enrollment fees and co-pays. The key difference in benefits for children is that Medicaid provides the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit to children, which is a comprehensive benefit that provides all medically necessary benefits, whether or not they are covered by the Medicaid state plan. CHP+ does not include EPSDT.

Colorado has both a CHIP Medicaid expansion for members who are between 108-142% FPL and a separate CHIP structure for members who are between 143-260% FPL. This has allowed Colorado to maximize federal flexibilities and matching rates. Within federal rules, states have considerably more flexibility in separate CHIP programs to determine benefit packages or set premium and cost sharing requirements.[8] Colorado set its program up to be a full-risk managed care model, so that it would more closely resemble private insurance. Thirty-eight states have both CHIP Medicaid Expansion and separate CHIP programs. Colorado's separate CHP program no longer requires members to pay a premium and includes limited or no cost sharing for covered benefits.

[8] http://www.nashp.org/wp-content/uploads/sites/default/files/Benefits.Cost_.Sharing.Separate.CHIP_.Programs.pdf

43. *[Sen. Zenzinger]* Discuss the proposal to eliminate member co-pays. Does the Department anticipate negative impacts on inappropriate utilization of emergency care or other high level services?

RESPONSE

Through this proposal, the Department will keep the $8 co-pays for improper uses of the emergency room for nonemergency services; the Joint Budget Committee (JBC) approved this co-pay amount last year. Co-pays are used to encourage desirable utilization and discourage undesirable utilization. The Department does not have any evidence that this decision would drive utilization of high-level services. If anything, the elimination of co-pays will improve the affordability and therefore access to primary care, basic care, lower-level care, and medication compliance, which will reduce avoidable disease and illness escalation and the need for higher intensity care and acute care.

Removing member co-pays will lessen the financial burden that members experience, and the tradeoff decisions that they have to consider between co-pays on necessary care versus being able to afford basic needs like rent, utilities or food. As part of its R-7 budget request, the Department proposes the following reductions:

- Pharmacy co-pays would be reduced from $3 per prescription/refill to $0 per prescription/refill for adults (it is already $0 for children and pregnant members);
- Co-pays for physician services and services delivered at federally qualified health centers and rural health clinics would be reduced from $2 to $0 per visit;
- Co-pays for durable medical equipment (DME), and laboratory and radiology services would be reduced from $1 to $0 per visit; and
- Co-pays for hospital services would be reduced from $4 per visit (outpatient hospital), and $10 per day (inpatient hospital) to $0, except in the case of nonemergent emergency room visits, which would remain at $8 each visit.

Study after study demonstrates that patient cost sharing burden reduces access to necessary services for low-income and chronically ill populations. Recent studies show that co-pays can lead to delayed care, pill-splitting, unfilled prescriptions, poor health outcomes and ultimately, more expensive care once members seek the treatments they need. An Oct. 31, 2022, publication from the Colorado Health Institute found Coloradans with Medicaid or CHP+ report affordability challenges, with 19.1% of those enrollees who take prescription drugs saying they struggle to afford medications. Even relatively small co-pays in the range of $1-$5 are associated with reduced use of care, including necessary services and increased use of the emergency room.

In addition, co-pays are currently a reduction in reimbursement for Medicaid providers. If the provider chooses not to invest in the administrative expense to collect or “chase down” the member co-pay or cannot collect the co-pay from the member, the provider’s total reimbursement is reduced by that co-pay amount. The Department does not increase reimbursement to providers if they do not or are unable to collect a co-pay - the amount is lost revenue to the providers. Therefore, the elimination of co-pays is an indirect means of providing an across-the-board increase to almost all Medicaid providers –

pharmacies, physicians, rural clinics and more – while also reducing their administrative expenses in serving Medicaid patients.

For all these reasons, the elimination of Medicaid member co-pays will also help the Department, stakeholders and the legislature achieve our shared goals of increasing Medicaid network provider participation as well as care affordability and in **so doing reduce health disparities for Medicaid members.**

44. ***[Sen. Kirkmeyer and Sen. Zenzinger]*** **How will the Department be accountable and will they report back to the General Assembly on the fraud, waste, and abuse? Please provide an accounting of some of the changes that the Department has made in the last several years, and what were the results of those changes?**

RESPONSE

The Department currently works with its county partners and the Medicaid Fraud Control Unit (MFCU) within the Colorado Attorney General's Office to submit an annual report on provider and member fraud which tracks prosecutions and recoveries for the past fiscal year.[9] If the 2.0 FTE requested in R-11, Compliance for Fraud, Waste and Abuse analysts are approved, the Department would incorporate the resulting impact to recoveries in subsequent annual reports. Additionally, the Department is audited on its fraud, waste and abuse activities by the Office of the State Auditor annually. CMS and the federal Office of the Inspector General (OIG) also conduct audits of the Department's fraud, waste and abuse activities. These audit findings are posted publicly and can be accessed by the General Assembly.

This past fiscal year, the Fraud, Waste and Abuse Division expanded to include greater emphasis on fraud investigations, wider focus on provider oversight, and a unit devoted to our recovery audit contractor (RAC) activities. These initiatives support better safeguards for taxpayer dollars. Further, the Department has leveraged data analytics to identify potential high-risk areas for fraud, waste and abuse that have resulted in both increased overpayment recoveries and guided policy improvements to reduce future instances of fraud, waste and abuse.

The Department has also increased and improved its relationships with its external contractors and partners. This has included improving management of the RAC and increasing participation in CMS-authorized partnerships, including the Healthcare Fraud Prevention Partnership and the Unified Program Integrity Contractor. The Department secured Fraud Capture Software at no cost to the Department. These contracts and partnerships have increased the identification of fraud, waste and abuse and increased provider overpayment recoveries related to fraud, waste and abuse made by the Department. In FY 2020-21 these recoveries totaled $18,429,084. In FY 21-2022 these recoveries increased to $37,526,075, and through November 2022 of FY 2022-23, these recoveries already totaled $22,191,700.

45. ***[Sen. Kirkmeyer]*** **How many FTE does the Department have performing audits now? By increasing the number of audits, the Department will increase the amount of time that**

[9] https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Medicaid%20Fraud%20Prosecution%20Report.pdf

hospitals and other health care providers will need to spend responding to audits. How will the Department ensure that the additional audits do not impact patient care and do not discourage providers from participating in Medicaid.

RESPONSE

Currently, the Department has 17 FTE conducting provider post-payment reviews for fraud, waste and abuse, of which 4.0 FTE are responsible for administering and overseeing the recovery audit contractor (RAC). The RAC is a federally mandated program that requires Medicaid agencies to contract with vendors to conduct post-payment review audits among all provider types. The Department's RAC vendor, Health Management Systems, Inc., employs approximately 64 health care professionals to conduct these audits on the Department's behalf.

The staff noted above are responsible for monitoring all providers enrolled in Health First Colorado. In the last fiscal year, they and the RAC vendor reviewed 0.28%, or approximately 104,000 claims, out of the 37,051,543 claims paid to providers.

With an increasing number of members enrolled in Health First Colorado (37% increase since March 2020 when the COVID-19-induced economic downturn started) and the uptick in related claims being paid, the Department has made efforts to increase its reviewer staff and program integrity activities in the last two fiscal years. In this past fiscal year, the Department recovered approximately $34.5 million in provider overpayments, all of which go back to the sand to the federal government based on the federal match paid by claim, to offset medical services that are provided to Health First Colorado members. So far in this fiscal year, the Department has recovered approximately $22.2 million. In comparison, the Department recovered approximately $13.8 million in FY 2020-21. The Department is on track to surpass $50 million for this fiscal year.

Additionally, the Department has program and audit obligations at the state and federal level that it must satisfy on an ongoing basis. The Office of the State Auditor and HHS-OIG audit recommendations often include claims review of questioned costs. CMS mandates ongoing reviews as part of compliance with programs and benefits. Additionally, the U.S. Department of Justice has conducted law enforcement actions and signed corporate integrity agreements involving national health care systems and organizations that conduct business in Colorado, which also affect Health First Colorado members.

The Department has worked to strike a balance between meeting state and federal requirements to conduct audits and maintaining ongoing program integrity review activities. Examples of these efforts include:

- Instituting a cooling-off period on audits at the beginning of the public health emergency (PHE) in March 2020 and postponing audits unless there was a suspicion of fraud occurring. Colorado was one of the handfuls of states that delayed reviews at the onset of the COVID-19 pandemic.
- Granting extensions to providers to allow for additional time for them to gather medical records to lessen the burden of provider record keeping and administration staff. This also respected the priority for health care professionals to concentrate on rendering care to members. In 2020, the

Department also briefly allowed extensions to the informal reconsideration process to give providers more time to respond to the Department's findings–which, in statute, is 45 days.

- Engaging in discussions with the Colorado Medical Society, the Colorado Hospital Association, and the hospital and provider community to identify ways to collaboratively achieve a balance of meeting everyone's needs and addressing concerns.

The Department has ongoing processes in place to ensure that providers receive a notification when they have been selected for audit, explaining their rights as allowed through statute and rule. With the implementation of SB 21-022, Notification Requirements for HCPF Audit, the Department takes additional steps to verify provider contact information and sends additional correspondence prior to a medical records review. The Department's RAC vendor conducts outreach to provider stakeholder groups and associations prior to conducting a new audit project, and regularly performs audit pilots on a small number of providers before fully rolling out new projects. Under state law, providers can ask for deadline extensions for medical records requests and can ask for any amount of time that is needed.

46. *[Rep. Sirota]* Considering that the federal Centers for Medicare and Medicaid Services (CMS) bars recoupment from members and has made that clear in recent guidance[10], how is the Department changing current policy? Please estimate the fiscal impact.

RESPONSE

The Department is currently reviewing the CMS October 2022 FAQ and working with CMS to get clarification on their interpretation of existing statutes and their expectations for implementation. Once the Department has clarified the requirements and expectations from CMS, the Department will provide guidance and work with county partners to ensure compliance with this new guidance.

Total recoveries from administrative proceedings and criminal proceedings vary significantly year to year. The counties self-report their recovery numbers on an annual basis. The recovery numbers for the last three fiscal years are listed below. The fiscal impact of the CMS written guidance, as it is currently stated, could reduce the total annual member recoveries for future fiscal years to $0, with no recoveries from administrative nor criminal proceedings permitted. If subsequent CMS clarification and further guidance only prohibits recoveries from administrative proceedings, but not criminal proceedings, as CMS has indicated in previous meetings on this issue, there may be an expected loss of somewhere around $2 to $3 million per fiscal year.

State Fiscal Year	FY 2019-20	FY 2020-21	FY 2021-22
Administrative Proceedings	$2,247,608.83	$3,178,312.17	$2,618,017.42
Criminal Proceedings	$253,588.38	$252,390.50	$415,610.86
Total	$2,501,197.21	$3,430,702.67	$3,033,628.28

[10] https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf

*Data from the Improving Medicaid Prosecution Report, the report can be accessed:

- 2020: https://hcpf.colorado.gov/sites/hcpf/files/Improving%20Medicaid%20Fraud%20Prosecution%20HCPF%20Report%202020.pdf
- 2021: https://hcpf.colorado.gov/sites/hcpf/files/Medicaid%20Fraud%20Prosecution%20Report%202021.pdf
- 2022: https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Medicaid%20Fraud%20Prosecution%20Report.pdf

47. *[Rep. Bird]* Please explain the Department's projections of the two types of savings identified in the table at the bottom of page 15 of the JBC staff briefing, as well as the implementation of related audit findings.

RESPONSE

The Department requested reductions to its budget for two different initiatives in R-11, Compliance, as described below.

- TPL Expansion – The Department secured a new third-party liability (TPL) vendor that will provide TPL data at a lower rate than the previous vendor. The new contract costs are estimated using the current contract rate and the estimated TPL segments that the vendor will provide. This results in lower contractor costs than currently appropriated for this work; therefore, the Department is requesting a reduction of $8,831,063 to the line item for TPL contractor costs. The Department is working with the new vendor to obtain all available TPL segments for the Medicaid populations and assumes these efforts will be realized in FY 2023-24. The Department is requesting 2.0 FTE to increase its ability to manage TPL claims analysis and to better ensure the data is timely, verified, and that claims are denied or paid appropriately. The Department is requesting a net reduction for this initiative of $8,666,243. The Department anticipates collecting TPL data at a lower cost while still achieving significant savings.

- Fraud, Waste and Abuse Compliance – The Department is requesting to hire 2.0 FTE to support the fraud, waste and abuse section. The FTE would provide legal and administrative support, which is being handled by current staff, leaving them with less time to handle overpayment recoveries. Hiring two FTE will allow the current staff to focus on overpayment recoveries. The Department estimated savings from reallocating staff to this work based on the actual reported overpayment recoveries collected in FY 2021-22 divided by the current FTE responsible for the recoveries. The Department estimated the incremental costs avoided by multiplying the average recoveries per FTE by the requested 2.0 FTE, adjusting FY 2023-24 for a training period before staff are fully equipped to handle the responsibilities. This resulted in a reduction of $2,706,725 in FY 2023-24, or a net reduction of $2,553,729. The new FTE would assist with addressing the

audit findings already handled by the Fraud, Waste and Abuse Division, allowing current staff to focus on overpayment reviews. In particular, the new staff will address the audit findings from the Statewide Audit Reports listed below.

- Audit finding 2019-057 – The Department should review the payments made for the service claims without matching prior authorizations identified in the audit to determine whether the payments were allowable and recover unallowable payments and over-payments, as appropriate. Until the Department implements Recommendations 2019-056 and 2018-053, it should also review claims that were paid after the audit review period to determine whether any lacked prior authorization, and recover unallowable payments and over-payments, as appropriate.
- Audit finding 2020-037 – The Department should improve its internal controls over Medicaid and Child Basic Health Plan (known as CHP+) overpayments and comply with the related payment and reporting requirements by:
  (a) providing adequate training to staff to ensure timely documentation and communication of recovery information in accordance with federal regulation
  (b) developing and implementing written policies and procedures to ensure that all necessary information required to correctly track overpayments is included on the tracking spreadsheet and recovered overpayments are refunded and reported to CMS
  (c) reporting recovered overpayments accurately in CORE to enable the Department to report these overpayments under the correct federal reporting lines in CMS quarterly reports and
  (d) implementing a supervisory review over the tracking spreadsheet and CORE overpayment recovery account codes to ensure completeness and accuracy of information to support timely recovery and reporting of overpayments.
- Audit finding 2021-048 – The Department should improve its internal controls over Medicaid and CHP+ payments for deceased beneficiaries by researching and recovering any overpayments made to providers on behalf of ineligible beneficiaries noted through the audit in accordance with state recommendations.
- Audit finding 2021-050 – The Department should improve its internal controls over Medicaid and CHP+ overpayments and comply with related payment and reporting requirements.

48. In relation to DOLA's R1: Additional Resources for DOLA/HCPF Voucher Program request, please describe how you calculate the savings to your department from these vouchers. Where exactly in the Long Bill will these savings show up? Are savings reflected in your FY 2023-24 request?

RESPONSE

To calculate the savings to the Medicaid program resulting from DOLA's R-1 request, the Department analyzed Medicaid claims data from members who have transitioned from a nursing facility to an HCBS program over the previous two years. The Department estimated the average savings resulting from a member transitioning from an institution to an HCBS program by comparing the average expenditure

pre and post transition. The Department calculated savings of $44,785 per member, per year, for members who transition and applied that savings to the number of anticipated transitions resulting from the increase in housing vouchers. The Department reflected the estimated Medicaid savings from DOLA's R-1 request in the Department's NP-01 request. This impacts the Medical Services Premiums line in the Department's Long Bill.

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH DELIVERY SYSTEM & PROVIDER NETWORK

49. *[Rep. Bird]* Discuss the Department's assessment of the Regional Accountability Entities (RAEs) and Managed Care Entities (MCEs) for delivering behavioral health services. Are they effective and the best organizational structure for behavioral health services? What are the weaknesses or challenges of this organizational structure?

RESPONSE

Colorado has developed a hybrid model of managed fee-for-service (FFS) physical health and capitated behavioral health in extensive collaboration with providers and stakeholders over the past 14 years. The state's capitated behavioral health program started in 1995 and became nationally recognized for decreasing the length and number of psychiatric hospitalizations while shortening overall recovery time and dealing with trauma-related behavioral health complications. Many states have implemented fully capitated managed care programs to deliver Medicaid services. Nationally, 41 states utilize risk-based managed care contracts to serve at least some of their members and 69% of all Medicaid-enrolled individuals receive care under risk-based managed care contracts.[11]

Individuals who qualify for Medicaid and have behavioral health needs are much more likely to be experiencing issues related to the social determinates of health. Rates of criminal justice involvement, chronic illness, smoking, and being the victim of interpersonal violence are all higher among those with behavioral health needs. This population also experiences the harmful effects of discrimination and stigma, coming from communities, family and even providers, leading them to be less likely to seek care. The flexibilities provided by a managed care system are particularly meaningful to those who need wraparound, whole-person care for mental health and substance use disorders.

The Department looks at a variety of factors to assess the effectiveness of the RAEs in relation to behavioral health services.

Through the capitated benefit, members are able to access alternative community-based services (B3) services, so called because they are authorized through a federal 1915(b)3 waiver. These services are especially important for members with serious mental illness and include prevention/early intervention, clubhouses/drop-in centers, vocational services, intensive case management, assertive community treatment, mental health residential treatment, respite care and recovery services/peer support. B3

[11] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

services also help members connect with peers, develop life skills and prevent isolation. Notably, 46% of members who received behavioral health services administered under the RAEs used these B3 services. Under a capitated model, providers also have more flexibility to be paid for these safety net services and the required underlying infrastructure.

Utilizing single, regional entities to address both physical and behavioral health improves the delivery of whole-person care and is aligned with the integration goals of CMS and the Center for Medicare & Medicaid Innovation (CMMI), which awarded HCPF a $65 million grant during the last decade to achieve that important goal. Care management and care coordination integration within our RAE structure further ensures that members have access to one entity that can recognize and care coordinate for the whole person, connecting individuals to the full range of Medicaid services, behavioral health care, as well as community organization supports. This has been particularly important during COVID-19 and natural disasters, such as the Marshall Fire.

Where available, the Department compares RAE performance against national metrics. The RAEs have performed higher than the national average on a subset of standardized Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health metrics. For example, in 2020 the overall average of the RAEs for follow-up within 7 days after hospitalization for mental illness was 68.71% compared to 39.4% for the Medicaid HMO National Average.[12]

Overall, the RAEs have been able to improve outcomes by offering value-based payments to support practice transformation and the maximization of evidence-based practices.

The Department sees the behavioral health capitation as being critical to promoting utilization of a continuum of community-based services and reduce the number and length of inpatient hospitalizations by keeping members healthy. Hospital alternative services help keep members in their communities, and the Department covers crisis and inpatient psychiatric services provided through Crisis Stabilization Units (CSUs) and freestanding psychiatric hospitals under the capitated payment arrangement approved by CMS. Other benefits are listed below:

- Managed care is much more flexible than fee-for-service in that the managed care entities are able to use their funds in creative ways with both members and providers. For members, RAEs can cover supportive services that would otherwise not be billable but can support a member remaining in the community and achieving behavioral health recovery. For example, during COVID-19 the RAEs paid for home delivery of medications and food, as well as the purchase of smartphones and other technological devices to enable members to participate in telehealth. For providers, RAEs can be responsive to regional network variations and increase the rates they pay for providers in high need. They can also use their funds to help providers build out infrastructure and create incentives to expand workforce and system capacity. For example, the RAEs used their administrative dollars to help providers modify their facilities to accommodate social distancing during the height of COVID-19 pandemic.
- RAEs can offer alternative payment arrangements that cannot easily be accomplished in FFS payments to shift the focus from quantity of services provided (prominent in FFS) to quality of services provided. Many RAEs already offer bundled and specialty payments for quality care in

[12] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

areas like youth substance use disorder (SUD) services, services for individuals who are unstably housed, and integrated care.

- RAEs must demonstrate that the use of B3 services and their management of behavioral health services are more cost-effective than if members were served through FFS, which they have accomplished every year through federal budget approvals. This is what allows Medicaid to have such a comprehensive benefit.
- RAEs conduct extensive data analyses to monitor the behavioral health system for gaps in services, need for provider education, and identifying member needs, such as outreach and additional service supports, such as care coordination.

At the same time, the Department recognizes the challenges posed by the RAE structure and managed care in general. Some of these include:

- RAEs are allowed to negotiate rates with providers; these rates can be higher or lower than the Medicaid FFS rates. This also means that individual RAEs may not pay the same rate for services. As a result, providers who contract with multiple RAEs may receive different rates for the same service. Smaller providers particularly do not have significant opportunity to negotiate these rates. We are actively working to address this opportunity.
- Except for single case agreements, members are restricted to seeing behavioral health providers that are contracted with their RAE as part of the network for nonemergency services. Many providers of behavioral health services don't wish to contract with any payer, so this issue is shared with the commercial industry and impacts nearly all Coloradans. We also are pursuing strategies to address this challenge.
- While the Department worked with the RAEs to establish a centralized credentialing process to reduce administrative burden, providers must still contract with each RAE to be one of their network providers, which, in some cases, means a provider must hold multiple contracts with multiple RAEs. This is particularly an issue for high population areas like Denver and Colorado Springs, or for specialty behavioral health providers.
- For individuals with complex needs, in which physical, cognitive, developmental and behavioral health conditions interact with one another, building comprehensive care teams has been difficult to achieve, especially when Medicaid is one of many payers involved in the care. We are working on solutions to this in the ACC 3.0 emerging design.

Some of the most common criticisms of the managed care system are criticisms of insurance plans in general. For example, setting actuarily sound rates that are not able to keep up with runaway inflation, requiring care follow evidence-based-medicine (which is proven to improve quality outcomes and affordability), and only allowing for services that are medically necessary are all requirements of all state Medicaid programs. These elements, which some might see as restrictive, are a necessary part of this federal-state partnership and what allows one in four Coloradans to have access to health coverage. If these functions were not executed by RAEs they would be executed by the Department to comply with federal regulations. The standards administered by the RAEs are essential to responsible and auditable operations, and are federally required.

Our recently released ACC annual report includes detailed information on our behavioral health approach.

50. *[Rep. Bird]* What is the Department doing to reduce duplication and inefficiencies in the behavioral health delivery system?

RESPONSE

The Department is working with the Behavioral Health Administration (BHA) to improve coordinated oversight and collaboration across the behavioral health system, while reducing duplication and inefficiencies. The Department and the BHA are working with stakeholders to drive several workstreams intended to improve the performance and accountability within the behavioral health safety net system. These efforts include: modernizing safety net provider and service definitions; revising, amending, or repealing regulations for behavioral health safety net providers; creating a universal contract; improving transparency and standards for safety net cost reports; streamlining processes for cross department oversight and administration; developing alternative and value-based payment models in Medicaid; investing in expanding safety net system; and decreasing the administrative burden to providers.

In the FY 2021-22 budget cycle, the Department requested R-23, Behavioral Health Claims and Eligibility Processing, which provided funding to consolidate behavioral health claims and enrollment systems for public benefits. This project will provide efficiencies by improving the member and provider enrollment functions, as well as billing and payment capabilities for the BHA into the Medicaid Management Information System (MMIS). Efforts to expand the Department's MMIS/PEAK systems intend to establish an eligibility system, a claims processing and submission system, and a data reporting system to serve all of the state's behavioral health programs.

The Department has initiated project work for all of these workstreams which are designed to improve coordination across the behavioral health system and are scheduled to be completed no later than July 2025.

Legislation to expand and strengthen the behavioral health safety net: To support the state behavioral health safety network, as introduced in SB 19-222 and the subsequent report to strengthen and expand the safety net, new definitions of the safety net and safety net providers are emerging to the benefit of all Coloradans, especially those who are low income and suffer from Serious Mental Illness (SMI). These definitions will ensure new criteria to be a safety net provider, while increasing the number of providers who can be part of the safety net system. The impacts of this bill have already begun and will be fully complete by July 1, 2025.

Rewriting the provider standards for all behavioral health providers: HB22-1278 modernized the definition of safety net providers and associated safety net services, which also created a new provider type for small and medium sized safety net providers. The BHA will be revising, amending or repealing their provider standards, and other regulations, based on these statutory changes. This first set of new rules provides the BHA with the opportunity to standardize provider services and state requirements, cut unnecessary requirements, and provide a single set of data reporting requirements. It will be effective April 30, 2023.

Universal contracting for publicly funded behavioral health providers: The universal contract provisions will establish uniform standards across different state agencies to use when contracting for

behavioral health services. Specifically, providers can expect all state agencies to require the same standards of quality, data reporting, grievance procedures, payment methodologies, and expectations of service and administration. These standardized state contracts aim to clarify and streamline expectations of providers in the behavioral health system and make it much easier for providers and payers to engage in a relationship. The BHA and the Department will have draft provisions completed by June 30, 2023.

HCPF cost reporting and safety net rate setting: To increase diligence on safety net cost-based rate setting and improve specificity and transparency, the Department released new Cost Report Templates for the CMHCs in May of 2022. All CMHCs must submit their cost information to HCPF in November 2022 using these new templates. The insights from these reports will be used to set new rates effective July 2023. While these reports require large safety net providers like CMHCs to provide more specific information, effectively increasing requirements, this effort was essential to identify potentially duplicative funding and give the state a better understanding of how we are spending behavioral health funds.

Behavioral Health Cross Agency Processes: The Department is working to finalize an interagency agreement with the BHA. The agreement will address processes that occur across multiple agencies in an effort to reduce duplicative or overlapping efforts. Specifically, the agreement will streamline the process of auditing large safety-net providers, improve data sharing and standardize grievance processes. For example, these have already improved the on-site review and quality oversight process. As a result, providers will have fewer independent, disconnected interactions with varying departments on the same matters being reviewed at a state level. The interagency agreements will be reviewed and improved annually.

Alternative Payment Models (APMs) and Value-Based Payments (VBPs): The Department is working with stakeholders and the BHA to develop new reimbursement methodologies for safety net providers that create greater accountability to the community and reward member outcomes. Specifically, the new APMs will create sufficient flexibility for providers to meet the needs of the community and members, while the VBP will better correlate reimbursements with results. APMs and VBPs can help move provider focus from billing by the minute to ensure they are capturing all available payment codes towards more patient-centered outcome-based care. The specifics are under development; however, HCPF is in the process of shadow pricing previous utilization using three different payment methodologies that will help inform the development of an initial APM. These payments will align with the Department and the federal government's efforts to increase APM and VBPs and evolve on an iterative basis with the initial APM effective July 2024.

Reducing Administrative Burden: The Department is closely involved as the BHA works through the process of promulgating rules that will impact the behavioral health system by:

- Reducing and aligning data collection and reporting requirements for behavioral health providers.
- Aligning on the minimum performance standards and key metrics for youth and adult services funded by the BHA and the Department.

- Providing minimum standards for all aspects of the operation of Behavioral Health Entities (BHEs) licensed within the state; these standards will impact some Medicaid providers. The BHA will additionally license and monitor BHEs in accordance with those standards.

51. *[Rep. Bird, Sen. Bridges]* Please provide information on the adequacy of the provider network over time and by managed care entity. What has the Department achieved in expanding the network and what still needs improvement? In what services and areas are provider shortages having the most impact on access to care and what is the Department doing to address these issues?

RESPONSE

Each behavioral health provider must complete three steps to provide services through Medicaid: 1) enroll with the Department, 2) credential through a RAE, and 3) contract with a RAE. The Department tracks provider enrollment and RAE contracting data to measure the adequacy of behavioral health provider networks over time.

The table below shows the growth of enrolled providers for the five behavioral health provider types from Nov. 1, 2021, through Oct. 31, 2022. It demonstrates an overall increase of 10.73% for these specific provider types.

Behavioral Health Provider Enrollment – November 2021 – October 2022

Provider Type	Total Enrolled Providers (11/1/21)	Total Enrolled Providers (10/31/22)	Total Increase	% Increase
Psychiatric Residential Treatment Facility	36	41	5	13.89%
Community Mental Health Center	251	259	8	3.19%
Licensed Psychologist	1,136	1,254	118	10.39%
Licensed Behavioral Health Clinician	7,680	8,562	882	11.48%
Substance Use Disorder - Clinics	410	418	8	1.95%
Total	9,513	10,534	1,021	10.73%

Each RAE must contract with a statewide network of behavioral health practitioners and facilities that offer access to covered health care services. The Department works with an independent external quality review organization (EQRO) to monitor and validate the behavioral health network data submitted by the RAEs in quarterly network adequacy reports. Data in the table below, reported to the Department from June 2021 through June 2022, demonstrates an overall growth in the number of practitioners contracted with every RAE region. It is important to note that individual practitioners often

contract with multiple RAEs, so numbers from different RAE regions cannot be added together to arrive at a statewide figure.

Total Unique Behavioral Health Practitioners by Region

	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
RAE 1	3,293	3,311	3,349	3,360
RAE 2	3,100	3,166	3,291	3,308
RAE 3	6,118	7,040	7,021	6,311
RAE 4	3,097	3,164	3,291	3,307
RAE 5	6,211	6,983	7,021	6,283
RAE 6	3,921	4,113	4,294	4,617
RAE 7	3,921	4,113	4,294	4,617

The Department also monitors member utilization of behavioral health services including the member behavioral health engagement rate. The most recent data for behavioral health engagement is presented below. Department data shows that the rate of engagement remained constant during the COVID-19 pandemic even as the overall number of members enrolled in Medicaid increased significantly. This represents an expansion of network capacity.

Behavioral Health Member Engagement

	Member Population	Engagement Rate
RAE1	193,860	21.68%
RAE2	103,100	14.87%
RAE3	353,687	17.37%
RAE4	148,545	17.01%
RAE5	147,639	20.84%
RAE6	191,630	18.86%
RAE7	217,786	17.58%

In July 2021, the Department requested the RAEs submit plans for expanding their behavioral health networks. The RAEs submitted actionable targets and provided quarterly progress updates throughout FY 2021-22. Initiatives included rate increases, increasing availability of services for special populations, and increasing intensive services. Workforce shortages were a consistent barrier to this work.

The Department identified high-intensity outpatient treatment as an area of need in the community. To improve these services, the Department is creating grants for local communities, including providers, nongovernmental organizations and counties, to implement programs that are specific to their behavioral health capacity needs and geographic area. Initiatives include:

- $24 million in grants to RAEs to expand the availability of high-intensity outpatient services for acute and/or chronic behavioral health needs; $6 million in education, technical assistance, provider trainings, communications, and community engagement to build out the statewide safety net, in partnership with the BHA.
- In addition to supporting RAE efforts there is a $14 million grant to support behavioral health transition services between residential/inpatient and outpatient care, prioritizing high-intensity outpatient care in communities.

52. *[Sen. Bridges]* Please discuss the performance by managed care entities (MCEs) reported in legislative request for information #2. Why are the performance rates so low? What explains the variation in performance by managed care entity? Are there lessons learned from the MCEs that are performing relatively better or worse? What is the Department doing to improve performance and behavioral health outcomes?

RESPONSE

The performance measures referenced are part of the behavioral health incentive program (BHIP). The BHIP allows the RAEs to earn up to 5% above their annual capitation payment by meeting BHIP performance metrics. As an incentive program, the measures chosen represent practice areas that could improve member care and outcomes but have structural or operational challenges the Department is asking the RAEs to solve. They are stretch goals that should not be easy to meet. If the RAEs do not meet their goals, the Department does not pay them their incentives. The Department sets new target goals each year that are based on the previous year's performance.

Four out of the five measures were designed after existing national Healthcare Effectiveness Data and Information Set (HEDIS) metrics but were modified to be inclusive of the alternative (B3) services that are uniquely available under the Department's capitated behavioral health benefit. The below table compares the overall ACC average performance to the Medicaid HMO National Average for the last three years where available.

HEDIS Measure	2019		2020		2021	
	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg

Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [13]	47.64%	14.4%	38.84%	14.1%	46.28%	Data Not available
Follow-up within 7 Days After Hospitalization for Mental Illness [14]	65.43%	36.2%	68.71%	39.4%	52.99%	Data Not available
Follow-up within 7 Days after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence [15]	34.93%	13.3%	36.02%	13.8%	33.27%	Data Not available
Follow-up After a Positive Depression Screen	50.19%	Data Not available	51.94%	Data Not Available	62.8%	Data Not Available

While not all RAEs are meeting their incentives, the ACC overall and each individual RAE performed higher than the national average for Medicaid MCEs, where national data has been reported. The Department includes and promotes the use of alternative services under the capitated behavioral health benefit that are not part of the fee-for-service benefit. These alternative services (also known as B3 services) are designed to wraparound evidence-based community and high-intensity services that effectively engage members in treatment and promote recovery in the community.

The fifth measure that is part of the BHIP program is the percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment. The Department created this measure based on community feedback, as there is not a national health care measure available that addresses concerns that children in child welfare are not receiving timely behavioral health services. This metric measures the percentage of youth who receive an assessment within 30 days of an out-of-home placement (excluding most kinship placements). The metric was designed to address data exchange/transfer barriers in the system and incentivize RAEs to engage counties to establish communication and collaboration around children and youth placed in out-of-home placements. ACC performance overall has improved from 8.67% in FY 2017-18 to 22.04% in FY 2020-21.

The Department recognizes there are multiple influences on BHIP performance including:

- Regional relationships, like the willingness of hospitals within RAE Regions to participate in discharge planning for inpatient and ED services.
- When working with regions with fewer members, change in numerators and/or denominators can drastically change the performance percentage. An example is total members (increasing

[13] https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/
[14] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[15] https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/

the denominator) based on PHE requirements that keep people enrolled who are no longer engaging with the Medicaid system. This may look like a decrease in access.
- Variations in member demographics and needs; for example, regions may have a smaller percentage of members who require access to behavioral health services.
- Rural and frontier areas of the state have resource challenges, most notably workforce gaps, lack of public transportation, and natural barriers like snow closed roads that are not experienced in urban areas.

The Department has established a collaborative relationship between the RAEs to provide support in reaching their goals. The Department helps disseminate lessons learned and best practices among the organizations and leverages its monthly Learning Collaborative. During the Learning Collaborative, RAEs who are doing innovative work in an area will present their activities to the larger group for discussion and sharing of insights. The Department holds monthly Performance and Data meetings with each RAE individually. Each month the group analyzes data for a specific performance metric or Department target, such as inpatient SUD utilization, maternal health, or a different incentive metric. These meetings provide an opportunity for the Department and RAEs to really explore what is happening based on the data and discuss opportunities for improvement.

53. ***[Sen. Zenzinger, Sen Kirkmeyer]*** **Please respond to the concerns raised in the series of articles by the Colorado Sun regarding children in foster care and the lack of services. Please relate the response to the poor performance of the RAEs in conducting behavioral assessments for children in foster care within 30 days of enrollment.**

RESPONSE

All children placed in a licensed foster care setting in Colorado and those children adopted from the foster care system are eligible to receive Medicaid funded services. There are several funding mechanisms at the Department for children in foster care:

- Most mental health outpatient services are paid by the RAEs;
- Residential services are paid directly by the Department under fee-for-service (not by RAEs);
- If necessary specialized services are not covered by the RAE or available in state, the Department pays for care under fee-for-service;
- If a child has intellectual or developmental disabilities that qualify for waiver services, the Department pays for those services directly.

The Colorado Sun series about the state's adoption processes presented the concerns within their article specific to Medicaid funded services. The article identified challenges related to a metric for screening children coming into foster care system; children with extended time in an emergency department for a mental health crisis; placement stability in residential treatment facilities; shortage of providers across the state who are able to provide trauma-based therapy or specialize in Reactive Attachment Disorder; and the number of available providers for children who accept Medicaid members.

Over the last several years, the Department has been working with counties, the General Assembly, RAEs, the Colorado Department of Human Services and the Behavioral Health Administration to identify

concerns and solutions. The Department hosts various forums to support collaboration and problem solving across stakeholders, including but not limited to:

- Human Services Policy Advisory Committee with counties;
- HRCC Collaborative Forum (HCPF, RAEs, CDHS Division of Child Welfare, counties);
- Meetings with Colorado Human Services Directors Association leadership and other county leadership groups;
- Children's Disability Advisory Committee;
- The Medicaid Subcommittee of the Delivery of Child Welfare Services Task Force; and others.

With the support and insight of these groups, the Department is leading and participating in a number of programs to address the challenges listed in the Colorado Sun article. The key efforts underway include:

- Partnering with CDHS to significantly increase residential bed rates for youth in psychiatric residential treatment facilities (PRTFs);
- Working with CDHS to increase residential/hospital capacity for specific complex needs, including use of 30 new beds for children;
- Working with CDHS and providers to comply with the federal Family First Prevention Services Act (FFPSA) and increase the number of enrolled Qualified Residential Treatment Programs (QRTP) and PRTFs;
- Working with a hired vendor to examine alternative payment methods for QRTP payment based on a child's acuity;
- Working with CDHS and BHA to create training opportunities for the workforce to gain additional competencies, especially to increase children's access to trauma-informed providers; and
- Supporting CDHS in its increase capacity of therapeutic foster care settings.

In addition to these efforts, the Department has made a number of permanent changes to our system to better serve this population.

- The Department implemented aggregate BH total capitation rates increases of 12% for FY 2021-22 and 3% for FY 2022-23. These funds were contingent on addressing specific identified service gaps in each region, including crisis and SUD services for youth.
- Each RAE/MCO completed a behavioral health network expansion plan and provided progress updates throughout FY 2021-22. Initiatives included rate increases, increasing availability of services for special populations, and increasing intensive services. Many initiatives directly and indirectly addressed items highlighted in the Colorado Sun reporting. Workforce shortages were a consistent barrier to this work.
- ARPA funds have been designated for use by RAEs/MCOs to support the expansion of high intensity outpatient services in all regions of the state. Distributing, investing and monitoring the impact of these funds is ongoing.

The Department created the Behavioral Health Incentive Plan (BHIP) measure #5, Behavioral Health Screening or Assessment for Foster Care Children, to address concerns that children in child welfare were not receiving timely behavioral health services. The metric measures the percentage of youth who

receive a behavioral health screening or assessment within 30 days of entering the foster care system. These assessments can be completed in physical health or behavioral health settings. The metric was designed to address data exchange/transfer barriers in the system and incentivize RAEs to engage counties to establish communication and collaboration around children and youth in the custody of a county.

The metric does not include all the ways behavioral health assessments can be provided but is an indicator of RAE efforts. For the ACC overall, performance on this measure has improved from 8.67% in FY 2017-18, to 22.04% in FY 2020-21. The data accounted for in the measure only includes children who are new to foster care and are in out-of-home placement. It is not inclusive of children who are under the Medicaid adoption benefit or in kinship care. This measure was designed to incentivize the RAEs to work directly with counties to get children entering foster care screened for behavioral health concerns in a timelier manner. RAEs are not notified in real time when children enter foster care and rely on counties, so children are connected to providers and receive appropriate screenings and assessment.

The Department, CDHS, counties and RAEs have had meetings to analyze and suggest improvements to this metric. The following steps have been taken to identify challenges and improve performance:

- Child welfare workflows, timing, and inter-departmental system coordination impacts performance on this metric. The Department worked with CDHS to publish guidance to minimize the negative impacts of these issues, increase coordination with managed care entities (MCEs), and help all parties overcome timing barriers by reaching out directly to MCEs for care coordination purposes. Implementing this guidance should have a positive impact on performance.
- The HRCC had a workgroup identify counties that have better outcomes on this metric. Specifically, these counties are sharing their processes to help other regions adopt best practices.
- The Department is also offering continued education and support on capturing this activity for accurate recording and as part of an overall quality improvement process to assess workflows and processes as well as outcomes.

BEHAVIORAL HEALTH PROVIDER RATES & HB 22-1268 UPDATE

54. *[Sen. Kirkmeyer]* Explain the periodic rate review process for behavioral health community programs. How do the rates paid by RAEs/MCEs compare to those paid by other entities? What are the administrative expenses that RAEs/MCEs are allowed to retain?

RESPONSE

Explain the periodic rate review process for behavioral health community programs.

The capitated rates for behavioral health community services are determined annually. A forecasting trend analysis is conducted by the contracted state actuary for unit cost and utilization change during the annual managed care capitation rate setting. For example, between FY 2020-21 and FY 2021-22, the

capitation rates for behavioral health services incorporated a year-over-year trend of 7.85%. Behavioral health community programs are not reviewed by the Medicaid Provider Rate Review Advisory Committee.

RAEs are responsible for establishing contracted rates with providers in their network, and the Department is not federally authorized to interfere with this process. However, the Department does influence the process by setting the overall RAE capitation rates. The estimates for the capitation rates and resulting budgets set by the Department are based on a number of factors, including: utilization of services by RAE/MCE, contracted costs incurred by the RAE/MCE, national trends, policy changes, and changes in the covered population. For the full risk capitated programs, including the behavioral health capitated program, the Department and its actuaries set actuarially sound rates for each individual RAE/MCE. Per 42 CFR 438.4(a), actuarial sound rates are, "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the [managed care plans] for the time period and the population covered under the terms of the contract..."

These factors apply to all behavioral health providers, including residential and inpatient substance use and mental health providers, outpatient therapists, crisis services and telehealth. About 60% of behavioral health services are provided in community mental health centers (CMHCs), which have additional rate setting standards. Per current state statute C.R.S. 25.5-4-403, the estimated payment rates for CMHCs are based on actual costs, which are determined based on audited cost reports submitted to the Department and the Behavioral Health Administration. Federally qualified health centers also receive a rate estimate based on actual costs of care. This specific requirement exists because safety net providers are required to maintain an infrastructure to provide an array of services that other providers are not required to offer. The state statute was recently revised through HB 22-1278 and by 2024 the rates methodology must also apply to all qualifying safety net providers, which extend beyond just CMHCs. The new rates, in addition to the cost of services, must consider quality, accessibility, equity, and accessibility by priority populations. These changes were developed to incentivize increased access, create more equitable care models, and include small and medium sized community-based providers that are providing safety net care.

How do the rates paid by RAEs/MCEs compare to those paid by other entities?

The Department does not have the data necessary to compare rates paid by RAEs and MCEs to other entities in Colorado. Other entities, like commercial plans, are not required to share the rates they pay to their contractors with the Department. In its Behavioral Health Rates Report released in August of this year, the Department committed to preparing an analysis comparing the behavioral health rates paid under Medicaid to commercial plans. That report is due to be completed in calendar year 2023.

What are the administrative expenses that RAEs/MCEs are allowed to retain?

RAEs and MCEs are permitted to retain a maximum of 15% of premiums to spend on administrative expenses. In recent years, the RAEs have had administrative expenses ranging between 10.5% and 14.5%.

Pursuant to federal regulations, the premium paid to the providers includes reasonable administrative costs, such as salaries, case management and claims processing. RAE/MCE administrative costs are

audited to ensure that costs are reasonable. Unallowable costs include lobbying, alcohol purchases and profit-sharing.

The RAEs have also used their administrative funds to help fund the capacity for the crisis line, pay for additional behavioral health assessments, invest in local community partners, and engage in care coordination.

If a RAE has a medical loss ratio (MLR) greater than the 85% floor, the additional dollars spent for medical care reduce the amount of remaining administration dollars. As an example, if a RAE had an MLR of 87%, that would leave 13% of the premiums available for administrative costs. If the RAE's administrative costs were 14% that year, the RAE would take a 1% loss. If, instead, the RAE's administrative costs were 12%, the RAE would keep the 1% as profit.

55. ***[Sen. Zenzinger]*** **The Department does not set the rates that the managed care entities pay behavioral health providers, but could the Department set minimum rates for key services? Would this be beneficial?**

RESPONSE

As the largest payer of behavioral health services in the state, the Department has successfully worked with our RAEs over the last few years to increase Medicaid reimbursement levels across the behavioral health spectrum as part of a shared and comprehensive effort to transform the state's behavioral health system. Medicaid funding into behavioral health has increased by more than $500M between FY2018/19 and FY2023/24, including the addition of the inpatient and residential services coverage and an expansion of behavioral health network providers of more than 25%.

In addition, the Department is in the process of seeking a "directed payment" option that will require Regional Accountable Entities (RAEs) to pay "no less than Department-established fee schedule rates" for certain services, such as psychotherapy services and residential treatment for children and adolescents. The RAEs would still have the ability to negotiate rates above the fee schedule rates under this emerging model. The Department agrees that limited use of a directed payment policy can be beneficial, as it is intended to provide additional opportunity for reimbursement consistency, allows providers to forecast their finances, would likely increase network provider participation, and is a stabilizing factor for access to services. The Department will require federal approval from the Centers for Medicare and Medicaid Services to implement directed payments.

56. ***[Sen. Zenzinger]*** **Please discuss the recent and planned changes in the way behavioral health providers are paid, including a new cost report, new relative value calculations, and new value-based payment models. Are these being developed and implemented in conjunction with each other? What is the roll out time frame? What are the implications for safety net providers and the communities they serve?**

RESPONSE

The Department is working on several behavioral health payment reform initiatives as part of a larger strategy to provide transparency and accountability in the current safety net system while the Department works in collaboration with the Behavioral Health Administration (BHA) to develop alternative payment models and value-based propositions for comprehensive and essential safety net providers, as defined in HB 22-1278, Behavioral Health Administration. The cost reports, value calculations and value-based payments are all an integral part of the state's plan to expand and strengthen the safety net and are being developed in coordination with one another. These changes currently apply to community mental health centers (CMHCs), but in the future will be more broadly applied to safety net providers. The universal contract provisions will be essential in implementation of these efforts, clearly outlining the process and standards for safety net payments.

In the spring of 2022, the Department worked in collaboration with the BHA and other stakeholders to update the cost reports completed by the CMHCs to provide a more detailed accounting of the service costs reported as part of cost-based rate setting. The Department released a new CMHC cost report template and related guidance in May of 2022 and provided technical assistance on how to complete the new cost reporting template in the summer of 2022. CMHCs submitted their cost reports, using the new template in November of 2022. These cost reports included updated cost categories for better transparency and included new limitations on reasonable allowable costs. These reports will be used to set the capitated behavioral health rates effective July 2023.

The Department is also working with stakeholders on properly valuing services reinforcing the provision of the most appropriate services by updating Relative Value Units (RVUs) assigned to alternative behavioral health services provided by safety net providers. RVUs are integral to the cost-based reimbursement methodology and will assist in the development of future alternative and value-based payment methodologies for comprehensive and essential safety net providers. Any changes recommended from the RVU workgroup will be incorporated into the cost reports in the spring of 2023 and would be effective in the rate setting for the capitated behavioral health rates effective July 2024.

The Department is working with stakeholders and the BHA to develop an alternative payment model (APM) for safety net providers that creates greater accountability to the community and rewards improved member outcomes. Specifically, the new APM will create sufficient flexibility for providers to meet the needs of the community and members, while value-based propositions will better correlate reimbursements with results. The Department just analyzed previous utilization using three different payment methodologies developed through a stakeholder process. The results of this pricing effort, along with a quality strategy developed in coordination with the BHA and stakeholders, will inform the development of an initial APM that includes value-based payments (VBPs) that will be effective July 1, 2024. The Department is seeking federal authority to direct the RAE to pay safety net providers using VBPs as of July 1, 2023.

These behavioral health payment reform efforts are collectively designed to fund safety net providers transparently and sustainably, while creating greater accountability by tying payments to values determined in collaboration with stakeholders.

57. *[Sen. Zenzinger]* What are the projected increases for behavioral health rates in FY 2023-24? How does this compare to the requested provider rate increases for physical health and long-term services and supports?

RESPONSE

Behavioral health capitated rates for FY 2023-24 are based on past utilization and have not yet been set. The data on which to build the rates has only recently been received and the Department will not have projected increases until mid-April. In recent years, the capitated rates have had increases varying from 4-10%. The Department projected expenditure for behavioral health services for the FY 2023-24 request with a related budget estimate that includes an increase of 5.3% for the capitated rates.

The Department is requesting various targeted rate increases for services reviewed by the Medicaid Provider Rate Review Advisory Committee to ensure that all reviewed services are paid at least 80% of the equivalent Medicare or benchmark rate. The Department requested a 0.5% rate increase for providers not affected by other targeted rate increases. The Department also requested a 16% increase for primary care medical providers. For home and community-based services (HCBS), the Department is requesting an increase of 5.7% on average. For nursing facilities, the Department is requesting an increase of 8.8% on average with variation based on Medicaid utilization. The Department is also considering a policy that will set a floor for what providers are paid for psychotherapy and inpatient and residential care for children for capitated rates.

58. *[Rep. Bird]* How do Medicaid rates impact the number of providers willing to provide behavioral health services?

RESPONSE

In compliance with HB 22-1268, Medicaid Mental Health Reimbursement Rates Report, the Department hired an independent auditor to do an analysis of behavioral health provider rates, which was used to publish the Behavioral Health Provider Rates Comparison Report.[16] This report also included Department recommendations for the development of equitable payment models between Medicaid community mental health centers and independent mental health and substance use treatment providers for comparable behavioral health services.

The report indicates that current reimbursement rates had no direct negative impact on behavioral health network adequacy, as the analysis shows the Department has continuously grown the behavioral health provider network and increased rates. The report showed that the number of providers within Medicaid's behavioral health network has increased for every region in the state within FY 2020-21. Still, that doesn't mean that the Department is satisfied with our behavioral health reimbursements; there is still work to do, given that we have less than half the available behavioral health providers in the state

[16] https://hcpf.colorado.gov/sites/hcpf/files/HB%2022-1268%20Report.pdf

enrolled in the Medicaid network. This provider engagement challenge is not specific to Medicaid; it is a challenge across all payers. The Department continues to work on addressing this challenge, expanding its network of available providers significantly over the last few years.

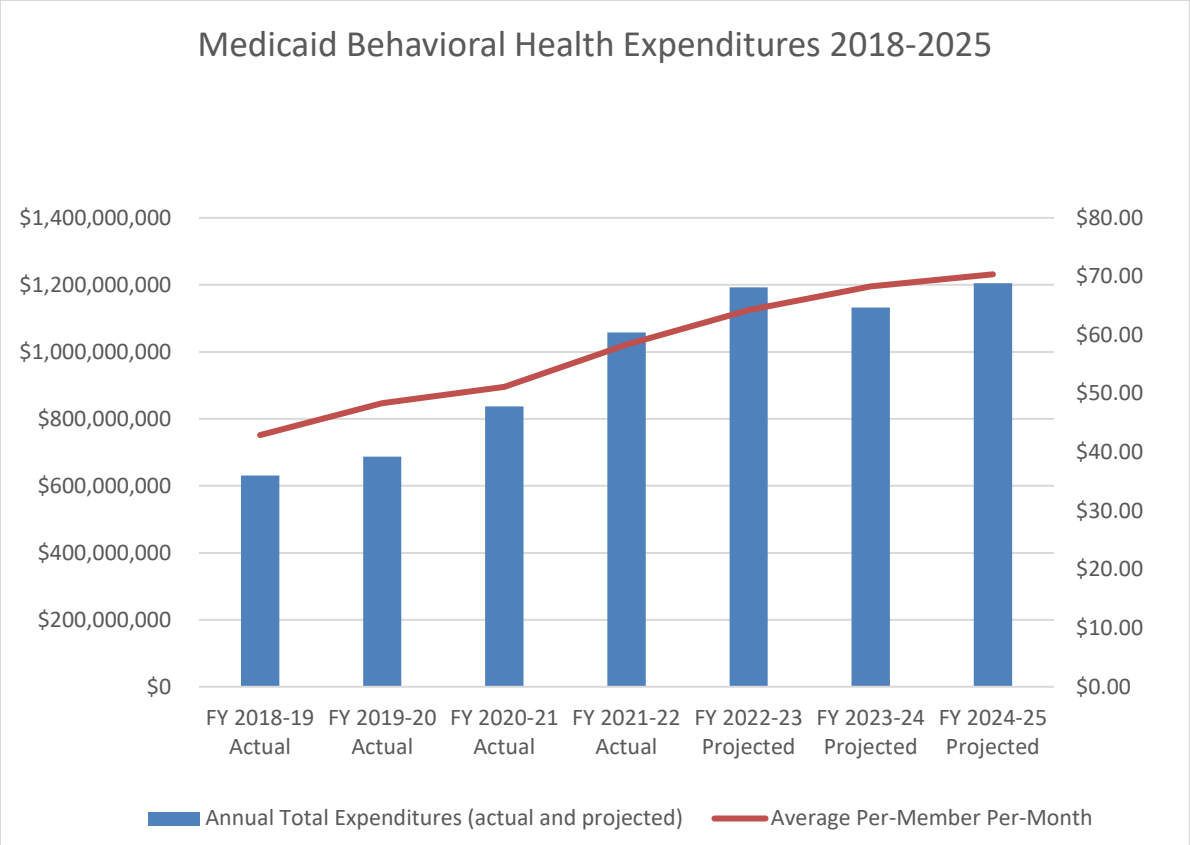
Specifically, the expansion of the Medicaid behavioral health network is a reflection of the provider reimbursement rates available through the managed care capitation. With the support of the General Assembly, the Governor's Office and community partners, the Medicaid behavioral health budget has increased by more $500 million compared to FY 2018-19. The Department increased RAE behavioral health budgets by about 6% in FY 2021-22, about three times the across-the-board increase provided to all Medicaid providers that year. Further, each RAE was required to provide an overview of how they will increase provider networks with a focus on substance use disorder (SUD) residential, medication assisted treatment (MAT), intensive outpatient (IOP) services and child/youth services. The current Medicaid behavioral health network is measured at 10,294 providers as of Sept. 1, 2022, representing psychiatric residential treatment facilities, community mental health centers, licensed psychologists, licensed behavioral health clinicians and substance use disorder clinics.

Despite these gains, the Department hears often from providers and community leaders that there is more to be done and agrees that behavioral health providers have historically been undervalued and underpaid. Even though the state is meeting minimum standards and accomplishing growth, the Department is committed to continuing to improve behavioral health rates with the goal of building the workforce and expanding access to comprehensive, essential, quality behavioral health services for Coloradans. The Department is working on three efforts to support payments to providers.

First, in collaboration with the Behavioral Health Administration, the Department is in the process of creating value-based payments and alternative payment models for safety net providers. This work reimburses for quality and outcomes and disincentivizes volume-based billing for both essential and comprehensive safety net providers. This provides enhanced and increased rates for providers who are helping members stay healthy. The Department wants to ensure that any rate increases are accompanied by increases in system capacity and patient outcomes.

The second effort is to be exploring an option to require that the RAEs pay Department-established fee-for-service rates for certain services, such as psychotherapy services and residential treatment for children and adolescents. This will provide additional opportunity for providers to forecast their finances.

The third is to build out options for more providers to join the safety net and access safety net funding if they meet state standards. These new essential safety net providers, authorized by HB 22-1278, will be approved by the BHA and sustainably supported through Medicaid payments that are based on actual cost of services, quality, equity, service for priority populations, as well as access to alternative and value-based payment arrangements.



R10 – CHILDREN & YOUTH WITH COMPLEX NEEDS

59. ***[Rep. Sirota]*** **How is the Department defining children with complex and co-occurring needs? Who will be served by the initiatives in R10 Children with complex needs?**

RESPONSE

The terminology of 'children with complex needs or co-occurring needs' used in R-10 is meant to be a broad description of children who are Medicaid eligible and whose individual circumstances lead to challenges in timely access to appropriate quality and specialty care. This budget request will benefit children who are Medicaid members and have a need for behavioral health services. There are situations where a child's mental health needs are compounded with other needs, such as intellectual or developmental delays, physical or medical limitations, trauma history, lack of family placement, behavioral challenges, or a combination of behaviors that interfere with treatment success. Some children have one condition that requires complex care planning, others have many conditions that are only complex when presented together; however, all these children require additional attention to achieve treatment success. For behavioral health services, "children with complex needs" or "co-occurring needs" is not an eligibility criterion for obtaining services, but a recognition that sometimes

the health and payment systems were built on the needs of the many and not the needs of individual members.

All Medicaid members under 21, by federal policy, are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. This budget request specifically provides extra focus and support for children who have not obtained treatment success to date, and/or those who get caught between multiple state, local, and federal program supports. For children with complex needs, they and their families and care providers are faced with challenges in the care system that other children are not. These may include delays in discharge, multiple placements, higher utilization, need for complex data sharing, and communications across providers that are not familiar with the child's condition or payment policies. The initiatives listed in R10 will help all children but will have a more profound impact on children who have yet to achieve treatment success or are facing barriers to obtaining the treatment that can produce the desired outcomes.

The Expanding Access to Skilled and Therapeutic Respite for Children portion of R-10 specifically serves children and youth with intellectual and developmental delays or disabilities who have very high medical and/or behavior support needs who are eligible for Home and Community-Based Services (HCBS) Respite services in the Children's Extensive Supports (CES) or Children's Habilitation Residential Program (CHRP) waivers.

The Department and its vendors use a collaborative case review process (known as Creative or Complex Solutions) to assist with the needs of members with complex needs. This process does not have a set eligibility criterion but instead seeks to support individuals who have unique or complex needs that call for the attention of resident policy and clinical experts. This case review process is used when the county or RAE requests additional assistance from the Department in identifying the appropriate services and provider payments for the child. These processes bring all interested parties together to develop a viable treatment plan for each individual member, as mandated by EPSDT – which is the right care at the right time. This personalized group allows the participants to find out what works well from the people who know the child the best – be it the educational system, the county child welfare staff, providers and most importantly, the families. The treatment plans developed can assist in keeping placement options for youth so they do not end up sleeping in county offices or in emergency departments. The positions requested in R-10 will facilitate efforts across state agencies (HCPF, CDHS and BHA) to create a singular case review process to better assist RAEs and counties in identifying services for a child.

60. ***[Sen. Kirkmeyer]*** **How would the department team for children with complex and co-occurring needs that is proposed in R10 Children with complex needs interact with work at the county level and at the RAEs to manage these populations? Is it duplicative? Will it result in increased work for the counties and/or RAEs?**

RESPONSE

For some children who are involved in multiple state and local systems, such as behavioral health, education supports, juvenile justice, and the child welfare system, Department staff expertise is directly required to help the child and their family find and receive treatment in a successful manner. In these

situations, staff work closely with the counties, providers, RAEs, and other key members of the child's care team through a process called Creative Solutions to review and identify treatment options, payment assurances, discharge planning, federal policy and transition care. The counties have various roles in this process, depending on the needs of the child, and have been dedicated advocates to help find the right care, in the right place, at the right time.

The team requested in R10 will help support these efforts, providing additional Department expertise and technical assistance to help counties, providers and families connect youth with complex needs to the appropriate care. This request will add FTE for the Department to engage in more assistance for counties and enable providers and RAEs to better identify the appropriate services, case management supports, and other state services needed for children with complex needs. This will not duplicate existing work or require increased work from the counties or RAEs, and will help alleviate some of their resource limitations.

61. *[Rep. Bird]* The Office of Community Living is not a service provider, so what would the proposed team (in R10) for children with complex and co-occurring needs do?

RESPONSE

All Medicaid members under 21, by federal policy, are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. This budget request specifically provides extra focus and support for children who have not obtained treatment success to date, and/or those who get caught between multiple state, local, and federal program supports. For some children who are involved in multiple state and local systems, such as behavioral health, education supports, juvenile justice, and the child welfare system, Department staff expertise is directly required to help the child and their family find and receive treatment in a successful manner. In these situations, staff work closely with the counties, providers, Regional Accountable Entities (RAEs), and other key members of the child's care team through a process called Creative Solutions to review and identify treatment options, payment assurances, discharge planning, federal policy, and transition care. The counties have various roles in this process, depending on the needs of the child, and have been dedicated advocates to help find the right care, in the right place, at the right time.

While the Office of Community Living is not a service provider, the resources requested in R10 will help support the efforts described above, providing additional Department expertise and technical assistance to help the counties, providers and families connect youth with complex needs to the appropriate care. This request will add FTE for the Department to engage in more assistance for counties and enable providers and RAEs to better identify the appropriate services, case management supports, and other state services needed for children with complex needs. This will not duplicate existing work or require increased work from the counties or RAEs and will help alleviate some of their resource limitations.

CRISIS SERVICES, UNIVERSAL CONTRACT & BEHAVIORAL HEALTH ADMINISTRATION (BHA) COORDINATION

62. ***[Sen. Zenzinger]*** **Last year the general assembly passed HB 22-1214 saying that crisis services must include services for people with disabilities, including those who are developmentally disabled and other disabilities. How has this been implemented? What guidance has been given? Has anyone tracked if people are getting crisis services? Also, are there loopholes that are allowing some providers to not serve people?**

RESPONSE

There are several initiatives to improve the crisis system outlined in HB 22-1214, Behavioral Health Crisis Response System, including increasing training and technical assistance for Administrative Service Organizations (ASOs) and contractors, more robust mobile dispatch criteria, including clarifying exclusionary criteria to disallow rejected requests for responses to this population, and updates to the rule volume to include language about best practices for serving this population. The directives in this bill are being led by the Behavioral Health Administration (BHA). While the Department is not named in the bill, we are supporting their improvements to ensure there is sustainable payment and drawdown of federal Medicaid dollars and education of changes to the public safety net provider networks. The ASOs under the BHA have implemented a variety of strategies in anticipation of supporting providers in achieving best-practice service delivery with any individual in crisis. The BHA is addressing service equity for people with disabilities by updating training standards and crisis provider contracts. They are pursuing potential partnerships with IDD service organizations to lend their expertise and adding specific training to all crisis staff. Once new reporting standards are in place starting in July 2023 the Department will be able to collect data to reflect how services are being equitably provided to all members, including the number of people with intellectual and/or developmental disabilities served.

This work also is connected to other crisis improvements outside of HB 22-1214, including the Department's work with the BHA to expand and standardize Mobile Crisis Response services for all Coloradans, regardless of geography, payer, or disability. The American Rescue Plan Act (ARPA) created some new federal standards for mobile crisis services and the Department is working with the BHA to provide grant funding across Colorado between January and July 2023 to ensure that providers are able to implement best practices following assessments of needs and readiness, as well as significant stakeholder input.

The changes for the mobile crisis response multidisciplinary teams include requirements to participate in BHA training to provide crisis services and receive an endorsement which includes training for working with people with intellectual and developmental disabilities (IDD); traumatic brain injury (TBI); severe mental illness (SMI); serious emotional disturbance (SED); co-occurring disorders; Deaf, Hard of Hearing and Deaf-Blind individuals; and individuals with other cognitive needs or who reflect neurodiversity. These trainings will also include provider training on technology used to be able to communicate with all individuals in crisis.

The Department relies on billing and encounter data to adequately track crisis service delivery and reviews any reports of services that have not been delivered. Medicaid providers must adhere to nondiscrimination standards held within the Health First Colorado Provider Participation Agreement and ASO contract language. Providers who do not adhere to this agreement will be subject to termination as a service provider. The improved dispatch criteria will clarify exclusionary criteria to disallow rejected requests for responses to this population. The Department is also managing implementation of HB 21-1166, Behavioral Health Crisis Response Training and HB 22-1189, Behavioral Health Crisis Response Training Deadlines, which direct the Department to secure a vendor to provide extensive statewide training to professionals who work with individuals with intellectual and developmental disabilities in a cross-system behavioral health crisis response and comprehensive care coordination and treatment model.

63. *[Sen. Zenzinger]* How will the behavioral health administrative services organizations (BHASOs) integrate or coordinate with the Regional Accountable Entities (RAEs)?

RESPONSE

The scope of the current contract for Regional Accountable Entities (RAEs) was effective July 1, 2018, awarded through a competitive process. It charged RAEs with the responsibility of coordinating care for all Health First Colorado members for Medicaid covered services. The Department has crafted a draft, new ACC 3.0 model which would be effective July 1, 2025. That draft model, which includes similar but evolving RAE functions, has entered the stakeholder process, so its ultimate design is not yet finalized.

Concurrently, the Behavioral Health Administration (BHA) is in the planning process for the July 1, 2024, implementation of the Behavioral Health Administration Service Organizations (BHASOs). As part of the planning process and stakeholder engagement, the BHA is developing the roles and responsibilities for BHASOs, especially as it relates to statewide care coordination. Under a no wrong door philosophy, BHASOs will offer access to a behavioral health care entry point for all Coloradans regardless of payer type (Medicaid or non-Medicaid).

The BHA recognizes that RAEs are a critical resource and partner within the safety net and is focusing on that relationship in the BHASO planning. HCPF and BHA leadership are collaborating to identify areas where integration or coordination among BHASOs and RAEs can be leveraged and maximized to support the people of Colorado, while ensuring efficient and appropriate use of state and federal dollars.

64. *[Sen. Zenzinger]* How will the universal contract address the administrative burden of variations in rates, billing procedures, and performance requirements across the managed care entities?

RESPONSE

A primary goal of the design of the BHA was to reduce fragmentation and duplication within the behavioral health system. One of the solutions for streamlining accountability and standards is to create universal contracting provisions (UCP) that can be used for all behavioral health contracts across state

agencies and intermediaries such as the Regional Accountable Entities (RAEs) and the Behavioral Health Administrative Service Organizations (BHASOs).

The UCP will apply to all entities that contract with a state department for behavioral health services. Therefore, Managed Care Entities (MCEs) are required to ensure that their subcontractors abide by the conditions outlined in the UCP. Specifically, MCEs will require that their contracted behavioral health service providers meet all the standards of care and performance requirements outlined in the UCP.

The UCP will align performance requirements, such as incentive programs, key performance indicators, data collection and reporting standards across HCPF contracting agencies (i.e.: RAEs) and the BHA, and other state agencies in future years. The provisions will also outline clearly the standard payment methodologies, like value-based payments, alternative payment models, prospective payments, and other payments standards, some of which are tied to the quality data and reporting.

Streamlining of billing procedures is being addressed through the Behavioral Health Claims and Eligibility Processing project. This effort consolidates behavioral health claims and enrollment systems for public benefits. This project will provide efficiencies by improving the member and provider enrollment functions, as well as billing and payment capabilities for the BHA into the Medicaid Management Information System (MMIS), managed by HCPF. The UCP will not be so specific as to determine the specific billing submission and payment processes across MCEs, or how an individual provider or agency manages their accounting or billing procedures.

The Department is in the process of seeking federal authority to require the RAEs to pay a minimum Medicaid established rate for psychotherapy services and for inpatient and residential treatment for children, which would be included in the UCP. However, the MCEs continue to have authority to make rate determinations and retain flexibilities within their capitated budget. The UCP will not change that, and therefore there will still be variations across payers, as there are across all health plans.

R12 - BEHAVIORAL HEALTH CLAIMS SYSTEM

65. ***[Sen. Kirkmeyer]*** **How is the Department coordinating with Human Services, other departments, providers, clients, and stakeholders to ensure that eligibility determinations, claims processing, and data reporting for non-Medicaid behavioral health services are actually more user friendly and efficient, rather than adding unnecessary layers of complexity?**

RESPONSE

The Department is working in collaboration with the Behavioral Health Administration (BHA) to implement a single fiscal management solution to consolidate eligibility determination, claims processing and data tracking across both agencies by leveraging the existing Medicaid Enterprise Solutions (MES) framework. The MES framework integrates the BHA and Medicaid programs within one system, which simplifies the interaction for providers and eliminates duplicative processes such as submitting data to multiple systems or having to utilize multiple data formats, creating a better user experience. Also, the MES framework follows industry standards that have been automated to reduce

manual processing and redundancy and will continually be enhanced to improve the experience for all behavioral health stakeholders.

The Department and BHA developed a phased operational approach to ensure that the solution will meet the needs of end users. This approach includes a pilot phase with a small group of BHA providers that will begin interacting with the MES prior to the July 1, 2023, go live date. This time will be used for the agencies, departments, and providers to test the system's functionality, edit processes, resolve defects, and allow time for operational change management for all stakeholders. The anticipated large impact of change for all stakeholders will be managed by a phased approach implementation post July 1, 2023. This approach will gradually expand the program change to a larger audience to mitigate any significant impacts or disruptions of services. Additionally, redundancies in current processes, parallel claims encounter submissions and reporting will continue during this phased approach to ensure accuracy and alleviate gaps in benefit services and/or data.

66. ***[Sen. Zenzinger, Rep. Bird, Sen. Kirkmeyer]*** **How will we know that the information technology systems to support eligibility determinations, claims processing, and data reporting for non-Medicaid behavioral health services will result in financial efficiencies? What will the Department hold itself accountable for achieving the savings? What will the affected programs do with the savings?**

RESPONSE

The Department is working in collaboration with the Behavioral Health Administration (BHA) to implement a single claims processing and data reporting system across both agencies. This work is still under development but is on track to be implemented by July 2023.

Using a single system is anticipated to provide significant financial efficiencies by leveraging the Medicaid federal match as much as possible. It would create a mechanism to ensure that Medicaid eligibility is verified for BHA programs, remove the risk of duplicative payments, and ensure that the state leverages enhanced federal financing whenever possible. A single system will help to prevent fraud, waste and abuse because many of the BHA-administered programs and providers serve vulnerable populations who may be eligible for Medicaid and have a potential overlap with Medicaid. In 2016, OSPB completed a Behavioral Health Billing Analysis that recommended "OBH/HCPF should take immediate action to significantly reduce or eliminate the payment of indigent client funding to CMHCs for individuals who are Medicaid eligible." An example of this is that 87% of 2020 mobile crisis visits were deployed for Medicaid members, but a majority of the payments for these services were covered by the BHA's crisis budget. Implementing a single claims processing system allows state program dollars to go further compared to other non-Medicaid programs by maximizing the ability to leverage federal match.

Upon implementation, the Department and the BHA will track instances in which the single system identifies duplicative billing and use that data to revise the long-term trends for the programs. This will inform future requests for funding for these programs, to include requesting to repurpose freed-up funding or to reduce the budgeted amounts for those programs. Since the BHA's funding is not variable based on utilization, any funding the BHA would save from this effort could remain within the BHA to serve individuals who are uninsured or supporting systemwide improvements. The departments will

provide updates throughout the implementation phase to the committee on the impact of integrating the billing system and the financial efficiencies achieved. This will also include an evaluation of the funding currently allocated across the agencies for the purposes of eligibility determination, claim processing and data collection and analysis.

67. ***[Sen. Kirkmeyer]*** **Are there companion requests to R12 Non-Medicaid BH eligibility & claims from Human Services and other departments to reflect financial efficiencies achieved? If not, why aren't the savings showing up?**

RESPONSE

The Department and the Behavioral Health Administration (BHA) are in the process of implementing the single claims processing and data reporting systems for behavioral health programs. It is too early to project concrete savings during the development phase. Once implemented and as BHA programs become operational within the Medicaid Enterprise Solutions (MES), the departments will evaluate the efficiencies gained to the non-Medicaid programs by streamlining eligibility and reducing duplicative payments across the programs. This will also include an evaluation of the administrative efficiencies. The departments will request any resulting changes through the regular budget cycle. A key goal of implementing a single claims processing solution is to maximize the use of Medicaid funds for all eligible services being paid from other various funding sources.

The BHA submitted the FY 2023-24 R-1, Behavioral Health Administration Personnel, to request the resources necessary for the BHA to be fully operational. This includes 3.0 FTE to support the information technology infrastructure needed for its programs. Specifically, these positions support the analytical functions, including claims/billings, data, and policy associated with the MES.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) GRANT

68. **[*Sen. Zenzinger]* Please provide an overview of the planning grant for the Certified Community Behavioral Health Clinic (CCBHC) model. How do the values of the CCBHC model align and differ with the state's historic approach to behavioral health? How much new money would come to Medicaid if the state participated in the federal CCBHC demonstration program?**

RESPONSE

The Certified Community Behavioral Health Clinics (CCBHC) program is a federal initiative launched in 2014 that was designed to increase access and improve the quality of community mental health and substance use disorder (SUD) treatment services. Colorado intends to apply for a one-year planning grant, due Dec. 19, 2022, for up to $1M. If awarded the planning grant, Colorado would spend March 2023- March 2024 analyzing the model and determining how it could advance behavioral health care access and outcomes. The state would then be eligible to apply for a four-year statewide CCHBC demonstration program beginning in 2024, which provides an enhanced federal match for most services provided in a certified clinic.

The CCBHC model aligns with the recommendations of Colorado's Behavioral Healthcare Transformation Task Force and the goals of the new Behavioral Health Administration in that it was designed to provide sustainable funding, standard data reporting, expanded service availability and state-led accountability. Federal CCBHC standards are extensive and require CCBHCs serve all clients regardless of ability to pay. CCBHC designation is available to a variety of nonprofit entities, including federally qualified health centers, substance use and mental health safety net providers, and health systems, like Denver Health which was recently awarded a CCBHC expansion grant. It is not restricted to agencies currently designated as community mental health centers (CMHCs). Colorado currently has seven SAMHSA-certified agencies who have received CCBHC expansion grants which help clinics develop and provide these services independent of the state. This includes six CMHCs and Denver Health.

National evaluations and the existing Colorado CCBHCs are showing both improved access and patient outcomes including overall health, social connectedness, housing stability and daily functioning. The recent Impact Report showed that CCBHCs that are state-certified rather than SAMHSA-certified have better outcomes in terms of expansion of care, increased caseloads, hiring and quality of care. The Department plans to utilize the planning grant to define the systemic application of the CCBHC model within the greater state behavioral health system.

The state still needs to complete several planning activities to determine if the CCBHC model fully meets Colorado's needs. Stakeholders and other states have identified some risks to the model that will need to be addressed in order to secure a demonstration grant, including concerns around the connection of state and federal policy, network expansion, and the use of value-based payments.

There are many factors that will impact how many additional federal dollars the state can expect to receive under the CCBHC demonstration. The largest factor will be the timing of the end of the public health emergency (PHE) and its impacts on Medicaid enrollment. There is also uncertainty in how many entities will be certified under the demonstration. An early analysis estimates that the state would have access to an additional $50M-$200M over the course of four years should it be approved for a demonstration grant.

69. *[Sen. Zenzinger]* The CCBHC model includes a federal cost report. Will the state shift to using the CCBHC federal cost report? Would there be advantages in adopting the cost report now?

RESPONSE

Later this month, the Department g will submit, in collaboration with the Behavioral Health Administration (BHA), an application for a federal Certified Community Behavioral Health Clinic (CCBHC) planning grant. If the state is selected for the CCBHC planning grant and a subsequent demonstration grant, the state will use the CCBHC federal cost report for entities certified as CCBHCs by the BHA; separate cost reporting structures will remain for other safety net providers. For CCBHC providers that are also providing state cost reports, the Department is considering a joint report and singular process, for example for federally qualified health centers or state licensed comprehensive behavioral health safety net providers.

There are no advantages to moving to the federal CCBHC cost report now, as it is very intensive and creates a high level of administrative burden for providers to complete a federal cost report that ties to a payment model that does not currently exist within the Medicaid behavioral health program.

OFFICE OF COMMUNITY LIVING

COMMUNITY-BASED PROGRAM GROWTH

70. *[Rep. Bird]* What is driving the caseload increases for the various waivers? Why are these caseloads growing faster than the general population?

RESPONSE

The Department forecasts caseload by evaluating historical enrollment and considering any policy changes or one-time adjustments. The Department uses these factors to project enrollment growth in caseload and waiver enrollments. The growth in caseload for home and community-based services (HCBS) has remained constant over the past several years, staying at approximately 3% for the six waivers that serve a cross disability population and 4.5% for the waivers serving only people with intellectual and developmental disabilities (IDD). One factor causing the maintained increase is the steady growth in the percentage of adults served in the community rather than institutions, with 72% served in the community in calendar year 2016 and 78% in calendar year 2021. Additionally, from 2020 to 2050, the Colorado State Demography Office estimates that adults age 65 and older will nearly double in population, from roughly 876,000 to more than 1.6 million. This will continue to drive growth in caseload for the adult waivers.

Separately, it should be noted that nationwide, Medicaid enrollment has increased since the start of the pandemic, primarily because of the continuous enrollment requirement through section 6008 of the Families First Coronavirus Act (FFCRA). For Colorado, and any other state, to receive the temporary Federal Medical Assistance Percentage (FMAP) increase, the state must provide continuous coverage through the end of the month in which the emergency period ends to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances.

71. *[Sen. Kirkmeyer]* What caused the dramatic increase in the CHRP waiver enrollment in 2018?

RESPONSE

The Children's Habilitation Residential Program, or CHRP, was initially developed to provide residential services for children and youth in foster care with intellectual or developmental disabilities and very high needs. CHRP has always been the only Home and Community-Based Services (HCBS) waiver option for out-of-home residential services for children with intellectual or developmental disabilities. Because the waiver was limited to children and youth only served in foster care, waiver enrollment was relatively stagnant. Historically, families who were not otherwise connected to the child welfare system would often be forced to relinquish custody of their child in order to receive out-of-home support.

Recognizing these concerns, the General Assembly passed House Bill 18-1328, Redesign Residential Child Health Care Waiver, to authorize the Department to make significant changes to CHRP to better support children, youth, and their families. Under the authority of this legislation, the Department implemented the following changes effective July 1, 2019:

- Removed the eligibility requirement that the child or youth be in foster care;
- Added two new services to support the child or youth to remain in the family home or transition back to the family home;
- Transferred case management functions for CHRP from the County Departments of Human Services to the Community Centered Boards (CCBs); and
- Transferred the administration of CHRP from the Colorado Department of Human Services (CDHS) to the Department of Health Care Policy & Financing.

The Department has conducted, and continues to conduct, statewide stakeholder outreach and provider recruitment to increase awareness of the services available in CHRP for eligible children and youth. These changes have directly contributed to the steady year over year increase in CHRP enrollment.

Since 2019, the Department has continued to evaluate the effectiveness of CHRP in meeting the needs of children, youth, and families and has made additional changes to the waiver which have also contributed to ongoing growth in enrollment, including:

- Increased rates for residential services
- Allowing family members who are not the legally responsible party for the child or youth to provide residential and respite services; and
- Increased respite unit limits.

PRIVATE DUTY NURSING (PDN)

72. ***[Rep. Bird]*** **Please discuss the Department's utilization management processes. What is the Department doing to minimize administrative barriers that limit access to care? Does the Department plan to expand the use of this vendor for other claims? What guardrails has the Department put in place to ensure that the actions of this vendor are not inappropriately denying care? Provide 2022 data on the number of private duty nursing hours that were reduced or denied before the Department made adjustments, as well as the number of families that were impacted.**

RESPONSE

Question: Please discuss the Department's utilization management processes.

Utilization Management (UM) is a process that evaluates the efficiency, appropriateness, and medical necessity of services or supplies and the place of service on a case-by-case basis. UM is a vital component of a quality health care management program that ensures appropriate access to care and reduces inappropriate costs by reviewing and identifying services that are medically necessary, include accurate coding, are not duplicates, and are covered benefits. UM helps the Department ensure that members have access to the right services, at the right time, in the right place, and at the right cost.

Several vendors perform UM on behalf of the Department, including a contractor who performs medical necessity prior authorization requests (PARs) for outpatient fee-for-service (FFS) services and supplies, including private duty nursing (PDN). Through a competitive Invitation to Negotiate process, the Department selected Kepro to administer the FFS UM program for outpatient benefits, services and supplies, select Physician Administered Drugs, out-of-state inpatient services (which includes PDN), and the Inpatient Hospital Review Program, under the umbrella of the ColoradoPAR program. Kepro's UM and care management program national footprint includes 30 years of experience, over 10 million PARs reviewed annually, and operations with 34 state Medicaid contracts. This is more than three times the number of contracts held by the next largest UM vendor.

Additionally, Kepro's provider PAR portal, known as Atrezzo, allows providers to submit requests 24 hours a day, seven days a week. During 2021, the PAR portal served over 87,000 Health First Colorado provider users and handled, on average, over 50,000 PAR submissions monthly. The Department has received positive feedback about Atrezzo and ease of use, and the Department is committed to continuing to evaluate provider satisfaction on the PAR submission process.

Question: What is the Department doing to minimize administrative barriers that limit access to care?
UM programs are necessary to ensure fiscal responsibility, appropriate access to care and satisfaction of federal requirements. However, the Department recognizes that these programs can burden providers, so the Department is committed to working collaboratively with Health First Colorado providers and stakeholders to evaluate and improve PAR processes and policies, while also positively impacting member outcomes and provider satisfaction. Actions taken as part of the ColoradoPAR Program to date to minimize administrative barriers and provider burden include:

- Configuration of Atrezzo to perform the following:
    - Provider reporting tool so staff who submit PARs can better track the status of PARs throughout the submission, review and determination processes;
    - Clear confirmation that clinical documentation was successfully uploaded;
    - Addition of a platform that connects users to clinical reviewers for specific clinical questions about a review;
    - A status box to provide a clear explanation of the status of the PAR in the review process;
    - Ability to create a list of preferred frequently used codes that will be available to providers entering new PARs; and
    - Improved communication to providers with clear and consistent instructions regarding documentation and/or information needed to support a medical necessity review.
- New option to request a rapid review, which are PARs that are reviewed the same day when submitted before 2 p.m. each business day (or by the next business day when submitted after 2 p.m.). A Rapid Review may be selected when a lack of DME supplies that immediately and adversely impacts a Health First Colorado member's ability to perform activities of daily living, for same day diagnostic studies required for cancer treatments, or for genetic or molecular testing requiring amniocentesis.
- Increase in the number of automated reviews, which results in real-time determinations for select surgical procedures and durable medical equipment, prosthetics, orthotics and supplies.
- Addition of several PAR questionnaires, decreasing the need to request more information from the provider resulting in faster turnaround times.
- Addition of a new Kepro escalation process for PAR inquiries.
- COVID-19-related policy and PAR changes (in effect since Nov. 8, 2021) as described in a provider bulletin on the ColoradoPAR website.
- RSV-related policy and PAR changes directly impacting Health First Colorado's pediatric members and hospital partners which allows a real-time PAR determination for select services and supplies needed for a timely hospital discharge for members age 20 and younger.
- Dedicated stakeholder engagement meetings with specific provider groups (therapies, durable medical equipment, private duty nursing) which resulted in changes to policy, PAR submission improvements, and a decrease in provider complaints related to the PAR process.
- Hiring a registered nurse as a Provider Relations Specialist who provides 1:1 and group sessions offering guidance, direction and clarifications impacting dozens of DME, pharmacy, behavioral health, imaging and other providers and hundreds of members they serve.

Question: Does the Department plan to expand the use of this vendor for other claims?
The Department selected Kepro to review ColoradoPAR services and physician administered drug (PAD) requests, as described above. Kepro will begin reviewing Inpatient Hospital Review Program (IHRP) authorizations on April 3, when a new version of IHRP, IHRP 2.0, is implemented. The program was placed on hold as of April 1, 2020, in recognition of pandemic demands on hospitals, and the Department has redesigned the program, responding to the requests and feedback from our hospital provider partners, to be more focused and effective when it is started again in the spring.

Specific changes to IHRP include reviewing a smaller subset of hospital admissions, performing concurrent reviews on hospital day 6 for a subset of stays (including sepsis, cellulitis, pulmonary edema and respiratory failure, thoracic and abdominal vascular procedures), post-admission reviews on all stays at hospital day 30 and every 30 days thereafter, and supplementing ADT data for the RAE to increase effective discharge planning/transitions of care.

Question: What guardrails has the Department put in place to ensure that the actions of this vendor are not inappropriately denying care?

Kepro performs medical necessity reviews using evidence-based criteria and determines the medical appropriateness of each service requested. As with all Department contracts, Kepro follows federal and state rules, Health First Colorado benefits and payment policies, and complies with contractual service level agreements (SLAs) related to turnaround times, customer service response, information system accessibility and staffing. Examples of Kepro meeting SLAs include:

- An average speed to answer each provider call of less than one minute; Kepro has achieved less than 16 seconds for each month from October 2021 through June 2022.
- In each month, 100% of provider telephone calls, voicemails and emails are resolved within three business days.
- Of the 33,731 inbound calls to the Provider Call Center, 99.98% of calls were resolved during the initial call and calls resulting in help line "tickets" were resolved within three business days 99.99% of the time.
- Over 98% of PARs must be completed within contractual requirements, and Kepro has achieved rates at 98.3% or higher since October 2021.
- Between May 1, 2021, and June 30, 2022, Kepro approved 91% of prior authorization requests (PARs) and had a total denial rate of 9%, a rate lower than the Department's previous UM vendor.

Kepro is contractually required to utilize pediatricians when reviewing PARs for members 20 and younger. They must also employ a variety of specialists to perform PAR determinations including, but not limited to, pediatric pulmonologists, radiologists, physical medicine and rehabilitation, surgeons, and most recently, a speech language pathologist. Kepro has maintained a 100% specialty match for PAR reconsideration reviews since contract implementation. Kepro must also adhere to all federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, and requires reviewers complete EPSDT training upon hire and annually thereafter. Kepro also has internal EPSDT processes in place to ensure reviewers comply with all EPSDT-related requirements.

Kepro, as a Utilization Review Accreditation Commission (URAC) accredited, certified Quality Improvement Organization (QIO), has internal quality improvement/quality assurance and utilizes an internal quality control process. QIOs are certified by CMS and must be recertified every five years in order to maintain their QIO status. Kepro has increased the number of audits performed to better evaluate compliance to state requirements and evidence-based criteria as well as identify areas of improvement.

In addition to Kepro's internal audit process, the Department has undertaken internal clinical reviews of several benefit areas to investigate provider complaints and ensure that Kepro is following state rules,

benefits and policies. For example, the Department's team of registered nurses have performed an independent review of 80% of all private duty nursing denials and is on track to complete 100% by the end of December. The Department's clinical staff have also completed 1:1 PAR submission training for eight private duty nursing (PDN) agencies, focusing on agencies with the highest percentage of denials compared to their peers. Additionally, the Department's External Quality Review Organization audits between 200 and 300 Kepro reviews on a quarterly basis.

Question: Provide 2022 data on the number of private duty nursing hours that were reduced or denied before the Department made adjustments, as well as the number of families that were impacted.

Between November 2021 and October 2022, a total of 852 Health First Colorado members had submissions for PDN PARs that were analyzed by the Department. Of the 852 members:

- 88% (751) had full approval on at least one PAR.
    - For members with a full approval for private duty nursing, the average was 17 and a half hours per day.
- 14% (123 members) had a medical necessity denial, either partial or full, on at least one PAR.
    - Of the 14% of members who experienced either a full or partial medical necessity denial, the average hours denied were just over eight hours per day.
- For the members with a full medical necessity denial, the average request was for eight and a half hours per day.
- For members with a partial medical necessity denial, the average request was for 18 hours per day and the average approval was for 10 hours per day.

In October 2022 the Department initiated a temporary administrative approval process in response to concerns about denials and the denial process for all PDN services. All PDN PARs will receive administrative approval through Feb. 28, 2023. This means no PDN services are currently denied and no members have lost services. During this time period, the Department will evaluate and remediate the issues that were identified.

73. ***[Sen. Bird]*** **The utilization management vendor is denying private duty nursing requests and saying that nurses should delegate tasks to Certified Nurse Assistants (CNAs). What is their authority to do that? Does the vendor have authority to force providers to delegate under their own licenses? It seems as though the vendor is trying to force nurses to delegate tasks that aren't in the CNA's scope of practice.**

RESPONSE

The Utilization Management (UM) vendor uses Department regulations when reviewing private duty nursing services. The Private Duty Nursing (PDN) benefit allows for skilled face-to-face nursing that is individualized and continuous and is not available under the home health benefit. Members using this benefit require the continuous care of a Licensed Practical Nurse (LPN) or Registered Nurse (RN). Skilled

nursing assessment, planning, intervention and evaluation are implemented continuously. Documentation submitted by the Home Health agency reflects the continuous nature of the care.

The home health benefit includes intermittent skilled nursing and Certified Nurse Aide (CNA) care. This benefit supports the intermittent medical needs of members and is generally focused on providing nursing care to complete a task. Assessment, planning, intervention, and evaluation that is intermittent or performed once per task or shift. Documentation reflects the sporadic nature of the care.

In addition to skilled nursing, the benefit allows CNAs to provide additional care within the scope of their practice and, in some cases, agencies can decide if delegation is appropriate. When reviewing private duty nurse (PDN) service requests, the UM vendor reviews the submitted plan of care (POC) which outlines the medical interventions necessary to support the member's needs as ordered by the medical provider. In the POC, there may be interventions that can be done under the CNA scope of practice. Within the Nurse Aide Practice Act, Title 12 describes delegation, which may be in place in certain home health agencies. There are also interventions that can be performed by a nurse on an intermittent basis and are not continuous in nature.

The UM vendor recommends consideration of other potential benefits, including CNA and intermittent nursing services, to meet the member's needs when continuous face-to-face nursing requirements are not met. The UM vendor does not have authority to make determinations on who "should" care for members. Home health agencies determine what, if any, delegation occurs with their staff based on authority.

The Department has worked directly with individual home health providers to provide training including a review of PDN and intermittent nursing benefits as well as necessary documentation to identify the continuous nature of the care being proposed in the POC.

74. ***[Rep. Bird and Sen. Zenzinger]*** **What is driving the decrease in utilization of private duty nursing services? Does it relate to workforce challenges?**

RESPONSE

There are likely two main factors driving the 2.2% decrease in overall utilization of private duty nursing (PDN) services, though it is important to note that there has been no decrease in the utilized hours per day per member. One of those factors very likely relates to workforce challenges. The COVID-19 pandemic has resulted in unprecedented workforce shortages across the health care industry. Mothers have left the workforce at four to five times the rate of fathers; through COVID-19, women in the workforce were reduced to levels not seen since the 1980s. About 90% of nurses are women.

The Department is working closely with other state agencies to help address these challenges. Collaboration with other agencies such as the Department of Regulatory Agencies (DORA), the Colorado Department of Public Health & Environment (CDPHE), and Colorado Community College System (CCCS) allows for cross state agency workforce strategies, as each agency is responsible for a different piece of the solution. There have been several recent bills that focus on expanding the state's nursing workforce. The efforts include fee relief for nurses and nurse aides (HB 22-1298), re-engagement grants for licensed

nurses, full tuition assistance for certified nursing assistants (CNAs) (SB 22-226) and building streamlined pathways for licensed practical nurses (LPNs) to earn their Bachelor of Science in Nursing (BSN) degree. While these bills are being led by other state agencies, the Department is highly engaged with the implementation and the communications, most especially around SB22-226, to ensure Medicaid providers and our members benefit from this legislation.

Another trend that likely is contributing to the decrease in overall utilization is the shift of some members from PDN services to In-Home Support Services (IHSS). IHSS is a participant-directed service delivery option that allows participants to direct their services. The member or their Authorized Representative (AR) has flexibility and control over their services through IHSS and is encouraged to select, train, and manage attendants. For IHSS, the Nurse Practice Act (NPA) is waived, which allows members and their families to broaden their search for caregivers, often to include family members. Because of the flexibility in this service delivery option, many members choose to receive their services, including nursing services, through this option.

The Department believes it is a combination of factors, including workforce challenges and some shifting of members to IHSS, that is driving the slight decrease in utilization of PDN services.

PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

75. *[Rep. Bird]* Why was a freeze implemented on the Program of All-Inclusive Care for the Elderly (PACE)?

RESPONSE

The Program of All-Inclusive Care for the Elderly (PACE) is a per member per month capitated benefit program that provides comprehensive health care services to Medicaid members 55 and older who require assistance with activities of daily living. InnovAge, one of the five PACE organizations, is currently the only Colorado PACE provider that has a Corrective Action Plan (CAP) in place and a suspension of any new enrollments of Medicaid beneficiaries.

One of the main objectives of the PACE program is to enable older adults to live in the community as long as possible. A PACE organization is responsible for providing care that meets the needs of each participant across all care settings. Services may be provided in the PACE center, home, community and inpatient facilities. Colorado PACE serves 4,430 Medicaid members through five PACE organizations. InnovAge is the largest provider serving 2,846 Medicaid members.

On May 26, 2021, the Department, in coordination with the Colorado Department of Public Health & Environment (CDPHE) and the federal Centers for Medicare and Medicaid Services (CMS), conducted an audit of all InnovAge Colorado operations. As a result of the audit, all three agencies identified numerous concerns related to the delivery of services, timeliness of service provision, and appropriate level of staffing. The findings uncovered that Medicaid beneficiaries were not provided services in accordance with contractual and regulatory obligations. The Department concluded that InnovAge Colorado failed

substantially to provide its members with medically necessary items and services covered under PACE, which adversely affected or had the substantial likelihood of adversely affecting its participants. On Dec. 23, 2021, the Department determined that the seriousness of the deficiencies identified during the audits required the suspension of any new enrollments for all of InnovAge's Colorado centers.[17] During the suspension, InnovAge was allowed to continue serving its current members. Individuals who were seeking InnovAge enrollment during the sanction were supported in finding placement with an alternative Medicaid long-term care program.

InnovAge continues to be under an enrollment sanction. The Department and CMS have been performing regularly scheduled monitoring of InnovAge's CAP implementation. Starting the week of Dec. 5, 2022, the Department and CMS began performing an audit to validate the improvements to which InnovAge has attested. InnovAge must show significant improvement in quality and service delivery to ensure the health, safety, and welfare of its Medicaid members and demonstrate that the identified deficiencies in the initial audit will not occur again. If InnovAge is successful, the Department will determine if the enrollment sanction may be fully or partially removed and whether there should be any post-sanction monitoring requirements.

PARTICIPANT DIRECTION

76. ***[Sen. Zenzinger]*** **What is HCPF doing to support consumer direction as a model? There are concerns about the fiscal management services that are under contract with HCPF being unresponsive to clients. Can HCPF do a reprocurement earlier to get some better quality vendors in the state? Why does one vendor have a higher rate than the other? There is also a training vendor that is supposed to provide training to clients to teach them how to self direct services. Are they doing in person training and if not why not? Many clients do not learn well on Zoom and need individual in person training. How are you evaluating the quality of this vendor?**

RESPONSE

What is HCPF doing to support consumer direction as a model?

An ongoing priority for the Department is to work closely with stakeholders to identify opportunities to improve the consumer directed service delivery options. This work is done at least monthly through Participant Directed Programs Policy Collaborative (PDPPC) meetings, workgroups, surveys, and direct phone and emailed communication. Additionally, the Department participates in national learning collaboratives on consumer direction where Colorado's program and model has been repeatedly elevated. The success of this work is in large part due to the close collaboration with stakeholders and the PDPPC. Additionally, the Department is working to develop a plan for how Community First Choice

[17] Information regarding the audit and the notice of action can be found here: https://hcpf.colorado.gov/program-all-inclusive-care-elderly

(CFC), which is a Medicaid program created by the Affordable Care Act (ACA) with the goal of making home and community-based services (HCBS) accessible for more Medicaid members, may be implemented in Colorado. Importantly, CFC includes an enhanced federal matching rate.

There are concerns about the fiscal management services that are under contract with HCPF being unresponsive to clients.

The Department's oversight of the Financial Management Services (FMS) vendors includes a process to evaluate all feedback and complaints from stakeholders about their performance. The Department's FMS vendors are evaluated for their customer service performance through monthly reporting and remediation of specific complaints. While there are always opportunities to improve customer service, no widespread issues of unresponsiveness have been identified. For each of the completed FMS Annual Member Satisfaction Surveys (2020-2022), the FMS entities have been rated 4.33 on average out of 5 for their respectfulness, consistency answering phone calls, returning calls or emails within one business day, and clearly answering questions.

Can HCPF do a reprocurement earlier to get some better quality vendors in the state?

The current CDASS vendor contracts were executed in 2019 with a five-year contract term expiring in June 2024. An interim procurement is not feasible given the extensive system requirements of new vendors and the brief timeline. The Department is developing the next Request for Proposal (RFP) now, which will focus on innovation and member engagement. This will include an informal Request for Information (RFI) phase, with specific focus on feedback from the PDPPC and general stakeholder community. The procurement process for CDASS vendors is expected to take 18 months, concluding with new contracts effective in July 2024. The Department commits to stakeholder engagement on vendor services and performance measures in the development of a high-quality RFP.

Why does one vendor have a higher rate than the other?

In the procurement of the FMS vendors in 2018-2019, the Department's RFP required prospective vendors to quote a per member per month (PMPM) administrative fee. Each vendor provided its cost for services to the Department in the RFP response. The evaluation committee assessed the cost of each vendor's bid. When vendors were awarded contracts, their quotes for PMPM fees were established as the contracted rate for the entirety of the contract. The PMPM rates have no impact on member services or budgets; they are rates requested by the vendors for the purposes of conducting their contracted financial management services.

There is also a training vendor that is supposed to provide training to clients to teach them how to self direct services. Are they doing in person training and if not why not? Many clients do not learn well on Zoom and need individual in person training.

The training and operations vendor provides training to Consumer Directed Attendant Support Services (CDASS) members and their Authorized Representatives, case managers, and In-Home Support Services (IHSS) agencies. The training is offered in a variety of modalities, including in-person, virtual, self-paced, and hybrid. In March 2020, when the COVID-19 pandemic started, the Department required the vendor to transition to a virtual training approach. The transition to all virtual training was completed with no delay in training or measurable decline in the number of CDASS members enrolling in the program.

Following the Governor's termination of the state of emergency in July 2021, the Department directed the training vendor to resume in-person training upon individual request. Since then, out of over 1,000 CDASS members/Authorized Representatives trained, only a handful have requested in-person training.

How are you evaluating the quality of this vendor?

The Department evaluates the quality of the training and operations vendor through monthly and quarterly reports providing data on training and resource delivery, post-training surveys, mediation services, and customer support; monthly contractor and Department meetings; and in-depth research of stakeholder complaints sent to the Department.

77. ***[Sen. Zenzinger]*** **Consumer Directed Services where the client has access to funds (not the actual money but the ability to direct it) has shown to improve quality and reliability and often is the only available service. Why have we not expanded that model to cover services beyond home health and personal care and homemaking. This model could be used for other services such as respite care, day supports, and even home modification or transportation. We have clients unable to use services because there are no providers, but the clients could often hire someone, pay them more even if they got fewer hours they would still be able to get something. Why has this program not expanded?**

RESPONSE

Consumer Directed Attendant Support Services (CDASS) is a service delivery option for homemaker, personal care, and health maintenance activities. Services rendered utilizing the CDASS option are paid through an allocation or budget based on the member's assessed needs. This assessment is completed by the case manager. The Department agrees that participant direction is a great model for some people, which is why the Department has prioritized determining the feasibility of significantly expanding consumer directed services through the adoption of Community First Choice (CFC), in which self directed service options would become available to all members. CFC would allow all members the option to self direct their personal care, homemaker, and health maintenance activity services. The Department received funding through its HCBS spending plan under the American Rescue Plan Act (ARPA) for the administrative costs to develop a plan to implement a CFC program in Colorado.

The expansion of CDASS to other services would impact IT systems, the case management system, and other vendors, and therefore funding and resource requirements would be significant. Additionally, the ongoing work around CFC, which would expand consumer direction, would allow the Department an opportunity to evaluate the feasibility of including additional services.

For example, the Department is currently working with a contractor to explore the feasibility of utilizing Transportation Network Companies (TNCs) under the nonmedical transportation (NMT) benefit, which would allow members the opportunity to use providers such as Uber and Lyft. Pending further feasibility analysis, this service would allow members to have more control over their NMT services, just as they are able to with self directed services.

Concurrent to efforts to potentially expand consumer direction, the Department is also working to bolster the direct care providers. The Department has created a comprehensive workplan that identifies ways to recruit, train, and upskill various workers so all service needs can be met. Although there is a shortage in direct care providers across all services, the good news is that the data shows 25% net increase in registered providers since 2018.

78. ***[Sen. Zenzinger]*** **How is HCPF ensuring rate parity for consumer direction? Are Denver clients getting a higher rate than non-Denver clients as the minimum wage has driven up salary expectations everywhere in Denver? How is the requirement to pay for sick days being accounted for in the budget of clients?**

RESPONSE

How is HCPF ensuring rate parity for consumer direction?

The Department's Consumer Directed Attendant Support Services (CDASS) rates align with those of other home and community-based services (HCBS) service delivery options. Fee schedule rates are calculated to include a component for agency administrative and overhead costs. The Overhead Adjustment is a 10.75% deduction from the fee-for-service (FFS) rate to account for costs not incurred by consumer directed attendants or member/employers. CDASS member/employers have the discretion to set pay rates, with a current maximum rate of $50.57 per hour for services. The maximum pay rate adjusts with every rate increase, which was an initiative spearheaded by the stakeholder-led Participant Directed Programs Policy Collaborative (PDPPC).

Are Denver clients getting a higher rate than non-Denver clients as the minimum wage has driven up salary expectations everywhere in Denver?

The Department's established rates for CDASS include variations by geographic location. In order to qualify for the higher Denver rate, a member must reside in the City and County of Denver. The financial management services (FMS) vendors ensure that every active CDASS attendant's wage meets or exceeds either the base wage of $15.00 or the local minimum wage, whichever is higher. The average attendant wage in CDASS is $21.56, with 9% of member/employers residing in Denver.

How is the requirement to pay for sick days being accounted for in the budget of clients?

The Healthy Families and Workplaces Act (HWFA) implemented paid sick leave in Colorado in 2020. There are two types of leave available: sick leave and public health emergency leave. A CDASS member/employer's employment-related costs are deducted from their allocation. Employers have an individualized "Cost to You," which includes payroll taxes, unemployment insurance, workers' compensation, and sick time premiums. The Department received funding in HB 22-1329 to offset the cost of this premium by implementing a 1.7% rate increase, which will be effective on Jan. 1, 2023.

79. ***[Sen. Zenzinger]*** **When the consumer directed program was a pilot there was a fund for additional services where clients could use 50% of funds left over to purchase something that**

would help them stay independent. Often this was technology, some people used it for worker bonuses, etc. When this was in place there were significant savings. When this ended HCPF also started penalizing people for having left over funds saying that this showed a need was not there and reducing allocations. While HCPF stopped this practice, the narrative is out there. We have heard from CMS that the policy now allows states to have a fund for additional services. Why has HCPF has been reluctant to reinstate this? We believe it could bring the program back to what it was, which is a program that saved significant amounts of money. It also gave people a way to buy technology that can help with employment and other independence related needs. Would HCPF consider reinstating this program? When the pilot ended CMS was not allowing this but that policy was changed years ago.

RESPONSE

Funds for Additional Services (FAS) was a component of the Consumer Directed Attendant Support Services (CDASS) pilot. A portion of the member's CDASS allocation or budget was available to cover costs "for services and equipment that promote the participant's independence or that ameliorate conditions related to the participant's disability." The services and equipment could not be covered through other available Medicaid programs. These included assistive devices, home modifications, and skills training or training materials. The Department does not have data on whether cost savings were an outcome of FAS.

Since the pilot ended, the above-referenced services, which were most frequently purchased under FAS, have become available to members through state plan and waiver services. To operationalize FAS in CDASS, the Department would need federal and state approval, statute changes, and additional funding. The Department has identified this topic as a recently renewed area of interest and a potential policy enhancement and has begun further research on national best practices, including discussions with other states. In addition, the Department welcomes the development of a formal recommendation from the PDPPC regarding what members would like the ability to purchase with FAS.

The Department does not penalize members for unused CDASS allocations. Prior to the implementation of the training and operations vendor in 2015, there were some reported instances in which members who did not utilize their entire allocation would have their subsequent service amount reduced under the assumption that those services were not needed. This practice has been ended and not in place for nearly eight years. Additionally, upon implementation of the training and operations vendor, dedicated training and resources were developed to help promote member management of budgets. Because member allocations do not roll over to the next certification year, members are encouraged to manage their spending accordingly and communicate with case managers when their needs change. Since 2018, 50% of members have used over 90% of their budgets. Members are never penalized for underspending.

NURSING FACILITIES

80. *[Sen. Zenzinger]* Discuss the Department's plans to ensure that nursing facilities can maintain sufficient staffing levels after the public health emergency ends.

RESPONSE

Colorado's nursing facility reimbursement methodology is uniquely outlined in statute and, in most years, has allowed reimbursement rates to grow by up to 3.0% each year. For over a decade, this methodology has largely financially benefited the nursing facility industry, guaranteeing a year- over-year increase, while other providers' rate increases depend on an annual appropriation from the General Assembly. However, the COVID-19 pandemic increased labor costs as well as the complexity of the resident population, resulting in costs that have outpaced the statutory reimbursement increase.

To support the health, safety, and welfare of Colorado's nursing facility residents, the Department has put forth a budget and legislative strategy aimed at immediately stabilizing the industry to allow for the development and implementation of longer-term transformational efforts. The proposals put forth are informed by the requirements of House Bill (HB) 22-1247, which required the Department to meet with community stakeholders to draft a report concerning "suggested changes for permanently changing Medicaid nursing facility provider reimbursement to prioritize quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions."

The intent of the recommended increase is to ensure that nursing facility reimbursement allows Medicaid nursing home providers to remain competitive in the labor market. Full analysis and recommendations can be found in the Nov. 1, 2022 Nursing Facility Reimbursement Recommendation Report.

To support the ongoing sustainability of nursing facilities and ensure that they maintain sufficient staffing levels after the public health emergency (PHE) ends, the Department is requesting funding and a concurrent statutory amendment to increase the daily reimbursement rate in FY 2023-24 R-7, Provider Rate Adjustments. Currently, per C.R.S. 25.5-6-202, increases to nursing facility daily reimbursement rates are limited to 3%. With this budget request and envisioned statute change, Medicaid nursing facilities rates would increase by a minimum of 5.86% in FY 2023-24. Critical nursing facilities that serve a high percentage of Medicaid members would receive a daily supplemental payment in addition to the 5.86% increase. Facilities with 85-100% Medicaid utilization would receive an additional supplemental payment equivalent to $10.00 per member per day, and facilities with 75-84.99% Medicaid utilization would receive a supplemental payment equivalent to $5.00 per member per day.

While the Department is recommending that rates be adjusted to reflect high labor costs in the short term, longer-term solutions are dependent on attracting more workers into health care related fields. High labor costs are primarily a symptom of the worker shortage Colorado is experiencing. The Direct

Care Workforce Collaborative, a stakeholder-led initiative facilitated by the Department, is working to support retention and recruitment of workers through various action groups. These action groups center around training and career advancement, compensation and benefits, and value and awareness. In addition, the Department is working to promote the Care Forward Colorado program authorized through Senate Bill (SB) 22-226, which provides no-cost community college options for entry-level health care workers (i.e.: CNAs) and has engaged with Medicaid providers to expand awareness of this opportunity. The bill additionally authorized the Colorado Department of Public Health & Environment (CDPHE) to fund re-engagement efforts with individuals who have left their positions in health care to recruit them back into health care-related jobs. The Department is providing support and data to CDPHE to assist in this effort.

CASE MANAGEMENT REDESIGN

81. *[Sen. Kirkmeyer]* Demonstrate how will the proposed CMA plan will enhance and improve the provision of services?

RESPONSE

The Department worked with stakeholders to define key outcomes that must be achieved through the plan for Case Management Redesign (CMRD), including:

1. Achieving federal compliance.
2. Increasing the quality of services.
3. Simplifying the system members interface with to access services.
4. Ensuring stability of case management agencies.
5. Increasing accountability of case management agencies.

These outcomes are set forth in HB 21-1187, Long-term Services and Support Case Management Redesign. CMRD will bring Colorado into compliance with federal conflict-free case management requirements, allowing the state to maintain federal funding. Foundationally, the Department will create and mandate standardized case management training to better ensure consistency and quality statewide. Central to achieving the goal of a simplified system is the creation of case management agencies (CMAs) that serve all individuals with disabilities seeking or receiving long-term services and supports (LTSS), regardless of disability or waiver program. Through CMRD, Colorado's case management system will become less siloed, making it easier for people to access services. CMRD will remove the requirement for members to change agencies when they want to enroll into a different waiver program, including moving from children's waivers to adult waivers. The system will become much more person-centered, focused on the whole person and not just their specific disability. Requiring case management agencies to competitively bid will bring stability and allow the Department to enhance and align contractual accountability requirements. Finally, the Department will also create publicly facing provider scorecards to bring transparency to measure the outcomes of this effort.

82. *[Sen. Kirkmeyer]* Is it intended that any case manager can serve any client, either IDD or LTSS? If so, would that require a lot of training?

RESPONSE

Yes, the expectation is that any case manager will provide quality case management services to all members. Very rarely does any one person present with a singular disability type. Department data shows that the majority of Home and Community Based Services (HCBS) waiver members have two or more disabilities.

Further, this model of case management is a reflection of continued efforts to remove the silos and simplify the long-term services and supports (LTSS) system in Colorado while moving toward person-centered case management practices. Person-centered practices support the process of identifying personal preferences in a strength-based approach despite any diagnosis or disability historically used to label or categorize members. This will not preclude case managers from having a specialty in a specific type of disability or for case management agencies to organize caseload composition by waiver program, as they will need to determine what is most person-centered for the members in their defined service area. This is currently common practice among some case management agencies, both SEP and CCB. To that end, the Department is confident that continuing efforts to focus on training case managers across Colorado in person-centered case management practices for LTSS members, regardless of waiver, will have a positive impact and support equity and consistency in case management services.

83. *[Sen. Zenzinger]* How is HCPF going to assure that the organization that wins the bid is competent to work with the whole population? If a CCB wins, how do they demonstrate they can work with physical and age-related disabilities? If a SEP wins, how do they demonstrate they can work with the IDD population?

RESPONSE

Through a formal procurement process, the Department will be soliciting proposals from offerors with experience providing case management services to individuals enrolled in and enrolling into Medicaid long-term services and supports (LTSS).

The Department has worked diligently over the past 10 years to de-silo the home and community-based services (HCBS) system, including case management. To prepare CMAs for the post-solicitation transitions, all case management staff will be trained through the new Learning Management System, which will require case management staff to meet certain competencies including technical skills, soft skills, person centeredness, and disability cultural competency.

In addition, the Department is working with an American Rescue Plan Act (ARPA)-funded contractor to ensure each agency awarded a contract in each defined service area is prepared to transition at the appropriate time. This will include hiring and training staff with experience and expertise in each area of required service delivery. The contractor will support CMAs by creating both a strategic plan and communication plan with all area members and stakeholders. The contractor will also support CMAs with coordinating member transitions with the discontinuing agencies to ensure member services are not disrupted as a result of the transition.

84. *[Sen. Zenzinger]* How is HCPF managing this contract differently in terms of training and accountability? Will agencies be fined if they do not deliver per the contract?

RESPONSE

Two key outcomes of the Case Management Redesign process are to increase quality and accountability. The Department is standardizing and enhancing training content for case managers. Future training(s) will be interactive and utilize web-based and virtual instructor-led modalities through a Learning Management System (LMS). Desk aids are also being developed to provide case managers with additional educational resources and supports. The new training curriculum is scheduled to be released in FY 2023-24. The Department also has specific case management training requirements outlined in the contract to ensure all case managers have the necessary skills to provide person-centered and culturally competent case management.

To bring accountability to these efforts, the Department is also working to develop agency-specific and public-facing scorecards that report to the community the performance of all case management agencies. Scorecards will utilize statistically valid sample sizes per case management agency and will include data obtained through member satisfaction surveys, case management performance audits, and contractually required oversight metrics. The Department is also developing new reporting measures to monitor compliance with standards outlined in the contract.

Additionally, there will be over 50 support level agreements within the contract that outline requirements related to case management agencies to ensure members experience consistent, high quality case management. The Department will measure case management agency performance by new reporting metrics for each of the support level agreements through data collected from the new Care and Case Management system. The Department will provide technical assistance and training, require corrective action, and/or suspend or recover funding from case management agencies that do not meet case management requirements. With this approach, the Department is moving to a continuous quality improvement model that will improve oversight and training to achieve a high performing case management system.

85. *[Sen. Zenzinger]* How is HCPF going to measure the success of case management redesign? Do clients have any input into what is important enough to measure?

RESPONSE

The success of Case Management Redesign (CMRD) will be measured against the five key outcomes set forth in HB 21-1187: federal compliance, quality, simplicity, stability, and accountability. Input from members and other stakeholders drove the identification of these five outcomes as the goals of CMRD. Success for individual Case Management Agencies (CMAs) will include the use of scorecards, continuous quality improvement strategies (QIS), and member satisfaction surveys to measure each CMA's success in fulfilling its contractual requirements. Members and other stakeholders will have an opportunity to comment on the specific metrics to be included in the scorecards and surveys, and waiver performance measures that contribute to QIS approaches are subject to public comment. Additionally, the

Department will require each CMA to create a Community Advisory Committee that reviews all grievances, partners with the CMA to determine resolutions, and offers opportunities for community members to bring up CMA areas for improvement.

86. ***[Sen. Zenzinger]*** **Currently people in the developmental disability waivers are allowed to use case management agencies outside of the one they are assigned to--this is not going to be the case in the new model. Everyone will need to use the case management agency they are assigned to. If a current CCB wins and there are clients with long difficult histories that have left that CCB and are now forced to use them, how will HCPF manage this? Clients who have spoken out are afraid of retaliation. What happens if there are ongoing conflicts between a client and a case management agency?**

RESPONSE

The Department considered different models for Colorado's Case Management Redesign (CMRD). Other states chose to use models offering more choice but have since abandoned those models because of the increased complexity and reported lower quality case management. Based on member stakeholder and Centers for Medicare and Medicaid Services (CMS) feedback and input, the Department chose to create a simplified system that focuses on quality, accountability, and stability while coming into compliance with conflict-free case management. Although the new system will principally rely on members' location within a given service area, it will still include an option for members in certain situations to be served by an agency in a different service area.

Currently, members receiving long-term services and supports are assigned a case management agency (CMA) based on the waiver program(s) in which they are enrolled and the location in which they reside. Each CMA is required to have a complaint and grievance resolution process. If a member is dissatisfied with their assigned CMA, they are encouraged to use this process, which includes protections from retaliation, to resolve their concerns. Members can also submit complaints directly to the Department. If issues cannot be resolved, members can request to be reassigned to a different case management agency.

Under CMRD, members will be assigned a CMA based on the location in which they reside. Based on current data, the Department estimates that fewer than 4% of HCBS members statewide are served outside of their defined service area. A transparent and publicly known grievance process will be required for each CMA, which will include but not be limited to, requesting a new case manager working with their local Community Advisory Committee, and escalation to the Department to ensure protections from retaliation. If disputes cannot be resolved, members may request to be served by a different agency. For those who are currently served outside their assigned service area, the Department will create a simple process to offer them options for case management that best meet their needs in the event there is a change.

CMAs will be required to report to the Department annually the number of members they serve outside their defined service area. The Department will monitor member use of CMAs outside of their defined service area as part of CMA quality oversight and accountability.

87. ***[Sen. Zenzinger]*** **HCPF is working on a new tool for assessment for all long term care waivers. This will be followed by development of a budget algorithm to be able to assess everyone the same way and identify a range of dollars appropriate for people based on specific needs. The questions about this process include:**
    - **Is the purpose of this to cut the budget or to cut services from some groups of individuals?**
    - **This is a technology project. What is the plan if errors in the coding or back-end system are discovered? For example, if a group of people with a certain type of condition are suddenly all found ineligible or have their services cut in a way that was not intended, what will HCPF do to remedy this?**
    - **What will happen if someone goes through the budget algorithm process and for whatever reason their needs cannot be met in their assigned budget? When the Supports Intensity Scale was implemented some people had their lives torn apart because the score was rigid and there was no way to allow people to keep the supports that were working. Some people ended up in institutional settings. Others had serious medical problems, and even a death occurred as a result. What will be done to avoid that level of disruption?**

RESPONSE

In 2016, the Colorado General Assembly directed the Department to create a single assessment and support planning process for all members seeking and receiving long-term services and support (LTSS). The goals from the beginning of this project have been to create a more objective, consistent, person-centered assessment and planning process for everyone, reducing the subjectivity and variability that exists without these comprehensive and streamlined tools. One tool being developed as part of the assessment and support planning process is a Person-Centered Budget Algorithm.

- Is the purpose of this to cut the budget or to cut services from some groups of individuals?

Response:

No, the purpose of the new assessment and budget algorithm is not to cut the budget or cut services for any individuals or group of individuals. The purpose is to objectively assess the needs of all individuals seeking or receiving long-term services and supports with a single Level of Care assessment, and to apply an objective, flexible, transparent and equitable budget algorithm to determine budget tiers to be used in the person-centered support planning process. As the Department has committed to throughout this process, implementation of this initiative will not result in any reduction to the Department's budget.

- This is a technology project. What is the plan if errors in the coding or back-end system are discovered? For example, if a group of people with a certain type of condition are suddenly all found ineligible or have their services cut in a way that was not intended, what will HCPF do to remedy this?

Response:

Implementation of the new Care and Case Management (CCM) system, Level of Care Eligibility Determination Screen (LOC Screen), Needs Assessment, Person-Centered Support Plan, and Person-Centered Budget Algorithm (PCBA) will take place in four phases to ensure successful implementation with limited defects.

The implementation plan includes explicit strategies to prevent this example from occurring. There will be three stages of testing system functionality for each phase to ensure the system is working correctly, including determining eligibility for LTSS and assigning the budget algorithm tiers, once developed.

Additionally, upon initial implementation of the new LOC Screen, any member(s) found ineligible will receive a secondary manual review by the Department prior to a notice of ineligibility being sent to the member. If the initial finding is determined to be due to a system defect, the defect will be reported for immediate remediation and the eligibility determination will be corrected.

The new eligibility determination instrument will be implemented gradually for all waiver programs, preventing any group from being "cut." After sufficient member data has been collected, the PCBA will be developed. The Department will engage stakeholders throughout the development of the PCBA. This algorithm will be designed to assign each member to a budget tier. The budget tier is assigned based on members' needs relative to others receiving services, in a transparent, objective, and equitable manner. Once the algorithm is developed, it will be piloted and tested, with outcome data analyzed and the algorithm refined as necessary. The algorithm outcome, or individual budget tier, will have been disclosed to each member prior to its being used to determine their budget for services.

For those with extraordinary support needs, there will be an exceptions process. With the extensive data collection, stakeholder engagement, commitment to transparency, and rigorous testing during the algorithm development and piloting process, the Department is confident that the system will be equipped to successfully implement this change without any sudden, drastic, or unexpected changes in member services and benefits. Similarly, to the new LOC Screen implementation, the PCBA will be implemented gradually as new members enroll in programs or go through the annual reassessment process.

- What will happen if someone goes through the budget algorithm process and for whatever reason their needs cannot be met in their assigned budget? When the Supports Intensity Scale was implemented some people had their lives torn apart because the score was rigid and there was no way to allow people to keep the supports that were working. Some people ended up in institutional settings. Others had serious medical problems, and even a death occurred as a result. What will be done to avoid that level of disruption?

Response:

The Person-Centered Budget Algorithm (PCBA) will include an exceptions process that will consider elements of the member's needs that may not be captured in their assigned budget tier. This process is being designed using lessons learned from the implementation of the SIS Support Level algorithm and extensive stakeholder engagement around best practices and process improvements. One lesson

learned from the SIS implementation is the need for the exception process to be developed and codified in rules in advance of PCBA implementation, which was not the case when the SIS was implemented.

The new needs assessment is designed to capture all support needs a member seeking or receiving long-term services may have. Yet, the Department understands that no assessment or budget algorithm can fully capture 100% of the needs of every individual, and that all individual needs are unique. The exceptions process will allow for flexibility to ensure individuals continue to receive the supports and services they need, without disruption, to live safely and thrive in their homes and communities.

88. *[Sen. Zenzinger]* Discuss how the rates for the new CMAs were determined. Does the Department believe that this will affect the number of service providers?

RESPONSE

The Department does not believe the proposed ongoing case management rate will affect the number of case management service providers, as there will be one case management agency (CMA) per defined service area contracted with the Department.

The Department has taken a multiyear approach in advance of implementing Case Management Redesign to bring alignment and enhance case management rates. Largely as an outcome of these efforts, the total reimbursement for case management has increased by $15,000,000, or 20%, in permanent ongoing funding over the last five years.

As part of Case Management Redesign, R-13 includes a new rate request for only the ongoing case management rate. This new funding is an additional eight percent increase to the overall case management appropriation. The Department contracted with an external rate development vendor, Myers and Stauffer, to complete an analysis of case management tasks and the associated rate of payment. The vendor recommended that the Department streamline the reimbursement structure for case management services to include a single ongoing case management rate for all population types and set a caseload size standard. The ongoing case management rate was developed using time survey data collected from case managers, as well as feedback from the existing Community Centered Boards (CCBs) and Single-Entry Points (SEPs). The proposed rate includes all ongoing case management activities including intake, screening, and referral, which was not reimbursed through the previous rates.

In addition to the reimbursement for ongoing case management, CMAs currently receive, and will continue to receive in the future, reimbursement for other activities. CMAs receive separate reimbursements for activities including but not limited to:

- Monitoring contacts
- Rural travel add-on
- Critical incident reporting
- Appeals
- Waiting list management
- Level of Care (LOC) screen
- Needs assessment
- Intellectual and developmental disabilities (IDD) and delay determination

- Other reports and deliverables

The rates for these additional activities were developed through time studies, site visits, and feedback from existing CCBs and SEPs and went into effect in FY 2020-21. The Department's rate development vendor reviewed these rates and determined that the rates developed by the Department in FY 2020-21 appropriately reimbursed case management agencies for the work.

89. *[Rep. Sirota*] Provide more information about the $3.0 million request. What is the basis for this dollar amount?

RESPONSE

The Department is requesting $3,602,309 in FY 2023-24, including funding for:

- $336,000 for one-time costs for federally required closeout reviews.
- $2,956,309 for an increase to the case management appropriation for the new targeted ongoing case management rate, which was calculated based on preliminary rate calculations and estimated waiver enrollment. Implementation of Case Management Redesign will occur in three phases, beginning in November 2023. FY 2023-24 will only see a partial impact from the ongoing case management rate adjustment, as outlined in Table 3.2 of the R-13 request.
- $60,000 for case manager training, which was calculated based on the hourly rate to develop the learning management system and estimated number of hours needed to support the system ongoing.
- $250,000 for case management system enhancements, which was calculated based on an estimated number of pool hours needed to support the system multiplied by the current rate.

The Department is phasing in the transition of case management agencies (CMAs) starting in FY 2023-24 through FY 2024-25; therefore, additional funding is being requested in FY 2024-25 and ongoing to fully implement these efforts. The additional funding represents annualized versions of the costs described in the second and fourth bullet points above.

The Department has been working closely with the General Assembly over time to make targeted investments within the case management appropriation to support the required activities. Over the past five fiscal years, funding for case management services has increased by over 20%, or $15,000,000. This includes various adjustments such as aligning rates between Community Centered Boards (CCBs) and Single Entry (SEPs), adjusting monitoring requirements, increasing SEP case management rates, and across the board increases.

90. *[Rep. Sirota]* Why is the forecast projecting a small net increase and a larger GF decrease for the case management adjustment?

RESPONSE

The Department projected a small net increase of $36,571 in its forecast for FY 2023-24 based on minor true ups of the number of members served by the case management agencies and the projected utilization. In particular, the Department increased its projection for reassessing members under the new single assessment tool in that year based on the updated timeline for implementation of the tool. The decrease in General Fund of $565,389 is attributed to truing up the state-only funding allocated for eligibility determinations & waitlist management under case management based on FY 2021-22 actual expenditure for that component. This resulted in shifting funding from General Fund only to Medicaid funding that receives a federal match, which led to the overall reduction in General Fund. The combined impacts lead to a small total overall fund increase paired with a larger General Fund decrease.

91. *[Sen. Kirkmeyer]* How does this new rate compare to previous and current ratios for SEPs and CCBs? Did the Department analyze the impact on the quality of services?

RESPONSE

Through the Department's R-13 request, the case management appropriation would increase by $7,883,491, or about 8%, once case management redesign is fully implemented in FY 2024-25. The Department expects the proposed ongoing case management rate to support a new caseload maximum for case managers. Based on the recommendations of the Departments' rates vendor and feedback from members and families, establishing caseload standards provides a foundation for increased accountability and achieving high quality case management. The overall decrease in caseload size per case manager and the ability for a member to receive their case management services through one case management agency will increase case management quality performance.

There are currently two different rates: one for people of all ages with intellectual and developmental disabilities (IDD) who receive services from Community Centered Boards (CCBs), and one for people with other disabilities who receive services from Single Entry Points (SEPs). Once the new ongoing case management rate goes into effect for all populations, there will be an overall increase in funding for Case Management Agencies (CMAs).

The below table illustrates this analysis using forecasted caseloads for FY 2023-24. As the table shows, with the proposed ongoing case management rate in the R-13 request, the Department would be reimbursing CMAs more than if the current rates were maintained bifurcated by population type. The Department is infusing $9,093,338 into the case management rate, which includes $1,209,847 and the requested $7,883,491 through the R-13 request. The $1,209,847 is being applied to the rate because of savings in contract administrative costs as a result of the Department's moving from 44 CCBs and SEPs to 20 CMAs.

FY 2023-24	Forecasted CCB Population	Forecasted SEP Population	Combined CMA Population with New Proposed Rate
# of Members	14,976	31,898	46,874
$ Rate	$144.59	$78.84, $86.99, $91.42	$118.04

<table>
<tr><td rowspan="2">Total Forecasted Reimbursement</td><td>$25,982,900</td><td>$31,320,003</td><td rowspan="2">$66,396,241</td></tr>
<tr><td colspan="2">$57,320,903</td></tr>
<tr><td>Total Forecasted Increase</td><td colspan="3">$9,093,338</td></tr>
<tr><td>Estimated Ongoing Administrative Savings from the Redesign</td><td colspan="3">$1,209,847</td></tr>
<tr><td>Total Request</td><td colspan="3">$7,883,491</td></tr>
</table>

92. *[Sen. Kirkmeyer]* What is the source of the 1:65 caseload ratio? How was that ratio determined? Is this a Department requirement or a recommendation?

RESPONSE

The Department's rate vendor provided the Department with a recommendation to limit caseload sizes, which the Department will require for all Case Management Agencies (CMAs). The vendor also provided the Department with guidance and tools to help develop the case management rates. Using national best practices around caseload sizes, the Department established a maximum caseload ratio of 65 members to 1 case manager as part of the ongoing case management rate of $118.04 each month per member for allowable activities.

93. *[Sen. Zenzinger]* Will case management redesign lower caseloads? If so, by how much? If not, why does HCPF think this will be better?

RESPONSE

Establishing caseload limitations was identified as a case management best practice by the Department's rate vendor based on a review of other states and national standards in addition to feedback from stakeholders. Establishing a new caseload ratio is one of the driving factors in the proposed new ongoing case management rate.

Currently there is no standard for caseload size and they vary by case management agency, ranging from 25-85 members per case manager for Community Centered Boards (CCBs) to 90-165 members per case manager for Single Entry Point (SEPs) agencies. Through the Department's R-13 request, the case management appropriation would increase by $7,883,491, or about eight percent, to support the Department's initiatives focused on expanding quality case management. The proposed case management rate of $118.04 each month per member for allowable activities would standardize a best practice for caseload sizes of 65 members per case manager across all population types.

94. *[Sen. Kirkmeyer]* Does the Department believe that the new blended rate for CMAs will limit flexibility?

RESPONSE

The Department believes the blended rate will allow for more flexibility for case management agencies (CMAs). The blended rate allows CMAs the opportunity to structure their business in the best way to support all members. Both intellectual and developmental disability (IDD) and long-term services and supports (LTSS) populations have members with varying levels of support needs, and a blended rate will allow for more person-centered case management. For example, a CMA can choose to have a team of case managers who support members with more complex needs, while another team might focus on members with less complex needs. CMAs may also create specialty teams that provide specific activities such as intakes, assessments, or transitions or that focus on specific populations. The Department will allow for this flexibility in caseload structures and case management operations.

If a case management agency determines that its business model supports exceeding a 1:65 caseload ratio, to best meet the needs of members, the case management agency must submit its proposal to the Department for consideration, including its plan for oversight and how it will achieve the quality standards for its defined service area.

DEVELOPMENTAL DISABILITIES (DD) WAITLIST

95. *[Sen. Bridges]* Discuss the DD waitlist and the plan the Department developed to eliminate the waitlist in response to a 2018 bill.

RESPONSE

HB 14-1051, Develop Disability Services Strategic Plan, created section 25.5-10-207.5, C.R.S., which required the Department to develop a comprehensive, strategic plan to eliminate the Developmental Disability (DD) waiver waiting list by Nov. 1, 2014; to submit annual reports on the waiting list and implementation of the strategic plan; and to present testimony on these subjects during a joint hearing of the Joint Budget Committee (JBC) and other committees. The Department submitted the Intellectual and Developmental Disabilities (IDD) Strategic Plan on Nov. 1, 2014, and has subsequently submitted an annual update on the IDD Strategic Plan to the General Assembly, including waiting list information required pursuant to section 25.5-10-207.5(3), C.R.S. *There was no corresponding appropriation for implementation of this strategic plan.* The most recent report, from Nov. 1, 2022, can be found here. The Department has also provided annual testimony as required at the joint hearing, which is generally scheduled in January.

Just prior to the pandemic, Joint Budget Committee (JBC) staff presented a high-level option to fund the waiting list over a period of six years. This option was not further evaluated following the initial discussion with JBC staff. Projections based on current waiting list data suggest it will cost $378 million, half of which is General Fund, over a six-year timeline to eliminate the DD waiver ASAA waiting list.

There are approximately 3,388 individuals currently on the DD ASAA waiver waiting list. Ninety six percent (96%) of individuals on the ASAA waiting list are receiving other forms of Medicaid services while they wait for authorization to enroll into the DD waiver. This means that most of the people on the waiting list are receiving services but may currently need or anticipate a future need for residential services.

Because the cost of funding the waiting list is significant, the Department has worked with stakeholders and legislators to implement alternative strategies to better ensure people access to the services they need. Through these efforts the Department has steadily increased the number of Coloradans with IDD served through waivers. Since 2013, the enrollment for the DD waiver has increased from 4,384 members to 7,853 members in June 2022, a 79% increase.

During this same period the waiting list for the DD waiver has grown by 38%. Despite significant investments, the growth of enrollment and reduced waiting list continues to be shadowed by the higher growth of members being added to the waiting lists.

The Department can authorize enrollments into the DD waiver three ways:

1. New enrollments authorized by the General Assembly:
    a. HB 18-1407 (300 authorizations)
    b. FY 2019-20 long bill (150 authorizations)
    c. FY 2021-22 long bill (667 authorizations)
2. Efficient management of the churn on the waiting list (people disenrolling due to causes such as moving out of state, voluntary disenrollment, or death):
    a. FY 2021-22 (120 enrollments)
3. Reserve capacity enrollments (emergency, youth transitions, aging caregiver or deinstitutionalizations):
    a. FY 2021-22 (485 enrollments)

Because of these efforts, people often have options for enrollment when an urgent need arises. Additionally, it is believed that the number of people on the waiting list for the DD waiver is much higher than the number of people who need DD services as soon as possible. This belief is confirmed by the declination rate for the most recent new enrollments authorized by SB 21-205, which allowed for 667 one-time enrollments. Of these, there were 234 declinations recorded (35% declination rate). Most individuals who declined authorization reported that it was because they currently receive sufficient services and supports through other Medicaid benefits. Members who declined the authorizations maintain their placement date on the waiting list.

In addition to securing funding to enroll people from the waiting list into the DD waiver, the Department also heard that service limitations on the Supported Living Services waiver often pushed people to pursue emergency enrollment authorization when residential services were not the primary need. To remediate this issue, the Department requested and received approval in FY2021-22 to enhance Supported Living Services (SLS) waiver flexibility, allowing SLS waiver members to receive additional supports to more effectively meet their needs in place of enrolling into the DD waiver.

COMMON QUESTIONS - FOR WRITTEN RESPONSES ONLY

1. **What are the major cost drivers impacting the Department? Is there a difference between the price inflation the Department is experiencing compared to the general CPI? Please describe**

any specific cost escalations, including but not limited to impacts driven by employee compensation, workforce challenges, and construction costs.

RESPONSE

The primary cost driver in the Department's General Fund costs in FY 2023-24 is the anticipated end to the enhanced federal match permitted by the Families First Coronavirus Relief Act during the public health emergency (PHE). During the PHE, states are eligible to receive a 6.2 percentage point increase in the base federal medical assistance percentage (FMAP). The current forecast anticipates the enhanced FMAP will end Dec. 31, 2022, therefore leading to a significant year-over-year General Fund increase in the FY 2023-24 budget. The Department is projecting an increase of $491 million from FY 2022-23 to FY 2023-24 to fund Medicaid and CHP+ services. Over half of that amount, around $289 million, is due to the expiration of the enhanced FMAP.

In the opposite direction, the Department's request projects a year-over-year decrease for overall Medicaid caseload in FY 2023-24. Medicaid caseload grew significantly from FY 2019-20 through FY 2021-22, primarily for children and adult populations, due to the downturn in the economy, the related increase in Medicaid enrollees, and the moratorium on disenrolling Medicaid members during the PHE. In this forecast, the Department projected a decrease in overall caseload as the PHE was expected to end December 31, 2022, as of the publishing of the forecast. The Department is projecting overall growth of 2.34% in FY 2022-23 and a decrease of 11.20% in FY 2023-24. Growth in FY 2022-23 is driven primarily by income-sensitive groups which are projected to grow by 2.64%. The income-sensitive groups are also expected to drive most of the decreases in FY 2023-24 where they are projected to decrease by 11.63%. This impact is dampened by a projected increase in acute care per capita costs. Per capita costs have been lower than normal throughout the PHE as the members who are locked into Medicaid are less expensive than members who are not locked into the program. After the PHE ends, the Department will redetermine all members who are currently locked into the program and will disenroll those who no longer qualify. The Department anticipates that per capita costs will return to pre-pandemic levels. In addition, there are underlying increasing trends in inpatient hospital and pharmacy costs, as well as higher costs due to the continued growth of available specialty drugs.

For populations in which eligibility is not driven by economic conditions, such as adults 65 and older and people with disabilities, the Department is projecting growth of 0.43% in FY 2022-23 and a decrease of 8.45% in FY 2023-24. The biggest cost driver for these populations continues to be the growth in utilization of Medicaid long-term services and supports, including home and community-based services (HCBS), the Program of All-Inclusive Care for the Elderly (PACE), and long-term home health. These costs have been offset by a reduction in nursing home residents, which has historically been a significant driver of Medicaid trends for long-term care services. Over the long term, the Department expects that this General Fund growth will be driven in large part by the aging of Colorado's population. Colorado is one of the fastest growing states for older adults. Services incurred by people 65 and older, and people with disabilities who qualify for Medicaid, are paid for using General Fund and will receive a 50% federal match rate once the PHE ends.

Many providers are dealing with workforce challenges. The Department's Nov. 1 budget request R-7, Provider Rate Adjustments, includes several provider rate increases to help address these issues. The Department's proposed targeted rate adjustments include an increase for nursing facilities, which are

currently experiencing staffing shortages, cost increases, and drops in overall utilization. The proposed increase would be higher for those facilities with the highest Medicaid utilization, which are more likely to be facing financial hardship. In addition, the Department is requesting an increase for home and community-based waiver services to reflect a $15.75 per hour base wage for workers statewide and $17.29 per hour in Denver to further support the financial stability of direct care workers and maintain an adequate provider network.

The above provider rate adjustments are falling short of medical inflation as the average price of health care in the United States increased 5.0% in the 12 months ending in October 2022 after climbing 6.0% previously, according to the most recent inflation data released Nov. 10, 2022, by the U.S. Labor Department's Bureau of Labor Statistics (BLS). Prescription drugs are the top driver of rising health care costs nationally – for all payers, with specialty drugs leading the way. According to the Department of Health and Human Services (HHS), there were 1,216 drug products whose price increases during the twelve-month period from July 2021 to July 2022 exceeded the inflation rate of 8.5% for that time period. The average price increase for these drugs was 31.6%.[18] Medicaid policy at the federal level mitigates this impact only to inflation. However, new specialty drugs to market are an extreme threat to our prescription drug budget because of the prices when they are introduced to the market. In fact, as the 2021 Reducing Prescription Drug Costs in Colorado report[19] illustrates, less than 2% of prescriptions are so expensive, they are driving about 50% of Medicaid prescription drug spend. This trajectory of new drug releases is ballooning and will increase the Medicaid specialty drug spend significantly in the months and years to come. Here are some examples of the emerging gene-therapies and their prices:

- Zynteglo is a drug that treats beta-thalassemia, which is a blood disorder that reduces the production of hemoglobin. It will come to market in the first quarter of 2023 at a price of $2.8 million for one infusion treatment. It is unclear if this drug is a cure or if it puts patients in remission for some period of time.
- In November, the Food and Drug Administration (FDA) approved a gene therapy to treat people with Hemophilia B, an inherited bleeding disorder. This one-time treatment called Hemgenix will cost $3.5 million, making it the most expensive drug approved to date.
- These two drugs follow the release of Zolgensma just a few years ago, which treats SMA, a degenerative muscle condition in infants, at a one-time infusion cost of $2.1 million. Until recently, this was the highest cost drug in the U.S.
- The Department is actively tracking 10 different high cost specialty drugs at the later stages in the FDA approval cycle and another 15 that are earlier in the FDA approval cycle.

The Department's focus is on implementing all the initiatives in our above referenced Prescription Drug Report, to the betterment of Medicaid and commercial affordability. In parallel the Department is focused on ensuring proper access to these drugs for members by administering them with the proper

[18] https://aspe.hhs.gov/reports/prescription-drug-price-increases
[19] https://hcpf.colorado.gov/sites/hcpf/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20Second%20Edition.pdf

drug utilization review policy to ensure the right drugs are dispensed in the right setting for the right price and that they are achieving the expected outcomes. This includes using value-based payments to ensure manufacturers are accountable for their clinical promises on the outcomes that should be achieved for these drugs. Concurrently, the Department is monitoring emerging policies to ensure that the Department is not in any way prohibited from leveraging all the tools available to control drug spend while improving member health. Last, the Department is also actively rallying other Medicaid programs to collaborate in negotiating the prices Medicaid could be paying for these drugs with the respective drug manufacturers.

Other areas where Medicaid rates move with inflation are in services with "cost plus" reimbursements, which include community mental health centers (CMHS), federally qualified health centers (FQHCs) and rural hospitals. For these providers, Medicaid payments increase as their costs increase with inflation. Other service categories also receive automatic rate increases when required by statutory formulas. Key examples include nursing facilities (required by state statute), pharmacy (required by federal regulation), managed care rates (required by federal regulation), and Medicare premiums.

Outside of the above outliers, the Department is generally able to mitigate "price inflation" by not automatically adjusting reimbursement rates in parallel with inflation. However, this inflation mitigation is at the expense of health care provider partners, who are still facing the realities of inflation, which is especially prominent due to the impact of health care staffing agencies and the number of workers leaving the health care workforce over the last few years. A number of collaborative solutions are in place to battle both of those inflationary drivers.

The Department adjusts most rates only when additional funding is appropriated by the General Assembly. As providers experience rising costs due to factors such as wage growth or increases in rent, supplies or other costs, they generally must absorb those cost increases until the General Assembly is able to appropriate funding to increase Medicaid rates. R-7 includes a number of provider rate increases and adjustments to reimbursement for providers outside of the increases for nursing facilities and HCBS providers. This includes funding to address recommendations from the Department's annual rate review process to promote equity in reimbursement for services, including adjusting rates for physician services, lab and pathology, dialysis, injections, and eyeglasses and vision services. The Department also requests the elimination of most member co-pays, an incentive payment for rural providers, and a 0.5% across-the-board increase.

3. **How is the Department's caseload changing and how does it impact the Department's budget? Are there specific population changes, demographic changes, or service needs (e.g. aging population) that are different from general population growth?**

RESPONSE

The Department is projecting moderate, positive growth in overall caseload as the ongoing economic uncertainty is expected to continue. The Department is projecting overall growth of 2.34% in FY 2022-23 due to the continuation of the public health emergency (PHE) and the corresponding continuous

coverage requirement to receive the emergency enhanced FMAP. This is driving an increase of about $149 million in the projected budget for Medicaid services in FY 2022-23, compared to FY 2021-22, holding all other things equal. The Department is forecasting an overall decrease of 11.20% in FY 2023-24 due to the projected end of the PHE, after which members who are locked into Medicaid are expected to be redetermined and potentially disenrolled. This is driving a reduction of about $611 million in the projected budget for Medicaid services in FY 2023-24, holding all other things equal. Growth in FY 2022-23 is driven primarily by income-sensitive groups which are projected to grow by 2.64%. The income-sensitive groups are also expected to drive most of the decreases in FY 2023-24, when they are projected to decrease by 11.63%.

For populations in which eligibility is not driven by economic conditions, such as adults 65 and older and people with disabilities, the Department is projecting growth of 0.43% in FY 2022-23 and a decrease of 8.45% in FY 2023-24. The projected growth is informed by projections of the aging population and historical growth of people with disabilities. The state demographer indicated that the 65 and older adult population in Colorado increased by 43% from 2010-2017, compared to 14% for the rest of the state's population, and is projected to increase by nearly 70% by 2030. The biggest long-term cost drivers for these populations continue to be the growth in utilization of Medicaid long-term services and supports, including home and community-based services (HCBS), the Program of All-Inclusive Care for the Elderly (PACE), and long-term home health. Over the long term, the Department expects this General Fund growth will be driven in large part by the aging of Colorado's population. Services incurred by people age 65 and older and people with disabilities who qualify for Medicaid are paid for with General Fund and generally receive the standard federal match rate. Federal contributions for this population are currently receiving an additional 6.2 percentage points from the Families First Coronavirus Response Act (FFCRA) during the PHE. The Department expects this enhanced federal fund rate to expire at the end of the PHE, upon which the state would need to resume paying the full General Fund share at 50%.

4. **Provide a list of any legislation with a fiscal impact that the Department has: (a) not implemented, (b) partially implemented, or (c) missed statutory deadlines. Please specifically describe the implementation of ongoing funding established through legislation in the last two legislative sessions. Explain why the Department has not implemented, has only partially implemented, or has missed deadlines for the legislation on this list. Please explain any problems the Department is having implementing any legislation and any suggestions you have to modify legislation.**

RESPONSE

Total HCPF-Related Bills 2008-2022: 392

Not Fully Implemented Bills with a HCPF Fiscal Impact 2008-2022: 5

The Department has records of the status of implementation for legislation dating back to 2008. Over the last 14 years, the Department has successfully implemented over 318 bills. Since Medicaid is

governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that require federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval which was denied. Without federal financial participation, the Department was unable to implement these bills.

Legislation	Legislation Summary	Barriers to Implementation
HB 21-1166 Cross-System Behavioral Health Crisis Response as it Relates to Persons with Intellectual and Developmental Disabilities	This bill makes an appropriation for the Department to obtain a vendor for the training of twenty (20) service providers, case managers, and mental health counselors state-wide in a comprehensive care coordination and treatment model.	The Department issued a solicitation for a Documented Quote (DQ) to secure a vendor to conduct the training as outlined in the bill. The DQ was issued from Sept. 27, 2021, through Oct. 6, 2021. This was six (6) days longer than the typical three (3)-day response request period. The Department did not receive any responses to the DQ solicitation. Due to the specificity written in the bill for the requirements of a vendor, there are limited vendors in the nation who meet the criteria to provide the type of training solicited. The vendor the Department anticipated would respond to the DQ solicitation was not able to respond in the time frame due to a contract they were engaged in with a project for the City and County of Denver. The potential vendor indicated that they would not be able to perform the work required in the bill in accordance with the time frames required in the bill. The Department reposted the DQ and the vendor did provide a response. The vendor did not fully address all of the requirements listed in the DQ in their response. The Department is working through this with the vendor and anticipates the ability to execute on a contract in early 2023.
SB 19-005 Import Prescription Drugs from Canada (Rodriquez, Ginal/Jaquez Lewis)	This bill creates a new program in the Department called the Canadian Prescription Drug Importation Program. Under the bill,	The Importation Program, SB 19-005, has been in the implementation phase since 2019. Based on statute, it was estimated that the program would be operational by December 2020 with our first annual report for 2021 reporting on savings achieved through the program. Due to reliance

	the Department must submit a federal waiver application to legally import prescription drugs from Canada. Once approved, the Department will work to design a safe and affordable system to import quality medications at a lower cost for all Coloradans.	on the federal rulemaking process, and the need for federal approval, the program continues to be in the developmental stage. Supply chain partners were identified in mid-2022 and the Department submitted a formal application to the federal government in December 2022. After the federal review and approval process, importation can begin, likely in late 2023 at the earliest.
SB 16-120 Review by Medicaid Client for Billing Fraud (Roberts/Coram)	The bill requires HCPF to provide explanation of benefits (EOB) statements to Medicaid members beginning July 1, 2017. The EOB statements must be distributed at least once every two months and HCPF may determine the most cost-effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only. The bill specifies the information to be included in the EOB statements, including the name of the member receiving services, the name of the service providers, a description of the service provided, the billing code for the service and the date of the service.	The SB 16-120 project is on hold due to COVID-19, implementation of legislative bills, and audits that need to be implemented next year in the eligibility system. SB 16-120 continues to remain on hold while further assessment and evaluation is conducted. The Program Eligibility Application Kit (PEAK) portal's account access and management is at the head of household level and not the individual member level. To maintain member privacy, PEAK would require significant changes to allow individual level access. The Department continues to explore feasible opportunities to grant individual level access to member claims data, which include but are not limited to, new requirements for Blue Button and the reprocurement of CBMS.

HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.	The Department has not yet implemented HB 15-1318, a fully consolidated Intellectual and Developmental Disabilities (IDD) waiver. The Department's actuarial findings from this work reveal a significant fiscal impact of a redesigned consolidated waiver for which there was no appropriation. Because of this fiscal impact and the lack of ongoing direct service funding associated with HB 15-1318 to implement this mandate, the Department is taking steps to move the work forward with smaller, incremental changes that will provide a better and more thoughtful experience for members receiving services.
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	The Department cannot implement this bill as written because it is contingent upon federal financial participation. In order for the state to receive federal financial participation, hospice providers must bill for all services and 'passthrough' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through State Plan or waiver to reimburse class I nursing facilities directly for room-and board, or to pay a provider licensed as a hospice as if they were a licensed class I nursing facility. Although licensed inpatient hospice facilities are a hospice provider type recognized by the Colorado Department of Public Health & Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.

5. **State revenues are projected to exceed the TABOR limit in each of the next two fiscal years. Thus, increases in cash fund revenues that are subject to TABOR will require an equivalent amount of General Fund for taxpayer refunds. Using the attached spreadsheet, please:**
    a. **List each source of non-tax revenue (e.g., fees, fines, parking revenue, etc.) collected by your department that is subject to TABOR and that exceeds $100,000 annually. Describe the nature of the revenue, what drives the amount collected each year, and the associated fund where these revenues are deposited.**

b. For each source, list actual revenues collected in FY 2020-21, and projected revenue collections for FY 2021-22 and FY 2022-23.

c. List each decision item that your department has submitted that, if approved, would increase revenues subject to TABOR collected in FY 2022-23.

RESPONSE

The following table lists each of the Department's sources of nontax revenue that is subject to TABOR that exceeds $100,000 annually. The table also shows the revenues collected in FY 2021-22 and the projected revenue collections in FY 2022-23 and FY 2023-24. The Department did not submit any FY 2023-24 decision items that would increase revenues subject to TABOR.

Nontax Revenues Collected by Department That Are Subject to TABOR (excluding sources that amount to less than $100,000/year)				
Revenue Source	Associated Cash Fund	Revenues Collected Annually		
		FY 2021-22 Actual	FY 2022-23 Projection	FY 2023-24 Projection
Motor Vehicle Registrations Per 42-3-217.5 (3)(c), C.R.S., a $25 surcharge on breast cancer awareness special license plates is to be deposited in the Eligibility Expansion Account. Because the eligibility expansion has been authorized, ongoing revenue collections are deposited in the main fund.	Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D0)	$819,666	$856,523	$925,120
Children's Basic Health Plan Premiums Premiums are collected from families of Child Health Plan *Plus* enrollees who enter the program. Premiums are $25 for families with one child enrolled and $35 for families with two or more children enrolled. Any families that are below 150% of the federal poverty level (FPL) do not pay a premium. Revenue is driven by the number of families enrolled in the program and the household size and federal poverty level of each family. As of FY 2022-23 CHP+ Premiums were eliminated.	Children's Basic Health Plan Trust (Fund 11G0)	$157,784	$0	$0

Nontax Revenues Collected by Department That Are Subject to TABOR (excluding sources that amount to less than $100,000/year)				
Revenue Source	Associated Cash Fund	Revenues Collected Annually		
		FY 2021-22 Actual	FY 2022-23 Projection	FY 2023-24 Projection
Health Care Service and Provider Fees Service fees are collected from private and public intermediate care facilities who provide care for individuals with intellectual disabilities. The fee level is set by the Medical Services Board, not to exceed 5% of the total costs incurred by all intermediate care facilities. Revenue is driven by the number of private and state operated intermediate care facilities that the Department collects fees from. Provider fees are collected pursuant to section 25.5-6-203, C.R.S. The Department is required to collect a Quality Assurance Fee from nursing facilities, including facilities that do not serve Medicaid members. Each year, the fee is increased by inflation based on the national skilled nursing facility market basket index determined by the Secretary of Health and Human Services for future years. In FY 2021-22, the provider fee could not exceed $16.06. and, in FY 2022-23, the provider fee shall not exceed $16.64.	Service Fee Fund (Fund 16Y0) and Medicaid Nursing Facility Cash Fund (Fund 22X0)	$56,403,821	$53,641,820	$54,778,815
Medical Premiums Premiums are paid by members eligible for and participating in the Medicaid Buy-In Program based on a sliding-fee scale. Revenue is driven by the number of members who participate in the program.	Medicaid Buy-In Cash Fund (Fund 15B0)	$0	$3,400,794	$6,481,548
Medicaid Provider Enrollment Fees Fee revenue currently consists of provider screening fee revenue which, pursuant to federal regulations under 42 CFR § 455.460, must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government. Revenue is driven by the number of Medicaid providers that need recertification and the number of new	Department of Health Care Policy & Financing Cash Fund (Fund 23G0)	$547,680	$547,680	$547,680

Nontax Revenues Collected by Department That Are Subject to TABOR (excluding sources that amount to less than $100,000/year)				
Revenue Source	Associated Cash Fund	Revenues Collected Annually		
		FY 2021-22 Actual	FY 2022-23 Projection	FY 2023-24 Projection
providers undergoing background checks to become a Medicaid provider.				
Other Intergovernmental Revenue The Department receives an annual intergovernmental transfer from Denver Health to assist with payments to eligible nursing facilities to expand access for patients who require special long-term services and supports because of physical, behavioral, and/or social complexities. The amount is expected to remain at $700,000.	General Fund (Fund 1000)	$613,200	$700,000	$700,000
Operating Transfer from TABOR Enterprise There is an annual transfer from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Cash Fund to the Department to offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums. The expected annual transfer amount is $15,700,000 in subsequent years. There was also a transfer of $203,606 in FY 2021-22 for the CBMS Staff Development Center.	General Fund (Fund 1000)	$15,903,606	$15,700,000	$15,700,000

Nontax Revenues Collected by Department That Are Subject to TABOR (excluding sources that amount to less than $100,000/year)				
Revenue Source	Associated Cash Fund	Revenues Collected Annually		
		FY 2021-22 Actual	FY 2022-23 Projection	FY 2023-24 Projection
Interest Nonexempt interest income is received from various cash fund balances. The amount of interest income is based on the balance of each cash fund. The Department has three cash funds that received nonexempt interest income above $100,000 in FY 2021-22. As of FY 2022-23, the Intellectual and Developmental Disabilities Services Cash Fund is repealed. Per statute, any interest from the HCSI cash fund shall go to General Fund.	Intellectual and Developmental Disabilities Services Cash Fund (Fund 27U0), Adult Dental Fund (Fund 28C0), and the Home and Community-Based Services Cash Fund (HCSI)	$3,011,271	$131,074	$131,074
TOTALS		**$77,533,495**	**$74,977,891**	**$79,264,237**

6. **Recent trends in funded and actual full time equivalent employee positions.**
    a. **Please use the attached spreadsheet to summarize the department's funded and actual FTE for the last three fiscal years.**
    b. **Please use the attached spreadsheet to identify the origin of changes in funded FTE for FY 2021-22, including the number of new positions the Department has been able to fill.**
    c. **If positions have not been filled, please respond to the following:**
    d. **How have vacancy savings been utilized?**
    e. **What challenges are preventing positions from being filled?**

RESPONSE

Part A: Please summarize the Department's funded and actual FTE for the last three fiscal years.

Trend Information: Funded FTE and Actual FTE				
Fiscal Year	Funded FTE*	Actual FTE	Actual Above/(Below) Funded FTE	% Difference
2019-20	544.6	565.6	21.0	3.9%
2020-21	557.3	604.0	46.7	8.4%
2021-22	654.9	629.6	(25.3)	-3.9%
FTE Change over 3 years	110.3			
% Change over 3 years	20.3%			

* "Funded FTE" equals the number of full time equivalent positions specified in the annual Long Bill or in appropriation clauses in other acts. These FTE figures reflect the number of positions that correspond to the amounts appropriated which include ARPA positions.

Part B: Please identify the origin of changes in funded FTE for FY 2021-22, including the number of new positions the Department has been able to fill.

FY 2021-22: Status of New Funded FTE				
Fiscal Year	**Funded FTE**	**Actual FTE**	**Actual Above/(Below) Funded FTE**	**% Difference**
TOTAL BASE: 2020-21	**562.2**	**539.9**	**(22.3)**	**-4%**
Decision Items:				
FY 2021-22 BA-10 Public Health Emergency	2.0	2.0	**0.0**	**0%**
FY 2021-22 BA-15 Implement eConsult	1.9	1.9	**0.0**	**0%**
FY 2021-22 R-9 Patient Access and Interoperability	1.0	1.0	**0.0**	**0%**
FY 2021-22 R-10 Convert Contractor to FTE	13.5	13.5	**0.0**	**0%**
FY 2021-22 S-10 PHE End Resources	(0.5)	(0.5)	**0.0**	**0%**
FY 2021-22 CUSOM Clinical Revenues IGT	1.8	1.8	**0.0**	**0%**
HB 20-1384 (SB 19-195) Wraparound Comeback	4.0	4.0	**0.0**	**0%**
Bills:				
HB 21-1085 Secure Transport BH	0.9	0.9	**0.0**	**0%**
HB 21-1198 Health Care Billing Indigent	0.7	0.7	**0.0**	**0%**
HB 21-1232 Establish Standard Health Benefit	0.8	0.4	**(0.4)**	**-50%**
HB 21-1275 Medicaid Reimb for Pharmacist	1.6	1.6	**0.0**	**0%**
SB 21-009 Reproductive Health Care	3.4	2.4	**(1.0)**	**-29%**
SB 21-025 Family Planning Services	1.8	1.8	**0.0**	**0%**
SB 21-038 Expansion of Alternative Medicine	0.9	0.9	**0.0**	**0%**
SB 21-039 Elimination of Subminimum Wage	1.3	1.3	**0.0**	**0%**
SB 21-137 Behavioral Health Recovery Act	2.8	1.9	**(0.9)**	**-32%**
SB 21-194 Maternal Health Providers	0.7	0.0	**(0.7)**	**-100%**
SB 21-286 FF ARPA for HCBS	4.6	4.6	**0.0**	**0%**
FY 2021-22 S-10 HCBS ARPA Spending Authority	49.5	49.5	**0.0**	**0%**
FTE changes unrelated to decision items or bills	0.0	0.0	**0.0**	**0%**
TOTAL: 2021-22	**654.9**	**629.6**	**(25.3)**	**-4%**

Vacancy savings are considered as the difference between the cost to fully fund all approved positions and what is spent for personal services because positions were not filled for the duration of the year. Vacancy savings are one-time in nature, and information regarding vacancy savings is not available on a systematic basis and cannot be quantified in available records as stipulated in the first bullet of this question. Bonuses or additional pay such as overtime are mechanisms that are often used to reallocate work on a temporary basis to existing staff. This information can be found in the annual burn report as well as the Schedule 14. Vacancy savings cannot be used to hire additional permanent staff, only temporary staff.

The Department recognized opportunities within the recruitment and intake processes to create recruitment efficiencies. The Department has created a step-by-step guide for the workflow process to

streamline recruitment efforts in order to hire qualified candidates in a timely manner, thereby preventing positions from being vacant. Additionally, the Department is in the process of standing up a project management tool to manage recruitment efforts for all positions. The Department also recognizes that IT and Finance roles are particularly difficult to fill, given competition with market wages for similar roles in the private sector. The Department is exploring available strategies, including special pay plans for targeted classifications.

APPENDIX A

Question 13 References Cited on the Efficacy of Doula Services

Department of Health (2022). New York State Doula Pilot Program. Retrieved November 23, 2022, from https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm#:~:text=The%20New%20York%20State%20Medicaid,and%20doula%20and%20member%20satisfaction.

Elevance Health Public Policy Institute (2022). Addressing Maternal Health Disparities: Doula Access in Medicaid. Retrieved November 23, 2022, from https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/54/EH_Doula_R4.pdf

Falconi, A. M., Bromfield, S. G., Tang, T., Malloy, D., Blanco, D., Disciglio, R. N. S., & Chi, R. N. W. (2022). Doula care across the maternity care continuum and impact on Maternal Health: Evaluation of Doula programs across three states using propensity score matching. *EClinicalMedicine*, *50*, 101531. https://doi.org/10.1016/j.eclinm.2022.101531

Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on Healthy Birth Outcomes. *The Journal of Perinatal Education*, *22*(1), 49–58. https://doi.org/10.1891/1058-1243.22.1.49.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/

Hans, S. L., Edwards, R. C., & Zhang, Y. (2018). Randomized controlled trial of doula-home-visiting services: Impact on maternal and infant health. *Maternal and Child Health Journal*, *22*(S1), 105–113. https://doi.org/10.1007/s10995-018-2537-7

HealthConnect One (2014). The Perinatal Revolution: Promotion and Support of Community-Based Doula Programs Report. *U.S. Department of Health and Human Services Health Resources and Services Administration. Grant Number G30MC11085.* https://healthconnectone.org/wp-content/uploads/2020/03/The-Perinatal-Revolution-CBD-Study.pdf

Heaman, M. (2009). A randomized controlled trial of continuous labor support for middle-class couples. *MCN: The American Journal of Maternal/Child Nursing*, *34*(2), 133. https://doi.org/10.1097/01.nmc.0000347314.98024.46

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2012). Continuous support for women during childbirth. *The Cochrane database of systematic reviews*, *10*. https://doi.org/10.1002/14651858.CD003766.pub4

John McConnell, K., Kaufman, M. R., Grunditz, J. I., Bellanca, H., Risser, A., Rodriguez, M. I., & Renfro, S. (2020). Project nurture integrates care and services to improve outcomes for opioid-dependent mothers and their children. *Health Affairs*, *39*(4), 595–602. https://doi.org/10.1377/hlthaff.2019.01574

Kozhimannil, K. B., Attanasio, L. B., Hardeman, R. R., & O'Brien, M. (2013). Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of Midwifery & Women's Health*, *58*(4), 378–382. https://doi.org/10.1111/jmwh.12065

Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. (2013b). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American Journal of Public Health*, *103*(4). https://doi.org/10.2105/ajph.2012.301201

Kozhimannil, K. B., Attanasio, L. B., Jou, J., Joarnt, L. K., Johnson, P. J., & Gjerdingen, D. K. (2014). Potential Benefits of Increased Access to Doula Support During Childbirth. *The American Journal of Managed Care, 20*(8). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5538578/

Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth*, *43*(1), 20–27. https://doi.org/10.1111/birt.12218

Mallick, L. M., Thoma, M. E., & Shenassa, E. D. (2022). The role of doulas in respectful care for communities of color and Medicaid recipients. *Birth*, *49*(4), 823–832. https://doi.org/10.1111/birt.12655

National Health Law Program (2022). Doula Medicaid Project. Retrieved November 28, 2022, from https://healthlaw.org/doulamedicaidproject/

Parikh, S. & Gannon, M. (2021). Impact of Long-Term Doula Services on Maternal and Fetal Health Outcomes in Women in Treatment for Opioid Use Disorder. *Phase 1.* Paper 3. Retrieved on November 23, 2022, from https://jdc.jefferson.edu/si_hs_2023_phase1/3

Struass, N, Sakala, C. & Corry M. P (2016). Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. *The Journal of Perinatal Education, 25*(3), 145–149, http://dx.doi.org/10.1891/1058-1243.25.3.145. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6265610/pdf/sgrjpe_25_3_A3.pdf

Thomas, M.-P., Ammann, G., Brazier, E., Noyes, P., & Maybank, A. (2017). Doula services within a healthy start program: Increasing access for an underserved population. *Maternal and Child Health Journal*, *21*(S1), 59–64. https://doi.org/10.1007/s10995-017-2402-0

Joint Budget Committee Hearing Health Care Policy & Financing

Dec. 21, 2022

Kim Bimestefer, Executive Director & Chief Executive Officer
Cristen Bates, Behavioral Health Initiatives & Coverage Office Director
Ralph Choate, Chief Operating Officer
Charlotte Crist, Cost Control & Quality Improvement Office Director
Adela Flores-Brennan, Medicaid Director
Tom Leahey, Pharmacy Office Director
Bettina Schneider, Chief Financial Officer
Bonnie Silva, Office of Community Living Director

Thank you for your partnership

- Covering 1.7M Coloradans
- That's 1 in every 4 Coloradans
- 43% of births
- 43% of the state's children

- COVID-19 economic downturn increased need for Medicaid
- 37% growth through pandemic, 460,000+ Coloradans, *and we met that need together*
- Medicaid Expansion Adults category grew by 84% (49% of overall growth)

"I wouldn't be able to afford [my daughter's] medications if we didn't live here and Colorado Medicaid didn't make it so simple." Member

Mission: Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

- Health First Colorado (Colorado's Medicaid Program)
- Child Health Plan *Plus*
- Buy-In Programs
- The Colorado Indigent Care Program
- Long-Term Services and Supports
- Dental Program

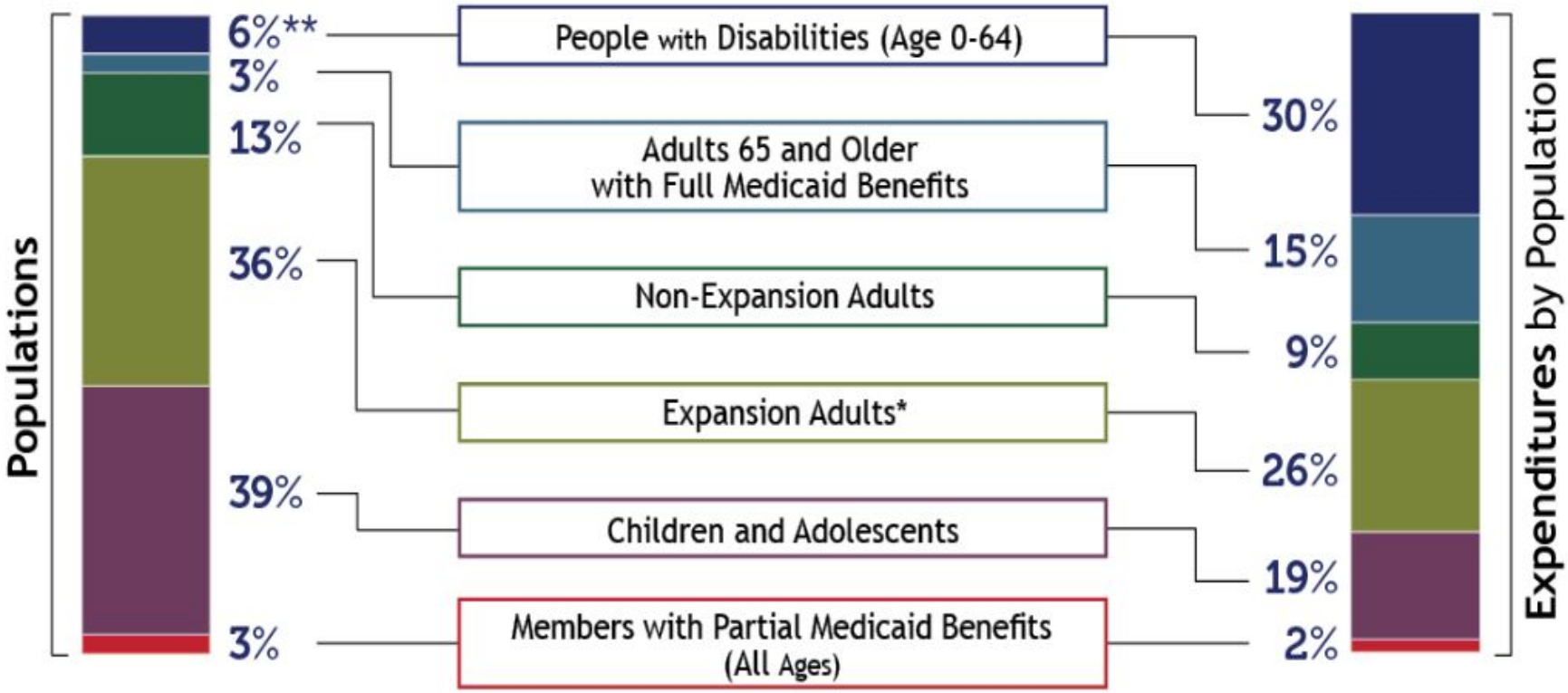
$14.9B Total Funds
$4.43B General Funds

30% of the total state General Fund operating budget

4% allocated to cover administrative expenses like staff and contracted partners

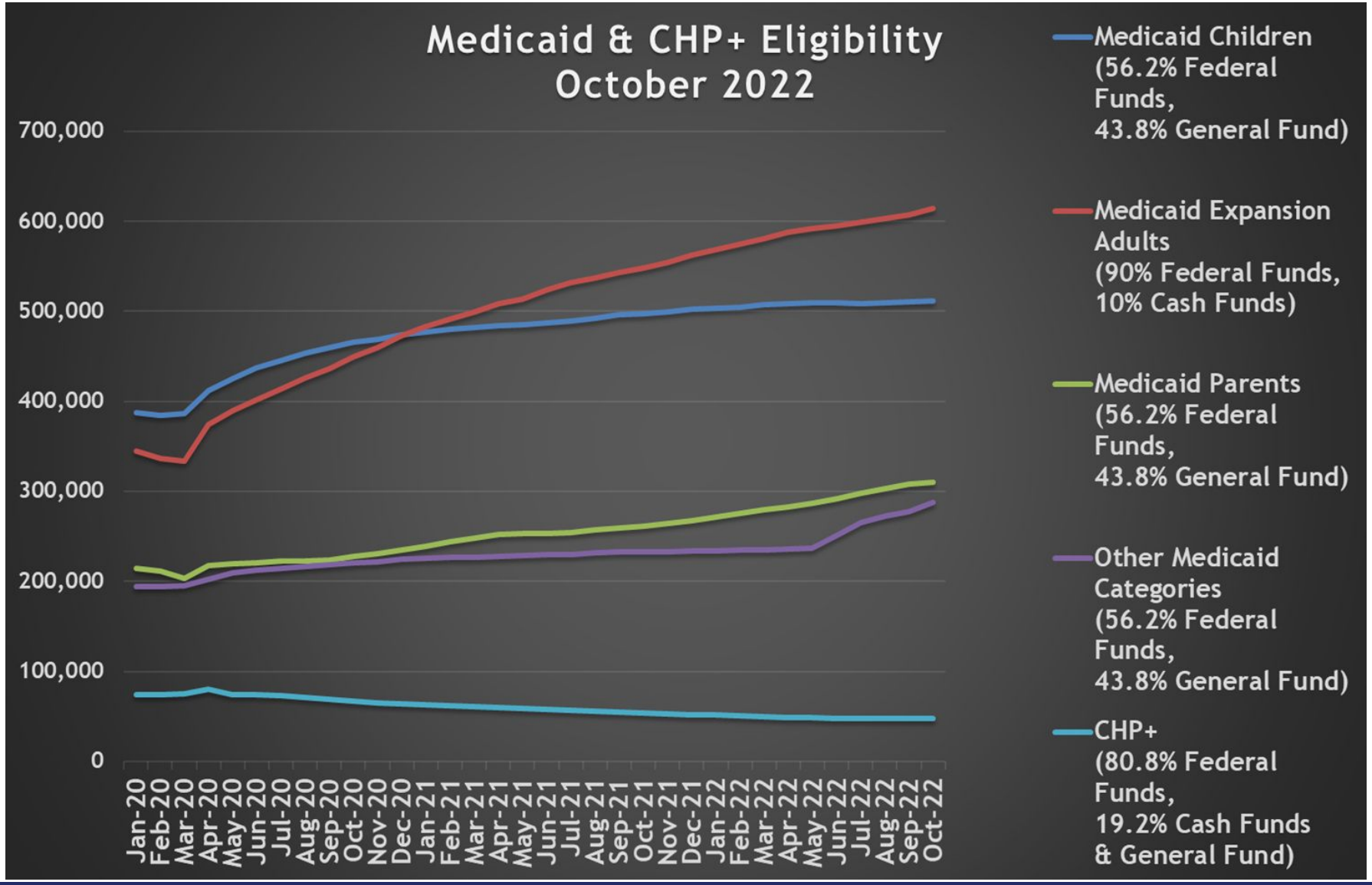
96% of our funding continues to go to providers

Who is covered and what does it cost?



Patient Protection and Affordable Care Act (ACA) Medicaid Expansion. Due to rounding, percentages may not total 100%. *The majority of funding for Expansion Adults is federal dollars, with the state fund source funded by the Healthcare Affordability and Sustainability Fee. **Not all members with disabilities use long-term services and supports.

Past Member Growth. Pending Decline >300k



End of PHE goals, redetermining 1.7M members, est. >300k disenrollment

Goals

1. Member continuity of coverage
2. Member experience, smooth transitions
3. Minimize impact to eligibility workers and state staff

Initiatives and Tactics

- Correspondence clean up
- Contact info refresh
- Educating, targeting
- Automation advances
- C4H partnership
- Educating providers
- And more

Workforce Impact

Free education!

Take advantage of free, short-term health care training with Care Forward Colorado!

In a year or less, become certified in one of these in-demand professions:

- Certified nursing assistant (CNA)
- Emergency medicine
- Phlebotomy
- Medical assisting
- Dental assisting
- Pharmacy technician

Learn more:

https://cccs.edu/new-students/explore-programs/care-forward-colorado/

Take advantage of free education courses to become a child care professional!

Enroll in free Early Childhood Education (ECE) 101 and 103 courses at a local community or four-year college. ECE 101 and 103 are the minimum coursework required to become a child care professional.

Learn more:

coecstimulus.com/faq-free-101-and-103-coursework

Responding to unique provider needs

COVID-19's impact didn't affect providers equally. **Our targeted rate increases** reflect that reality:

Nursing Homes - lower margins, staffing crisis, changing consumer preferences/needs - perfect storm. Need for industry transformation.

Home and Community-Based Services - wage challenges with growing need for direct care workers.

Struggling hospitals: rural, community and our Denver Health safety net.

Provider rate increase approach

Calculation of across-the-board (ATB) provider rate increase

- R-7 equivalent to 3% ATB increase: $70M GF
  - funding for targeted adjustments for providers with critical shortfalls
- Remainder directed to 0.5% ATB, which compares to a 1% average over the last 5 years

FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	Average
1.0%	-1.0%	2.5%	2.0%	0.5%	1.0%

- Co-pay elimination increases provider reimbursements by $8.7M TF ($1.7M GF) and reduces provider admin burden
- MPRRAC increases without balancing decreases = +$8M GF

Importance of Managing Medicaid Medical Trend

- **Goal:** Protect benefits, provider reimbursement rates, eligibility access to Medicaid programs
- **Challenge**: Medical CPI is increasing 50% faster than CPI.
  - CY 2000-2020: CPI 71.3%; Medical CPI 110.1% (KFF)
  - PwC's Health Research Institute (HRI) projects **6.5%** medical cost trend in 2022 and 7% in 2021
  - Medicaid Cost Trends: 2.4% PMPM. 12.9% Paid (member growth of 10.3%)
- Impacting 30% of the state's GF operating budget

Quality, health equity and innovation to manage cost trends

- **Utilization Management**: Right care, right place, right time, right outcome, right price
- **Population Health**: Maternity, Diabetes focus
- **Health Equity**: COVID-19 vaccination, Maternity, Behavioral Health, Prevention
- **Complex Case Management**: High need, high cost members
- **Innovations**: Prescriber Tool, eConsults, Providers of Distinction drive better provider decisions, quality, efficiency
- **Value-Based Payments**: Hospital Transformation Program, Primary Care, Maternity, Prescriber Tool, Behavioral Health, Nursing Home/PACE, Providers of Distinction

Prudent cost controls and innovations battle medical trend and future state budget challenges in order to protect member benefits, provider reimbursements and eligibility access while increasing quality and closing disparities.

Leveraging our solid foundation

- **Expanded network access to care:** added over 23K providers (30%), 739 pharmacists (+32%), 2,578 (+29%) behavioral health
- **Exceeded service standards:** claims paid (<6 days), calls answered (<80 sec)
- **Transformational eligibility automation**: >60% for those eligible, >30% all renewals
- **Implemented system changes to advance policy:** executed 171 internal IT projects with zero defects in MMIS, medical claim system, since Sept.1, 2019
- **Controlled Medicaid cost growth:** 2.4% PMPM
- **Kept Admin Low: <4%** of spend (carriers 13.5%+); FTE <0.43% of spend
- **Protected member benefits, provider reimbursements** through fiscal crisis
- **$1.5B in add'l FMAP (6.2%)** through Dec. returned to the JBC/General Assembly over 12 quarters
- **Stabilized system** with $147M in relief payments to NHs and HCBS providers FYs 2019-21

Leverage Transformational Work

- **ARPA investments**
  - $530M HCBS funding 63 projects, incl $15/hour base wage increase ($15.75 this budget)
  - $10M rural hospitals/clinics affordability and access + $17.4M rural connectivity & access to virtual care (and $12M in HTP assistance fund)
  - $32M to advance integrated behavioral health
- **Nursing home investments & industry transformation**
- **Innovations**: eConsults, Telehealth, Prescriber Tool, Providers of Distinction
- **Advanced value-based payments** to reward quality, equity, affordability
- **Driving health equity** priority initiatives to tackle health disparities
- **Designing ACC 3.0**, our delivery model

$14.9B Total Funds, $4.43B General Funds (30% of state's GF operating budget)

- Increase of $673M TF, $346M GF, most from:
  - $178M GF - utilization growth (1.5M Medicaid/CHP+)
  - $142M GF - provider rate increases
- Discretionary budget requests ($73M):
  - R6 | Supporting PCMP Transition with Value-Based Payments
  - R7 | Provider Rate Adjustments
  - R8 | Cost and Quality Indicators
  - R9 | Advancing Birthing Equity
  - R10 | Children and Youth with Complex and Co-Occurring Needs
  - R11 | Compliance
  - R12 | Behavioral Health Eligibility and Claims Processing Operations
  - R13 | Case Management Redesign
  - R14 | Convert Contractor Resources to FTE
  - R15 | Administrative Technical Request

Budget summary: CO.gov/HCPF/legislator-resource-center

Discretionary budget requests focus on:

Provider rate increases

- 0.5% across-the-board rate increase
- Targeted adjustments for nursing homes
- Increased base wages for home and community-based services workers
- Incentive payment for rural providers
- Eliminating most co-pays paid by members

Health equity

Improving health equity for our members

Quality

Resources to improve quality and ensure compliance

Children, Youth

Supporting children and youth with complex needs

Improve-ments

- BHA claims processing
- Case management

Common Questions for Discussion

COVID-19 Public Health Emergency Questions 1-9

Timing & Federal Updates

Current PHE continues to run through Jan. 11, 2023

We expect this to be extended again

New working dates are:

Feb. 10, 2023 - *next 60 day notice date*

April 11, 2023 - *new expected end date*

Recent Tweet from HHS official on 60 day notice

"The COVID Public Health Emergency remains in effect & HHS will provide a 60-day notice to states before any possible termination or expiration. As we've done previously, we'll continue to lean on the science to determine the length of the PHE. Read FAQs:
https://phe.gov/Preparedness/legal/Pages/phe-qa.aspx

Question 1 & 2: Department's Plan for Public Health Emergency End Renewals

COVID Renewal Unwind Timeline

2023											2024					
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CMS 60 Day Notification 02/12/2023	Ex-Parte runs 03/15/2023 for Feb renewal	PHE Ends (Continuous Coverage Protections End)	CMS Option B - Feb Renewals with term 5/31/2023													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14		
							November-23									
April-23								December-23								
	May-23								January-24							
		June-23								February-24						
			July-23								March-24					
				August-23								April-24				
					September-23								May-24			
						October-23								June-24		
				Appeals												

Renewals during COVID PHE - Continuous Coverage (renewed) regardless if approved or denied

Renewals COVID Unwind - If approved, renewal month reset; If no longer eligible, will not continue to be enrolled

Renewals post COVID Unwind - Return to normal

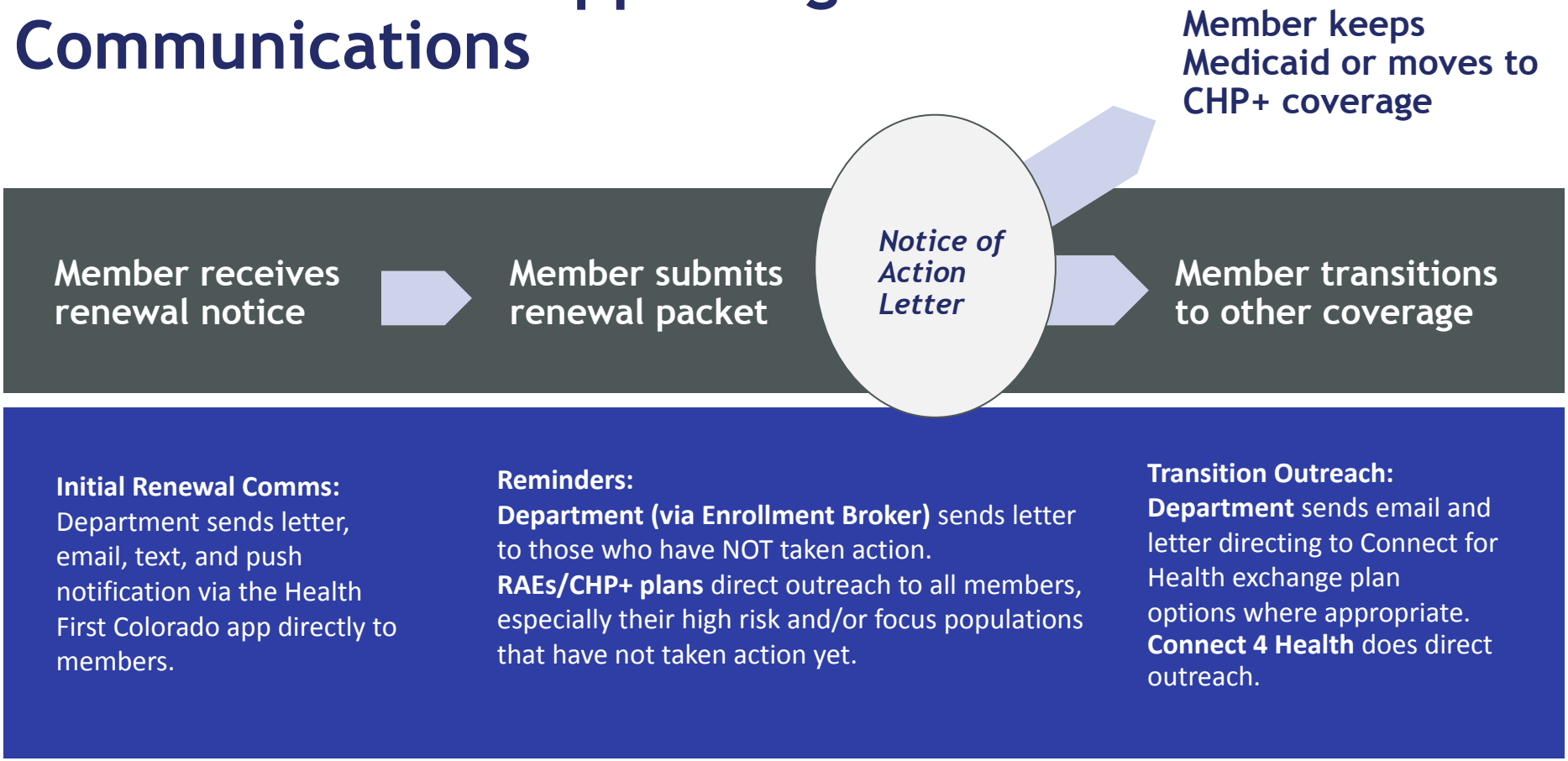
Note: The PHE was extended again on Oct. 14 for another 90 days. The federal government has not indicated an end date for the PHE yet. **This plan is assuming the PHE will end in April 2023 and is subject to change as dates are finalized.**

How We Have Been Preparing: Renewals Strategy

Minimize impact on members through:

- Enhanced ex-parte (use of interfaces and information on file for approval without member engagement)
- Reformatted renewal packet for clarity
  - Special call out on the newly required signature
- Enhanced online member tools (PEAK, electronic signature)
  - Telephonic signature implementation to mitigate paper and expedite processing
- Targeted outreach for members with a call to action
  - Messaging asking to send back a signed renewal packet!

Question 3: Renewal Process Notifications & Supporting Communications



Initial Renewal Comms:
Department sends letter, email, text, and push notification via the Health First Colorado app directly to members.

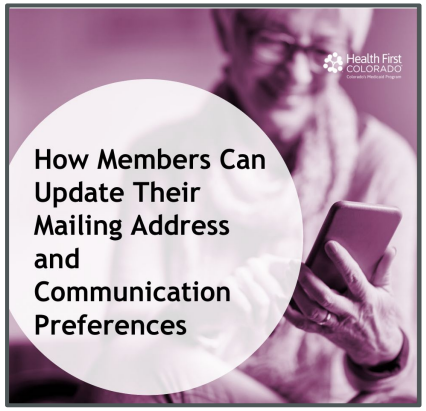
Reminders:
Department (via Enrollment Broker) sends letter to those who have NOT taken action.
RAEs/CHP+ plans direct outreach to all members, especially their high risk and/or focus populations that have not taken action yet.

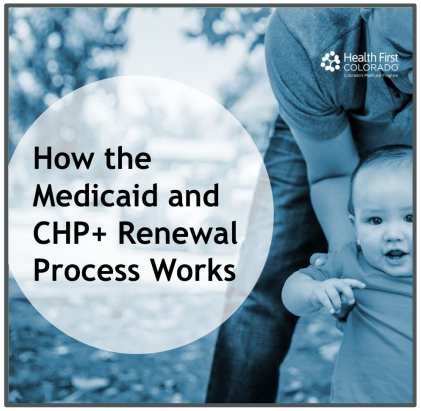
Transition Outreach:
Department sends email and letter directing to Connect for Health exchange plan options where appropriate.
Connect 4 Health does direct outreach.

Ongoing broad outreach: Health First Colorado website, traditional & social media, Health First Colorado app, PEAK, member newsletters, call centers, partner and provider messaging, posters/flyer materials in libraries, homeless shelters, clinics, etc.

Video Series & Toolkits

Accessible for partners & members to understand key actions in the renewal process (English & Spanish)





https://www.youtube.com/playlist?list=PLFlKrQC_PrCGEuVySAlzoUNN23ihtKrD4

Questions 4 - 8: Predicting Who May be Disenrolled & Societal Costs

- Members must be renewed based on **current data at their renewal time**. As member circumstances change, we cannot exactly predict who may no longer qualify until their renewal process is complete.
- Many will still qualify and be automatically renewed or complete the renewal process.
- Others may have employer sponsored coverage or could benefit from a marketplace plan.
  - Colorado Unemployment Rate
    - October 2020: 6.1%
    - October 2022 (most current): 3.6%
  - Colorado Pandemic Job Recovery Rate - 125%
- Connect for Health Colorado partnership

Source: Labor statistics from the Colorado Department of Labor & Employment, “Colorado Employment Situation – October 2022.”

Question 9: Supporting Eligibility Workforce

Budget requests and supplementals to increase workforce

- Combination of new staff, temporary staff, overtime
- Address retention of current staff

Performance management of eligibility sites

- Business process improvement and technical assistance (renewals, backlog)
- County accountability regarding accurate and timely eligibility determinations

Constant collaboration and engagement with eligibility workers

- Small weekly workgroup
- Monthly statewide meetings with county directors and monthly statewide meeting for eligibility workers

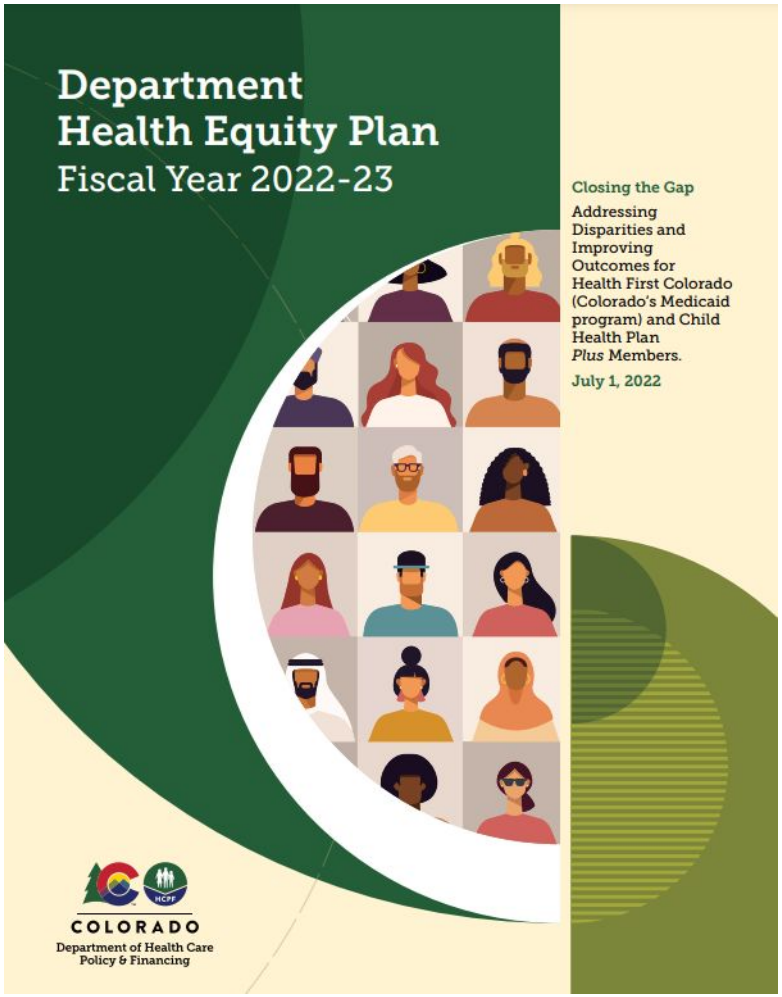
Overflow Processing Center

Consolidated Returned Mail Center

Hospitals
Questions 10-11

R9 Birthing Equity & Doula Services Questions 12-15

Question 12: Doula Benefit Addresses Key Health Equity Priority



- The doula benefit focuses on **reducing disparities, improving health outcomes** and **reducing costs** *for all Medicaid members* with an emphasis on Black, Indigenous, People of Color (BIPOC) birthing people.
- Engagement began with Maternity Advisory Committee & is part of request

Questions 13 & 14: Doula Research & Evidence

Dept. researched implementations in other states to learn from their experiences, and will engage birthworker community to ensure success.

Decreases/Reduces	Increases/Improves
• Cesarean section rates and associated costs • Preterm birth rates • Low birth-weight rates • Rate of birth complications • Rates of perinatal mood and anxiety disorders • ER and hospital visits • Labor duration	• Breastfeeding rates • Adoption of infant safety precautions • Patient satisfaction • APGAR Scores (a test of five measures to evaluate an infant's health at birth)

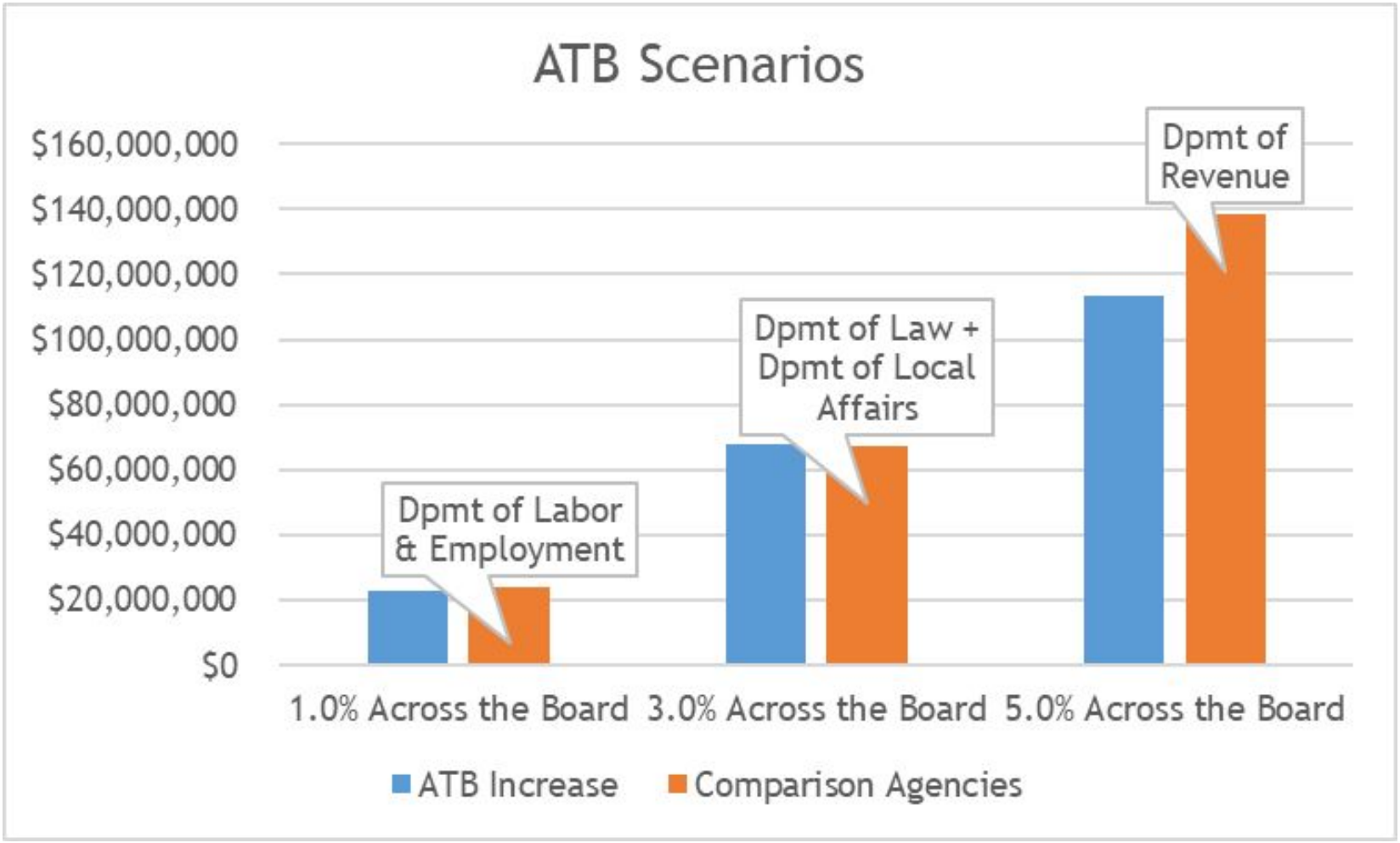
Question 15: Doula Benefit Intersection with Nurse Family Partnership Programs

	NFP	Doula Benefit
Population Served	First-time parent on Medicaid	All pregnant or postpartum Medicaid members
Care Provided	Prenatal through 2 years postpartum nurse visits at the home (frequency varies according to period of pregnancy or child development). Does not include presence at birth to support.	Prenatal, birth support, and postpartum support, usually through the first several weeks. *Note: Colorado model will include stakeholder work to determine how far into postpartum visits may go.* Doula is present at and supports during birth.
Providers of Care	Registered Nurses	Support persons trained specifically in perinatal and postnatal care

R6 Value-Based Payments & R8 Cost & Quality Indicators Questions 16-19

Provider Rates, Participation & Medicaid Provider Rate Review Advisory Committee Questions 20-34

Examples of Magnitude: Across the Board Provider Increases = Entire Agency General Fund Budgets



Question 20: 17% of R7 Request is Across the Board Increase: Other Targeted Rate Increase Focus Areas

Address critical needs
facing the most vulnerable Medicaid providers

- 59% of request to Nursing Home and Home and Community-Based Services providers

Rebalancing rates
based on Medicaid Provider Rate Review Recommendation Report

- 22% of request

Targeted investments
incentive payments for Rural Hospitals to support Health Information Exchange

- 2% of request

Pharmacy Questions 35-37

R14 - Convert Contractor Resources to FTE Questions 38-41

Questions 38-39: Hiring Progress and Confidence

1. 155.6* FTE funded in last 3 FYs
2. 133.2 FTE currently filled
3. 13.5 are in active recruitment

*Some FTEs are short-term ARPA-only ST funded.

Questions 40 - 41: Reasons to Convert Contract to FTE

1. Creates robust and cohesive capacity for stakeholder engagement
2. Greater success in implementing legislative and executive priorities
3. Enhances member engagement in program development
4. Better informs and prepares partners for policy changes

Other Topics - Child Health Plan Plus (CHP+), Co-pays, Recoupments, Audits & Fraud/Waste/Abuse Reporting Questions 42-48

Question 42: CHP+ and Medicaid Differences

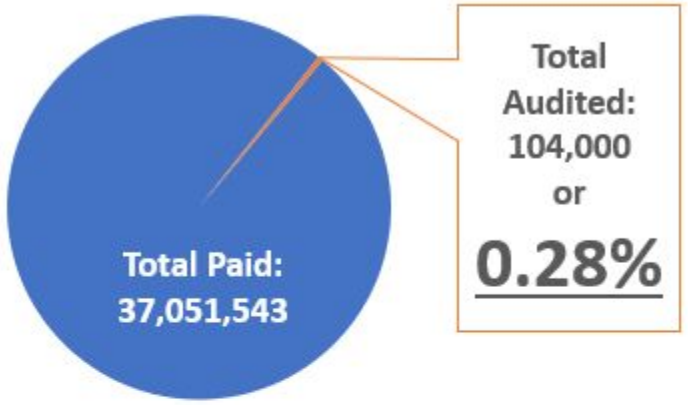
	CHP+	Medicaid
Authority	Title XXI	Title XIX
Federal Matching	65% (PHE Enhanced Federal Medical Assistance Percentage [eFMAP] = 4.34%)	50% (PHE eFMAP = 6.8%)
Eligible Members	Children under 19 and Pregnant People	Children and Adults
Recent Enrollment Numbers	48,200	1.7 million
Federal Poverty Level (FPL)	143%-260%	147% FPL for children 138% FPL for adults under 65 195% FPL for households
Additional Differences	4 Managed Care Organizations with Service Area Overlap (Competition) in Many Counties	Key Performance Indicators and Performance Incentives Regional Service Areas
Payment & Delivery System	Capitated	Capitated and Fee-For-Service
Additional Similarities	Dental Coverage 12-month postpartum expansion Cover All Coloradans (HB 22-1289) look-alike program $0 enrollment fee *1115 Prenatal Waiver	

Question 43: Co-pay Elimination

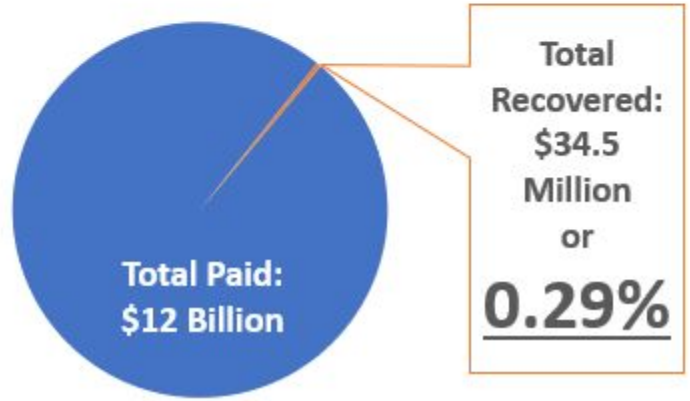
- Reduces barriers to getting care and prescriptions
- Reduces administrative burden
- Only non-urgent use of the ER has a co-pay ($8)
- Elimination essentially a provider rate increase

Questions 44-45: FWA Auditing in FY 2021-22

Claims Paid vs. Claims Audited



Dollars Paid vs. Recovered



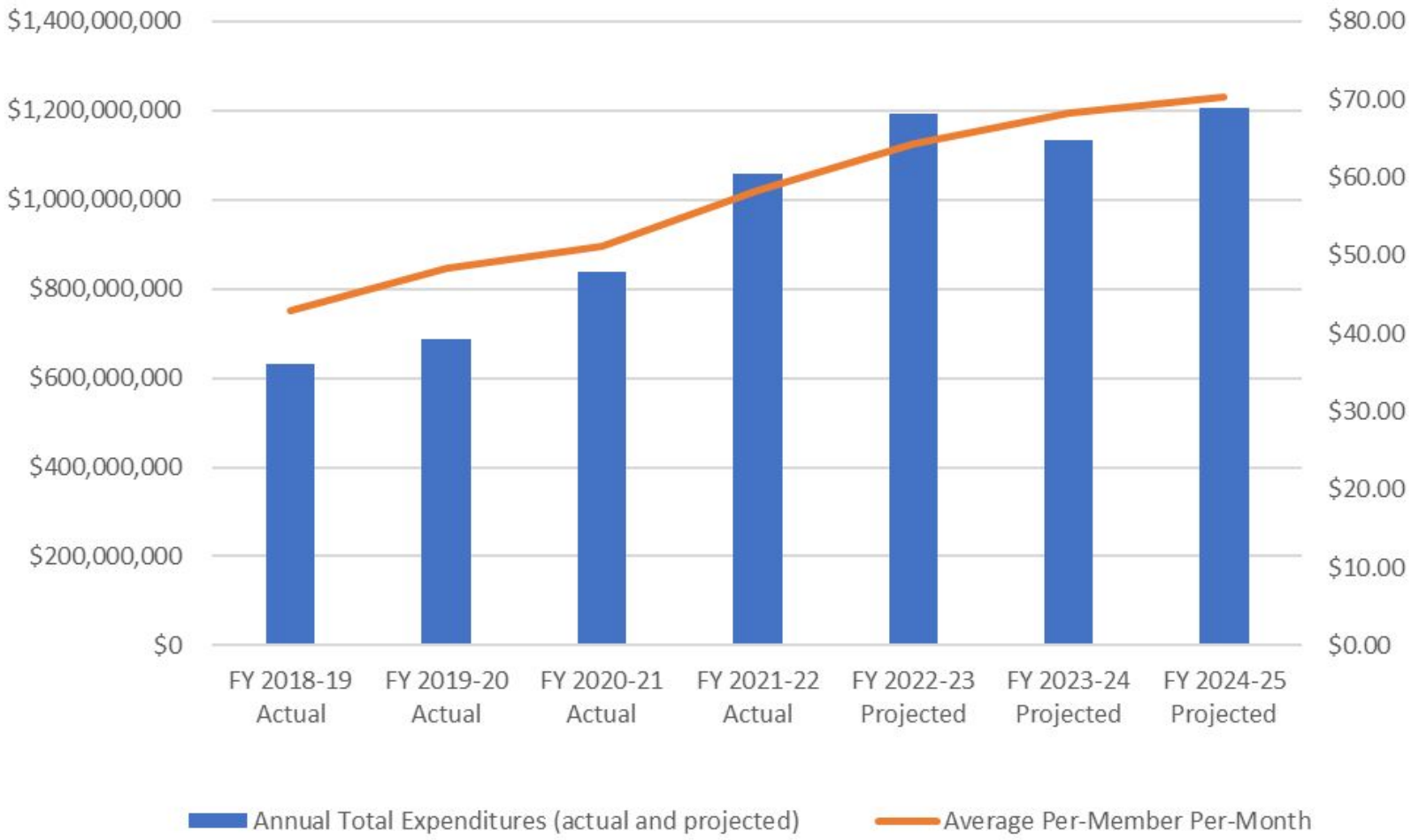
- 17.0 FTE and 1 contractor responsible for reviewing all provider, claim types
- Recovery amount up from $13.8 million to $34.5 million
- Types of audits:
  - Post-payment review
  - CMS program requirements
  - OSA/OIG audit recommendations
  - Law enforcement related

Behavioral Health

Dec. 21, 2022

Kim Bimestefer, Executive Director
Cristen Bates, Behavioral Health Initiatives & Coverage Office Director
Charlotte Crist, Cost Control & Quality Improvement Office Director

Medicaid Behavioral Health Expenditures 2018-2025



Coverage Across Care Continuum

Prevention, Harm Reduction

- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Overdose reversal (Narcan), Rx and hospital
- Outreach, case management
- Wound care, medical care for SUD-related conditions

Outpatient Treatment and Supports

- Medication-Assisted Treatment (MAT)
- Outpatient; individual, family & group
- Intensive outpatient
- Care coordination and navigation from RAE
- Care management, peer services
- Transportation for appointments (NEMT)

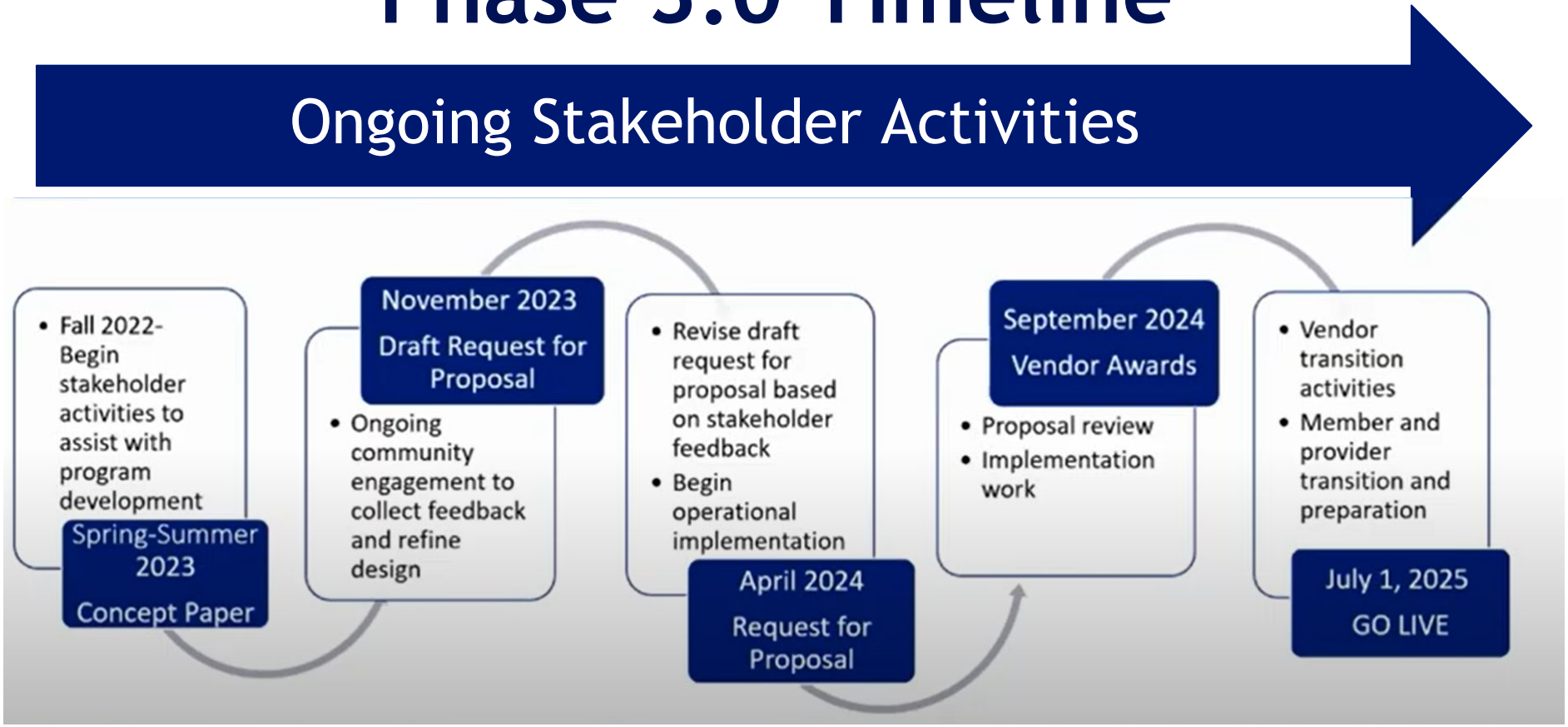
Inpatient and Residential

- Withdrawal management
- Inpatient care
- Residential
- All must follow ASAM Criteria
- Overdose services and MAT in the ER

Behavioral Health Transformation & Investment

- **20+ bills, $550M+ in ARPA stimulus to transform the industry**
  - Redefining the safety net and increasing high-intensity outpatient services
  - More adult beds, youth residential beds, tribal substance use disorder facility
  - Funds to increase integrated care and care coordination technology
  - Mobile crisis response and secure transport
  - Community investments and much more!
- **New Department Office:** Office of Medicaid & CHP+ Innovations and Coverage
- **Medicaid** >$1B (+>$500M since 2018-19). >1,000 behavioral health added last yr (10k+)
- **7 workstreams to improve Community Mental Health Center accountability**

Accountable Care Collaborative Phase 3.0 Timeline



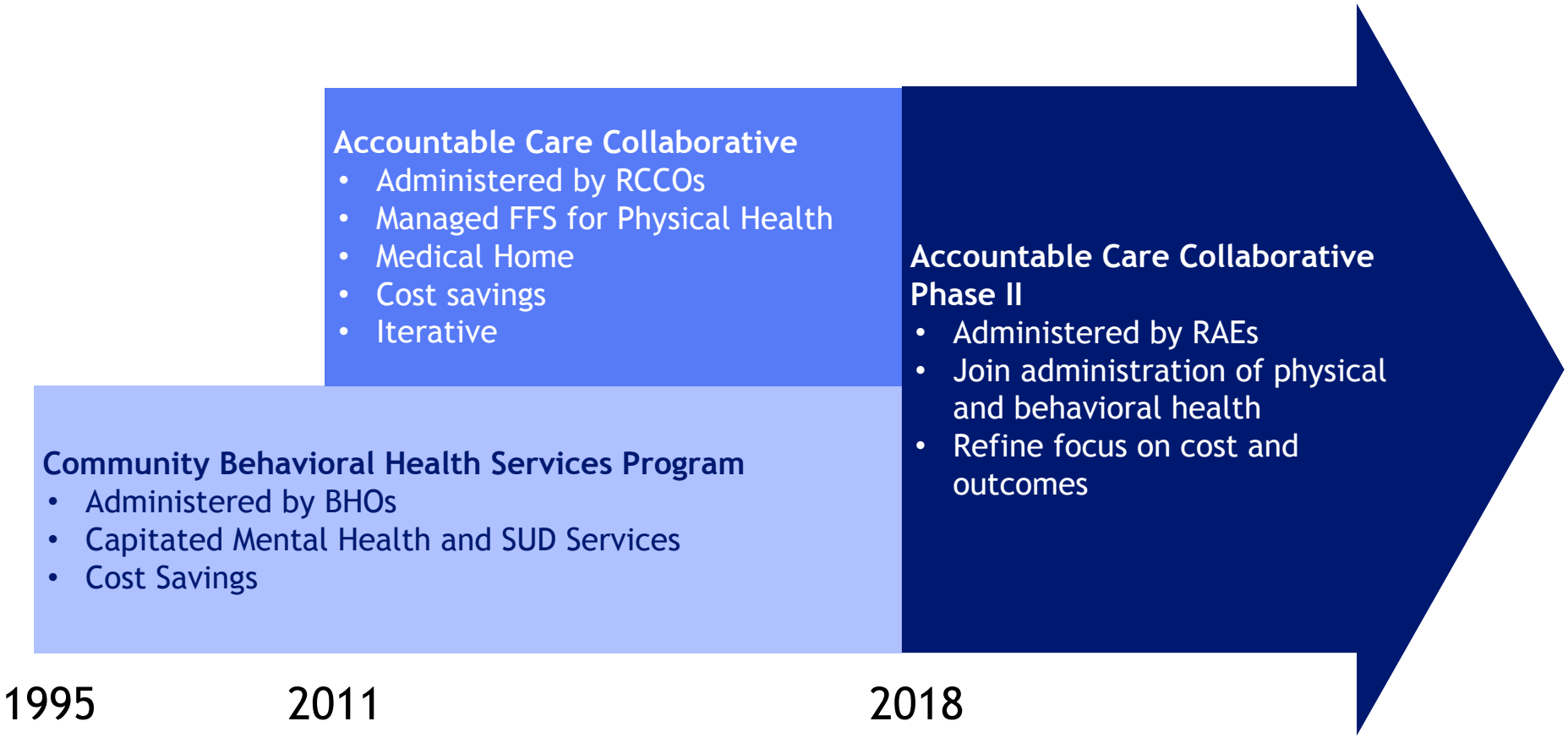
Behavioral Health Delivery System & Provider Network Questions 49-53

Managed Care Across the U.S.

41 states use risk-based managed care contracts to serve at least some of their members.

69% of all Medicaid members receive care under risk-based managed care contracts.

Colorado's Hybrid Managed Care Model



Role of Regional Accountable Entities (RAEs)

- Lead a whole-person health care system for all Medicaid members, including prevention services, care coordination, primary, behavioral health and specialty care to promote members' physical and behavioral health
- Contract with a regional network of Primary Care Medical Providers (PCMPs) to serve as medical home
- Administer capitated behavioral health benefit
- Support providers in coordinating care across disparate providers
- Provide administrative, financial, data and technology, and practice transformation assistance
- Maintain and monitor performance and quality of a diverse network of providers

Join Physical & Behavioral Health

Capitated Behavioral Health Benefit

State Plan/Medical Services

Behavioral Health Assessment

School-Based Mental Health Services

Psychotherapy

Physician Services

Pharmacological Management

Outpatient Day Treatment

Outpatient Hospital

Psychosocial Rehabilitation

Crisis Services

Emergency Services

Inpatient Psychiatric Hospital

State Plan/Medical Services—SUD Specific

Substance Use Disorder Assessment

Alcohol/Drug Screen Counseling

Medication Assisted Treatment

Social Ambulatory Detoxification

Inpatient Withdrawal Management (1115 Waiver)

Residential Withdrawal Management and Treatment (1115 Waiver)

Community-based/Alternative Services

Prevention/Early Intervention

Clubhouses/Drop-in Centers

Vocational Services

Intensive Case Management

Assertive Community Treatment

Residential (Mental Health)

Respite Care

Safety Net Accountability

- **Rewriting the provider standards for all behavioral health providers:** April ‘23
- **Cost Transparency:** ‘22 Behavioral Health Rates Report
- **HCPF leading payment claims and data collection for state-funded behavioral health services**
  - Single process for eligibility and billing starts July ‘23
- **Value-Based Payments (VBPs) for Safety Net Providers**
  - Flexible funds based on patient outcomes: July ‘23
- **Universal Contract and Reducing Administrative Burden**
  - Contract for providers in the public system, clear and aligned role for all parties, connected to VBPs

Behavioral Health Provider Enrollment November 2021 - October 2022

Provider Type	Total Enrolled Providers 11/01/21	Total Enrolled Providers 10/31/22	Total Increase	% Increase
Psychiatric Residential Treatment Facility	36	41	5	13.89%
Community Mental Health Center	251	259	8	3.19%
Licensed Psychologist	1,136	1,254	118	10.39%
Licensed Behavioral Health Clinician	7,680	8,562	882	11.48%
Substance Use Disorders Clinic	410	418	8	1.95%
Total	9,513	10,534	1,021	10.73%

Total Unique Behavioral Health Practitioners by Region

	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
RAE 1	3,293	3,311	3,349	3,360
RAE 2	3,100	3,166	3,291	3,308
RAE 3	6,118	7,040	7,021	6,311
RAE 4	3,097	3,164	3,291	3,307
RAE 5	6,211	6,983	7,021	6,283
RAE 6	3,921	4,113	4,294	4,617
RAE 7	3,921	4,113	4,294	4,617

Behavioral Health Member Engagement

	Member Population	Engagement Rate
RAE1	193,860	21.68%
RAE2	103,100	14.87%
RAE3	353,687	17.37%
RAE4	148,545	17.01%
RAE5	147,639	20.84%
RAE6	191,630	18.86%
RAE7	217,786	17.58%

Overall Accountable Care Collaborative (ACC) Average Performance & National Medicaid HMO Performance

HEDIS Measure	2019		2020		2021	
	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [1]	47.64%	14.4%	38.84%	14.1%	46.28%	Data Not available
Follow-up within 7 Days After Hospitalization for Mental Illness [2]	65.43%	36.2%	68.71%	39.4%	52.99%	Data Not available
Follow-up within 7 Days after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence [3]	34.93%	13.3%	36.02%	13.8%	33.27%	Data Not available
Follow-up After a Positive Depression Screen	50.19%	Data Not available	51.94%	Data Not Available	62.8%	Data Not Available

[1] https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/
[2] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[3]https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/

Behavioral Health Provider Rates Questions 54-58

Moving Toward More Equitable and Accountable Payments - HB 22-1268

- **Cost Reports:** changing the way we determine enhanced rates for the safety net, expanding the process beyond CMHCs
- **Universal Contract:** standardizing the processes and policies on payment, claims, data, and priorities for all publicly funded BH providers, reducing burden of multiple expectations
- **Value-Based Payments:** new payment methods for safety net providers based on quality and equity
- **Directed Payments, Valuing BH Provider time:** working with CMS to develop a minimum base rate for providers, called a directed payment, and updating cost value calculations

R10 - Children & Youth with Complex Needs Questions 59-61

Children and Youth with Complex Needs

- Youth with multiple diagnoses and connected to multiple systems (juvenile justice, child welfare etc.) present unique challenge
- Improving the systems
  - Significantly enhance cross-trained staff to serve youth and families - Early Periodic Screening, Diagnostic & Treatment
  - More Colorado-based residential facilities providing the set of programming the youth need
  - Expansion of step-down care from residential facilities, that includes community-based services (wraparound, family and natural supports, in-home treatment)

Crisis Services, Universal Contract & Behavioral Health Administration (BHA) Coordination Questions 62-64

Mobile Crisis Response

Colorado is launching a Mobile Crisis Response (MCR) Medicaid benefit available to all Coloradans regardless of insurance status.

The Department and the BHA are collaborating to design and launch this benefit set to launch in July ‘23.

This service will standardize MCR services, and is designed to de-escalate, stabilize and keep members in community while preventing excess hospitalization and arrest.

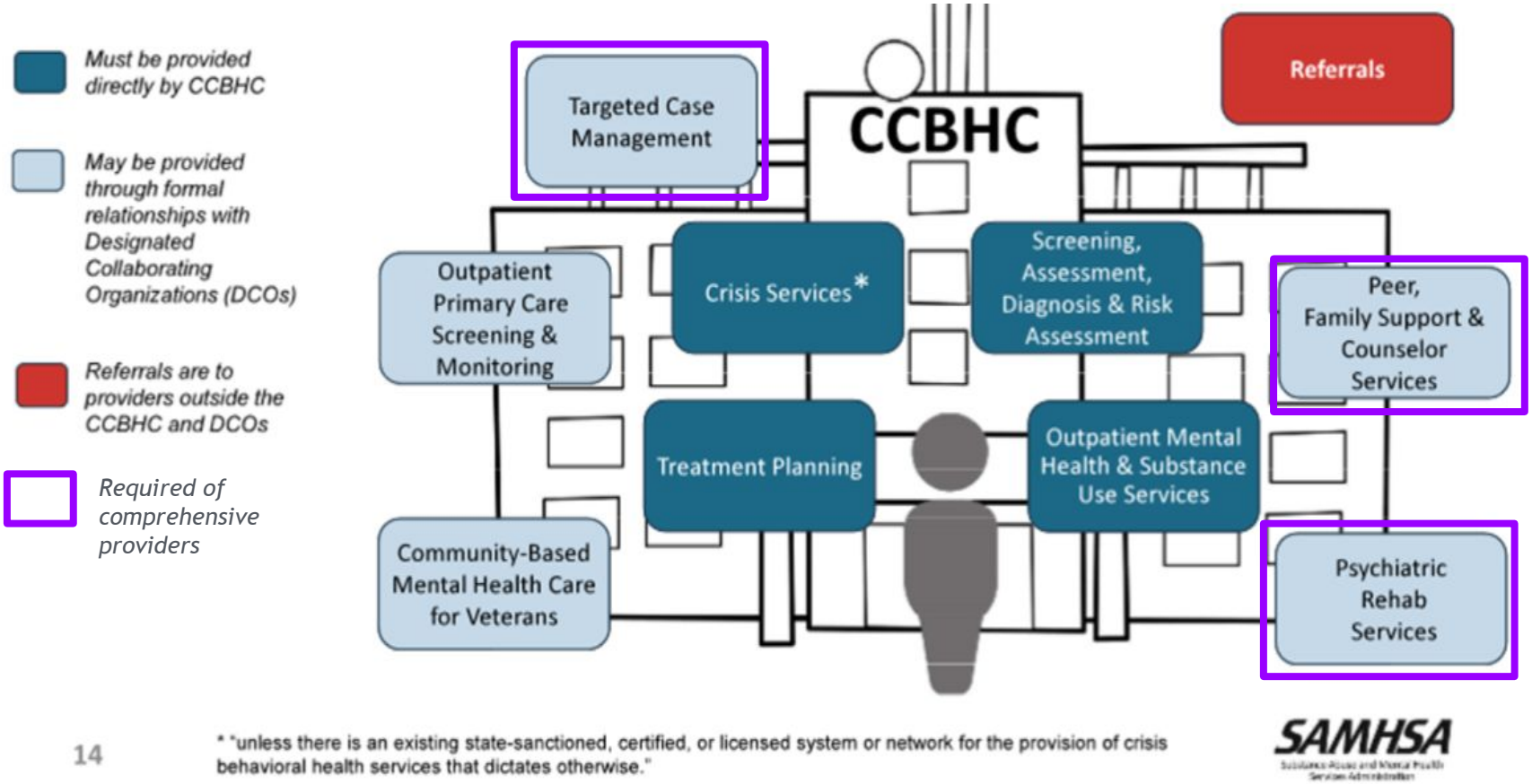
- Funded by ARPA CRSE 9813 planning grant to develop the benefit, and HCBS ARPA 2.02 to administer funds to providers to meet new services standards
- Benefit informed by: BHA rule 2 Colo. Code Regs. § 502-1-21.400.5; Guidance from CMS SHO letter #21-008; ARPA requirements, state and nation best practices
- Enhanced federal match (85/15) for states through 2027

R12 - Behavioral Health Claims System Questions 65-67

Certified Community Behavioral Health Clinics (CCBHC) Grant Questions 68-69

CCBHC Essential Services

9 Key Services of the CCBHC



14

* "unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise."

SAMHSA

Benefits of Prospective Payment Models

- Consistent, predictable, and sustainable funding
- Provider flexibility to meet need of clients
- Cost-based rate
  - Colorado law also requires rate to consider quality, equity, and access for priority populations
- Moving from volume to value
- Administrative Burden changes
  - Providers must still document encounters, but reduce admin time related to rate negotiation and claim submission

Large Activities for Planning Year

- The Department will work with the BHA, providers, advocates, payers, regulators, local community partners, families and members through multiple types of feedback and events, including
  - Surveys
  - In-person and virtual public meetings
  - Targeted interviews
  - What else?
- Will work to include clients to meet grant requirements without unnecessarily duplicating effort, and build on existing pathways for stakeholder feedback where we can.
- Partnership with advocates and members will be key in informing our choices, stakeholder feedback on provider interest in participating, payment models, required metrics, data reporting, and the design of certification will be crucial to moving forward.
- Policy and Fiscal Analysis
  - Crosswalk of state and federal policy
  - Looking at other state successes, challenges
  - Clear financing direction and budget

Office of Community Living

Dec. 21, 2022

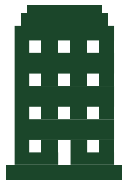
Kim Bimestefer, Executive Director
Bonnie Silva, Office of Community Living Director
Colin Laughlin, Office of Community Living Deputy Director

Long-Term Services and Supports

Community-Based Care

Including Home and Community-Based Services (HCBS), Long-Term Home Health, Private Duty Nursing, or State General Fund Programs

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



Institutional Settings

Nursing Facilities, Intermediate Care Facilities, or Hospital Backup Program

Long-Term Services and Supports System

Direct Services

- At home
- In community
- In facilities

Case Management

- Community Centered Boards (CCBs)
- Single Entry Points (SEPs)
- Private Agencies (Children's Home and Community-Based Services Waiver (CHCBS) Only)

NOTE: CCBs also provide direct services.

Who Receives Long-Term Services & Supports?

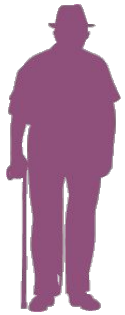
9%

Children & Adolescents
ages 20 & younger & qualifying former foster care youth

45%

Adults
ages 21-64

46%



Older Adults
ages 65 or older

Cross Disability

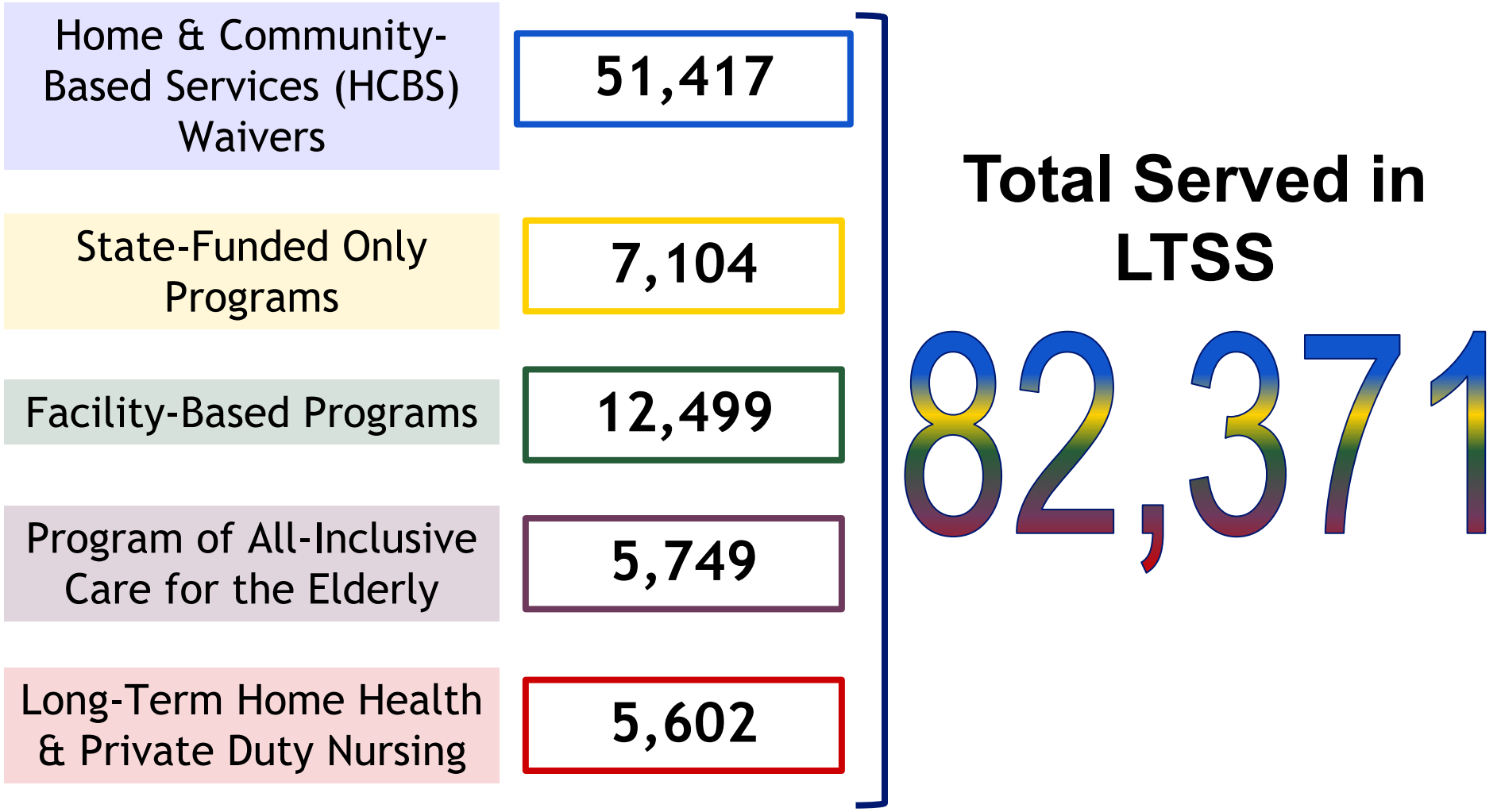
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

85% have a **chronic condition** (compared to 41% of all Medicaid members)

32% have 5 or more chronic conditions

FY 2021-22; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Long-Term Services & Supports Programs



SOURCE: FY 2021-22; based on claims in MMIS.

Community-Based Program Growth

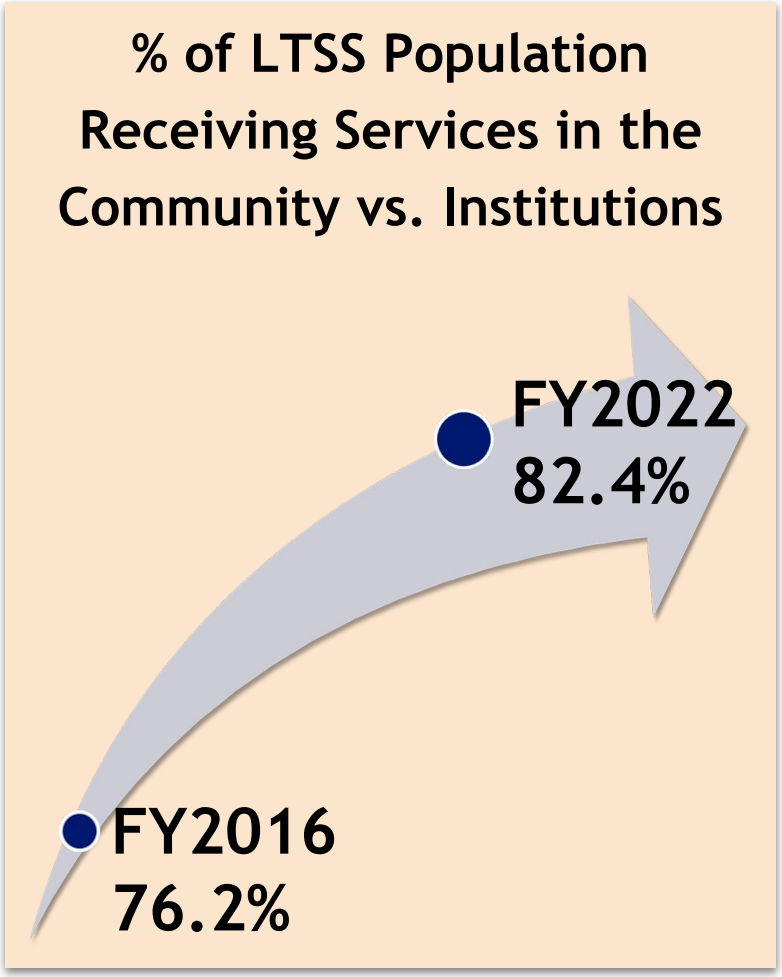
Questions 70-71

Program Growth by HCBS Waiver From FY 2016 - FY 2022

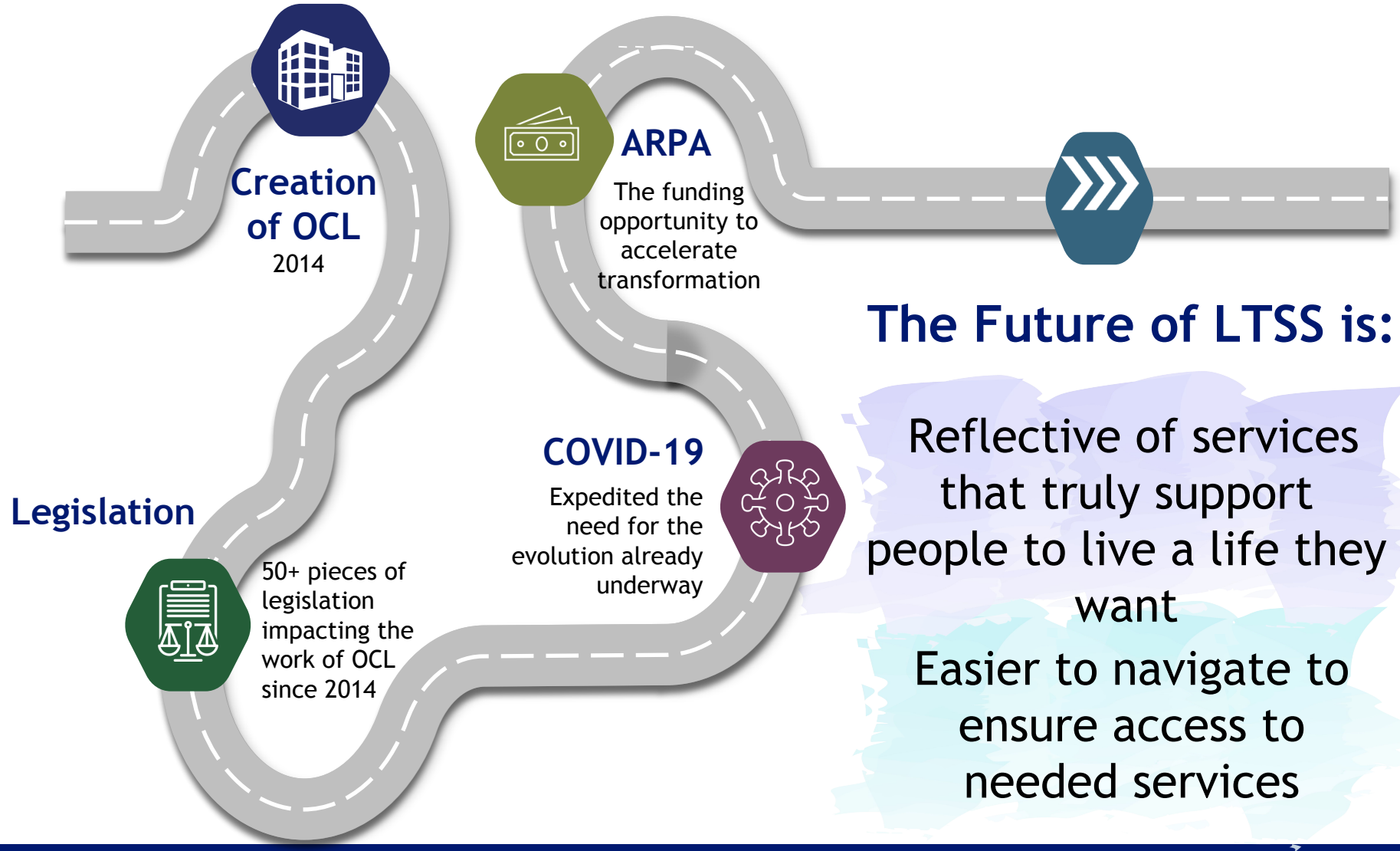
Brain Injury	Children With Life Limiting Illness	Children's Extensive Supports	Children's Habilitation Residential Program	Children's HCBS
+71%	+13%	+67%	+488%	+68%

Community Mental Health Supports	Developmental Disabilities	Elderly, Blind, & Disabled	Spinal Cord Injury	Supported Living Services
+8%	+53%	+14%	+311%	+7%

% of LTSS Population Receiving Services in the Community vs. Institutions



An Evolution of LTSS in CO



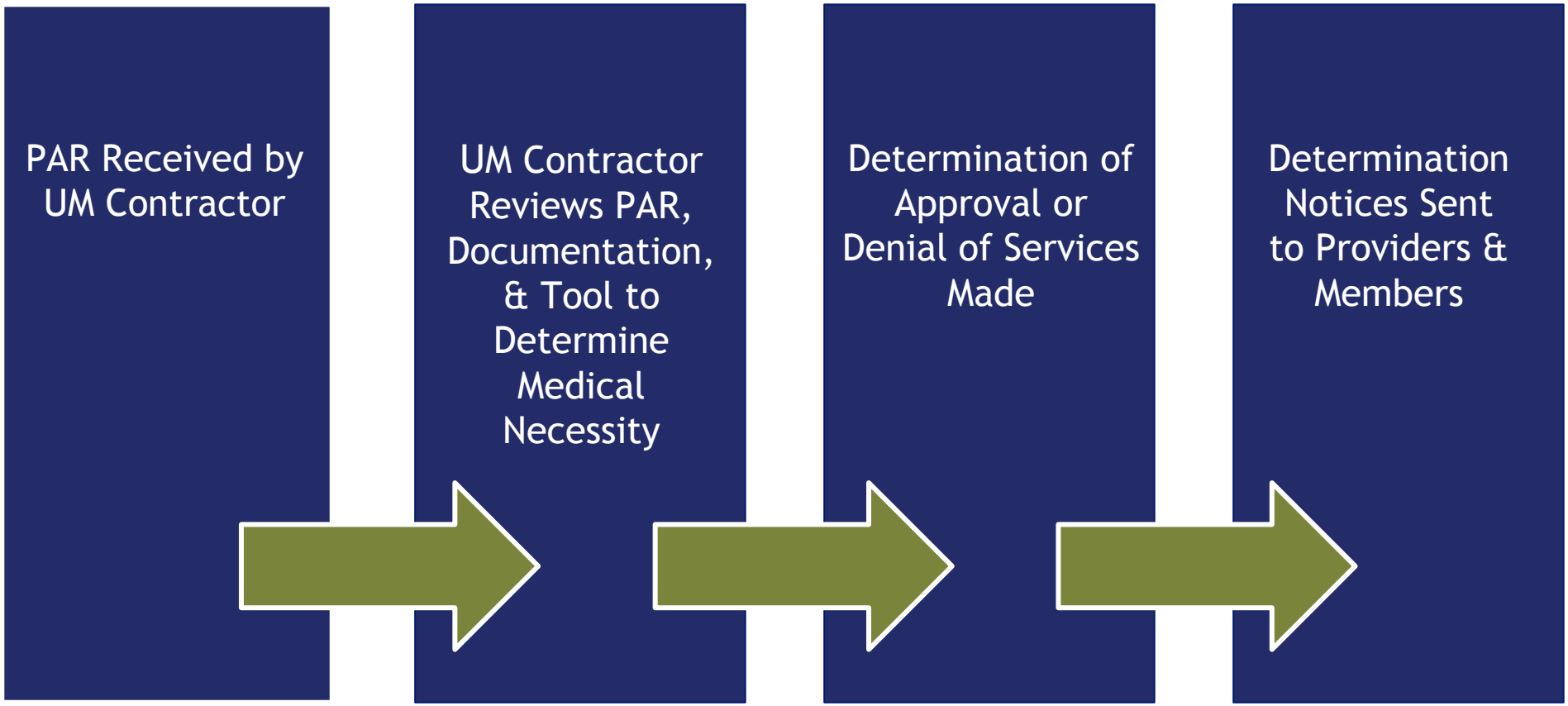
The Future of LTSS is:

Reflective of services that truly support people to live a life they want

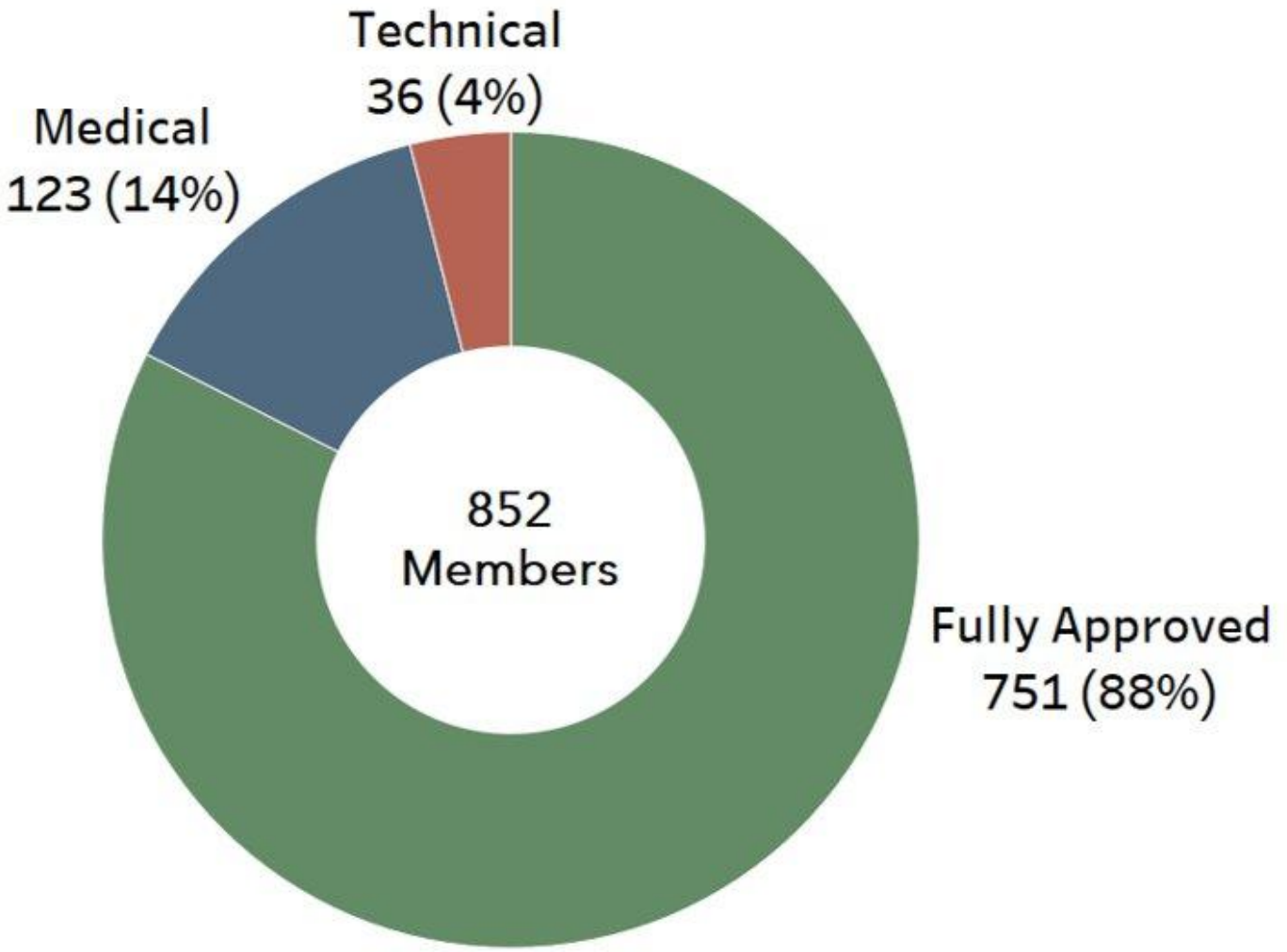
Easier to navigate to ensure access to needed services

Private Duty Nursing (PDN) Questions 72-74

PDN: Utilization Management (UM) and Contractor



PDN Medical & Technical Denials

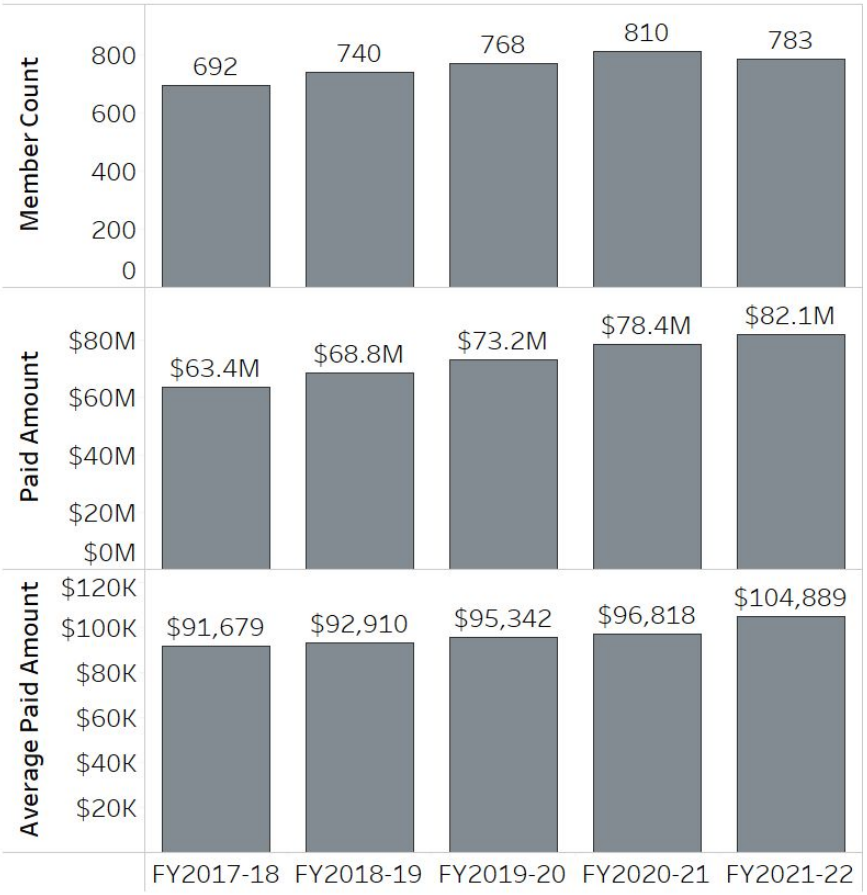


Includes PARs beginning November 2021 through October 2022 under Kepro

PDN Utilization Trends

PDN Adult

PDN Kids



Program for All Inclusive Care for the Elderly (PACE) Question 75

PACE Background

Per-member per-month capitated benefit program that provides comprehensive health care to members over 55 who require assistance with activities of daily living

Main objective is to enable older adults to live in the community as long as possible. A PACE organization is responsible for providing care that meets the needs of each participant across all care settings.

Colorado PACE serves 4,430 Medicaid members through five PACE organizations. PACE services are available in 13 Colorado counties.

InnovAge Enrollment Sanctions

1

May 26, 2021

The Department, with CDPHE & CMS, conducted an audit of all InnovAge Colorado operations

2

Dec. 23, 2021

The Department determined that the seriousness of the deficiencies identified required the suspension of any new enrollments for all of InnovAge Colorado centers

3

Dec. 5, 2022

The Department & CMS began performing an audit to validate improvements to which InnovAge has attested

Participant Direction Questions 76-79

Participant-Directed Programs

Consumer-Directed Attendant Support Services (CDASS)

- Population served: Adults on an approved Medicaid waiver
- Number of members served: 3,665
- Number of attendants: 12,641
- Average attendant wage: $21.56
- Member/AR is the employer
- Member/AR responsible for backup care
- Family members, including spouses, can be hired as attendants

In-Home Support Services (IHSS)

- Population served: Adults and children on an approved Medicaid waiver
- Number of members served: 7,503
- Number of IHSS agencies: 198
- Member/AR chooses an approved IHSS agency for support
- IHSS agency is responsible for backup care, access to a nurse, and independent living core services
- Family members, including spouses, can be hired as attendants

Nursing Facilities Question 80

State & Federal Financial Support

Federal Provider Relief Fund for SNFs	$119,626,046*
State COVID-19 Payments	$43,876,410
HB 22-1247 Payments	$27,001,000
Civil Monetary Penalty Funds to SNFs as grants	$700,000

$191.2 Million

SNF = Skilled Nursing Facility | *Likely higher |Figures through 12/15/2022

1247 Report Recommendations

PLANNING

- Conducted **stakeholder engagement** sessions to gather feedback on potential solutions
- Convened a small group of stakeholders to **evaluate feasibility** of proposed solutions
- **Analyzed cost** report data
- Evaluated factors impacting **sustainability**

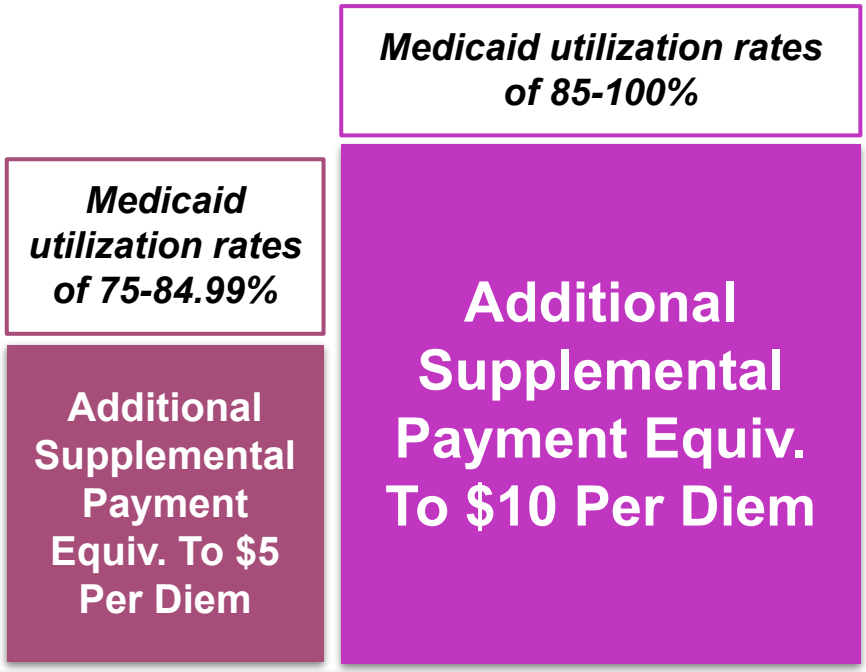
Goal: Stabilize nursing facility solvency while prioritizing quality and innovation

ACTION

- **Improve Stability**- Distribute additional funds to improve stability and retain staff (short-term)
- **Increase Efficiency and Equality**- Address duplicative and inequitable payments (medium-term)
- **Evolve Reimbursement Structure**- Modify reimbursement methodology and incentives (long-term)

R-7: A Thoughtful Approach to NFs

- ❑ Tiered Structure
- ❑ Prioritizes providers who take **Medicaid** and serve more **complex needs**
- ❑ Historic Investments



5.8%
Per Diem Increase Across All Facilities

Case Management Redesign Questions 81-94

How We Got Here

2014
Community Living Advisory Group (CLAG) & CMS

Mandate Issued

Conflict-free Case Management & Streamlined Access into HCBS System

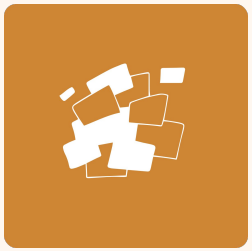
2014 - 2021
- National review of state best practices
- Legislation & rates
- Stakeholder work
- Alignment with CO LTSS Future Vision

Department Planning Process

Implementation

2022 - 2024
Case Management Redesign
- Rule change
- RFP & new contracts
- Transitions

The Future of Case Management



New Structure

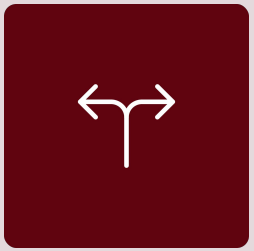
A more person-centered approach with each agency serving people with all disabilities in their geographic area with a rate structure that supports quality

Knowledge

Training for agencies to serve all members in a disability culturally competent manner through a new Learning Management System (LMS) and direct agency support

Accountability

Public-facing score cards and appropriate caseloads to ensure consistent, quality case management



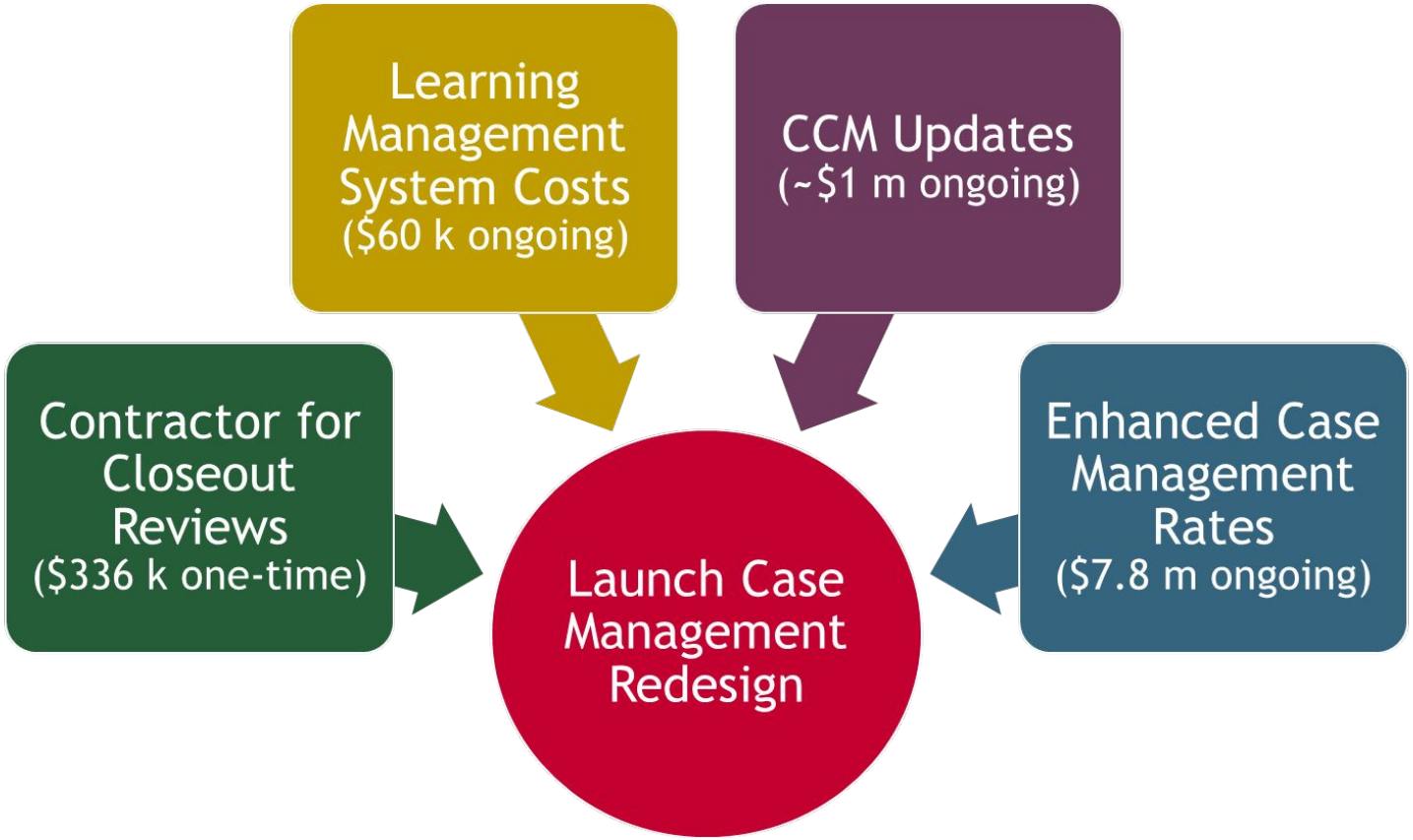
Conflict-Free

Case management and service delivery done by separate entities unless a rural exception is granted; meeting federal requirements and opening doors to additional program expansion and enhancement

Key Outcomes of Case Management Redesign

R-13: Case Management Redesign

Increase allocation by over **$3.6M in FY 23-24** and around **$9M annually ongoing**

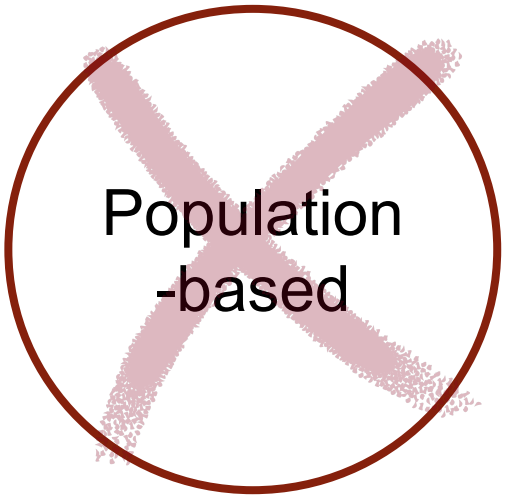


Current vs. New Rate Analysis

FY 2023-24	Forecasted CCB Population	Forecasted SEP Population	Combined CMA Population with Proposed Rate
# of Members	14,976	31,898	46,874
$ Rate	$144.59	$78.84, $86.99, $91.42	$118.04
Total Forecasted Reimbursement	$25,982,900	$31,320,003	**$66,396,241**
	$57,320,903		

Case Management Caseloads

Current System



CCBs: 25 - 85 members per case manager

SEPs: 90-165 members per case manager

- Large variation agency to agency

Future System

CMAs: 65 members per case manager

- Flexibility within agencies
- Based on national best practices, stakeholder feedback
- More balanced

Developmental Disabilities (DD) Waitlist Question 95

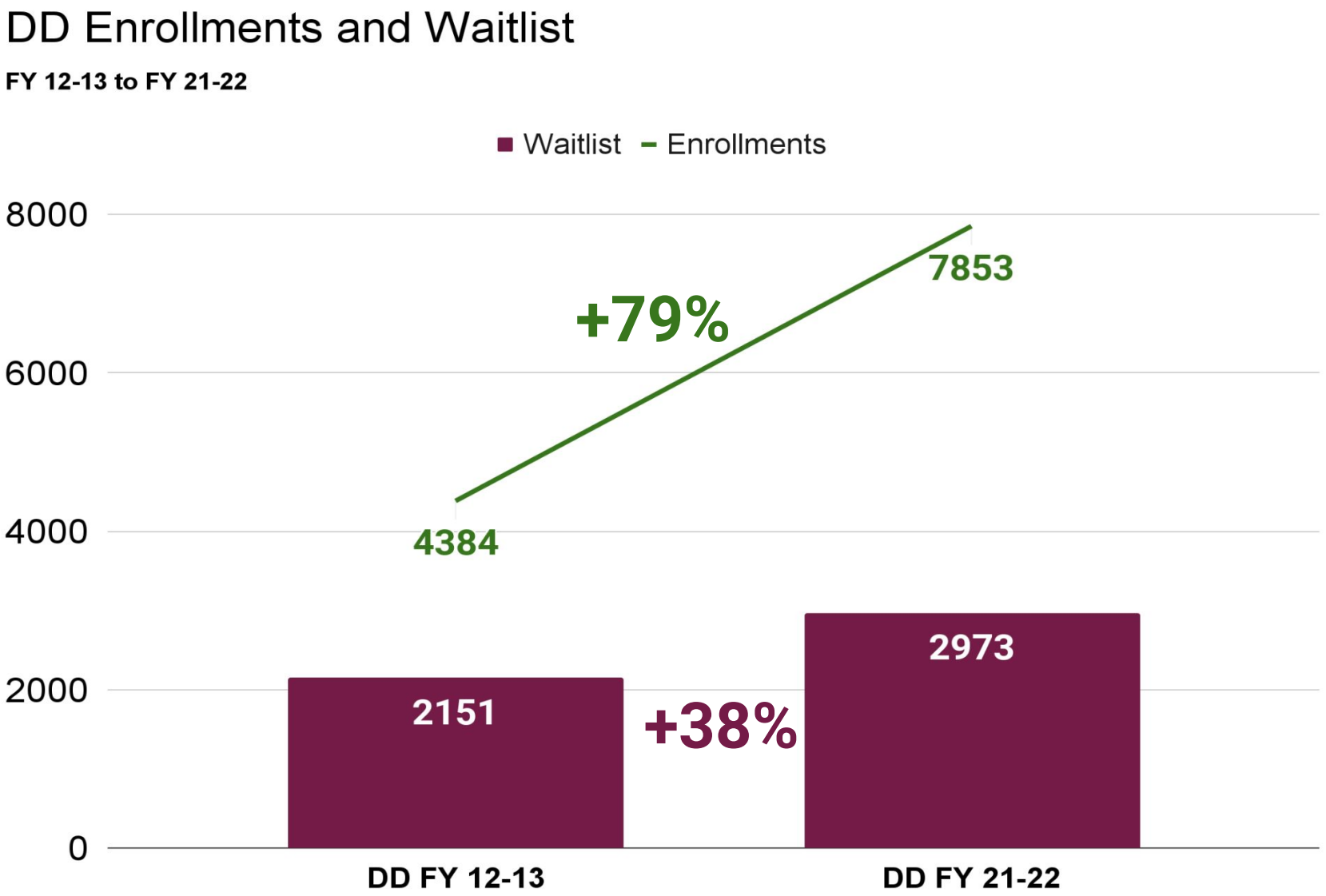
Managing the Waitlist

The Department submitted the **Intellectual and Developmental Disabilities (IDD) Strategic Plan on Nov. 1, 2014** in response to HB 14-1051 and has subsequently submitted an annual update. There was **no corresponding appropriation** for implementation of this strategic plan.

The Department can **authorize enrollments** into the DD waiver three ways:

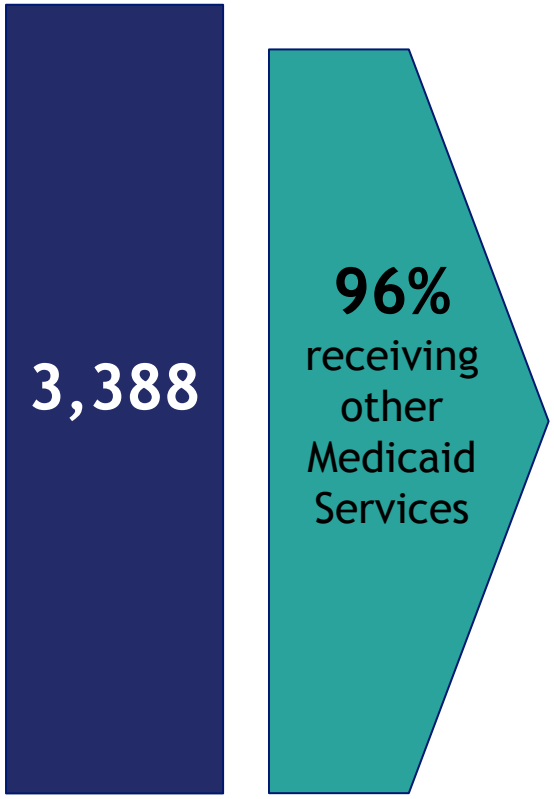
- New enrollments
- Efficient management of the churn
- Reserve capacity enrollments

Waiting List Progress



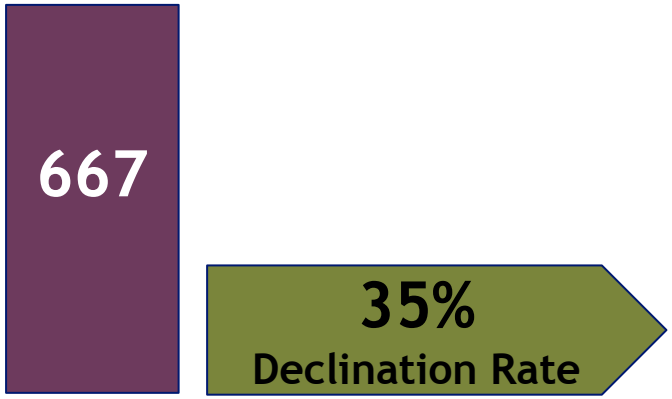
DD = Developmental Disability Waiver

Meeting The Needs of Members



"As Soon As Available" DD Waiting List

Declination Reason: Most individuals reported that it was because they currently receive sufficient services and supports through other Medicaid benefits.



New Enrollments Authorized through SB21-205

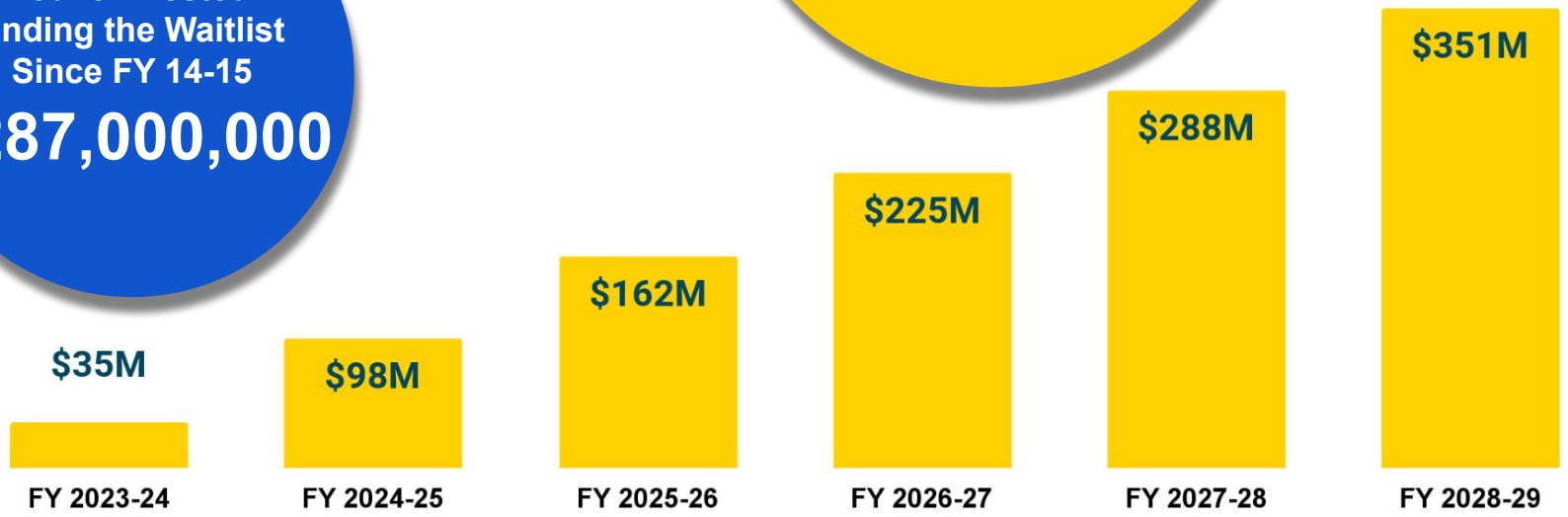
Investment for Enrollment Growth

Amount Invested in Ending the Waitlist Since FY 14-15

$287,000,000

Total cost to end the waitlist by 2030 & ongoing

$378,000,000



Year-Over-Year Investment Path

Thank you!

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 15, 2022

The Honorable Julie McCluskie, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative McCluskie:

Enclosed please find the Department of Health Care Policy & Financing's action plan to the Joint Budget Committee on Medicaid behavioral health reimbursement rates as directed by 25.5-1-132(2) C.R.S.

Pursuant to Section 25.5-1-132(2), C.R.S. requires that on or before November 15, 2022, the Department present an action plan for implementation to the Joint Budget Committee of steps it will take to reach the recommendations outlined in its HB22-1268 Behavioral Health Provider Rate Comparison Report from August 2022. The State Department shall produce a progress report on the State Department's progress made in implementing the action plan presented to the Joint Budget Committee on November 15, 2022 on or before August 1, 2023 and annually thereafter through August 1, 2025. The Department must fully implement the action plan no later than December 31, 2025.

The action plan details the Department's efforts, in collaboration with other state agencies, to update provider definitions and responsibilities, improve transparency, and increase accountability. This includes better defining the safety net, increasing the availability for providers to engage in safety net services, and updated funding mechanisms for safety net services.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF Action Plan on Behavioral Health Reimbursement Rates as Directed by 25.5-1-132(2) C.R.S.

Cc: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

HB 22-1268 Action Plan

Nov. 15, 2022

Submitted to: The Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Introduction

In accordance with HB 22-1268, the Department of Health Care Policy & Financing (the Department, or HCPF) published the Behavioral Health Provider Rate Comparison Report and submitted it to the Colorado General Assembly[1]. The report includes recommendations to address payment variations and methodologies across different provider types for behavioral health services. In addition, HB22-1268 also directed the Department to create an action plan to implement the recommendations presented in the report. This action plan meets the requirement and outlines steps the Department will take to improve the behavioral health payment processes by implementing the report's recommendations.

The Department agrees the state's behavioral health system needs to be transformed. Accordingly, Department leaders and subject matter experts have actively and passionately participated in all aspects of transformation planning, including the original Behavioral Health Task Force directed by Governor Polis which crafted the Behavioral Health Blueprint for Change in 2019 and the Behavioral Health Transformational Task Force which created the Behavioral Health Recommendations Report. The Department continues to work statewide, across agencies, and with stakeholders to implement transformative changes to the betterment of the one in four Coloradans we serve. In the last three years, HCPF significantly increased the number of behavioral health providers enrolled in Medicaid, increased behavioral health provider reimbursement rates, increased Medicaid behavioral health budget investment from $600 million in SFY 2018-19 to over $1 billion annually in the current fiscal year. We greatly appreciate the Joint Budget Committee's partnership in making these critical investments necessary to achieve our shared goals.

The continuing expansion of HCPF's Medicaid behavioral health network over the last year reflects the success of increases to the provider reimbursement rates during challenging times, especially important given the growing shortages in the health care workforce. To ensure access to care, providers of behavioral health services, including substance use disorder (SUD), must receive payments that support delivery of care in all areas of Colorado. As such, the delivery of comparable services should

[1] https://hcpf.colorado.gov/sites/hcpf/files/HB 22-1268 Report.pdf

receive equitable payment, given the contractual requirements associated with the various provider types. Based on the analysis presented in the Aug. 15, 2022 report, and to address issues related to discrepancies in rates between community mental health center providers and the independent provider network, the Department presented the following five recommendations:

1. Update rates and service definitions to align with new provider definitions and improve payment models and reporting accuracy.
2. Evaluate appropriate payment methodologies as viable alternatives to the Relative Value Unit payment model.
3. Continue improvement for safety net cost reports.
4. Expand value-based payment models to larger groups of providers.
5. Continue to analyze and periodically post publicly, rate review and analysis on behavioral health rates, to show changes over time.

The Department is completing the action items outlined below to implement the report's recommendations for improving the behavioral health rate structure. This report further includes the estimated timeline for each action item, the responsible parties, and any possible dependencies.

II. Action Steps

1. Update rates and service definitions to align with new provider definitions and improve payment models and reporting accuracy

New Safety Net Provider Definitions

- Responsible Entities: Behavioral Health Administration (BHA) in collaboration with HCPF
- Dependencies: None
- Status: In Progress, initial rule-making process complete July 1, 2023, continuing through July 1, 2025

The Department is collaborating with the BHA to implement and respond to the new safety net services provider definitions created in HB 22-1278. This work includes creating new Medicaid provider types in claim processing and data IT systems to align with the new statutory definitions and aligning payments with licensing requirements

for providers. **These new definitions allow the Department to better track spending through cost reports, create more accurate budgets, and increase the number of providers eligible for higher safety net rates.**

This is part of the state's collaborative effort to support the state behavioral health safety network, as introduced in SB 19-222, and the subsequent report to strengthen and expand the safety net. These new definitions of safety net services providers include high level criteria for providers interested in becoming safety net providers, including two levels of safety net providers. The Department anticipates the two new definitions will increase the number of providers who can be part of the safety net system in all parts of the state. The impacts of this bill have already begun and will be fully implemented by July 1, 2025.

The two new behavioral health provider types will be:

- Comprehensive Safety Net Providers (CSNP)
- Essential Safety Net Providers (ESNP)

The new statute also clarifies that Federally Qualified Health Centers are behavioral health safety net providers. The BHA will be revising, amending, or repealing their provider standards, and other regulations, based on these statutory changes. The first set of new rules will be effective July 1, 2023.

The statutory change will encourage greater participation, especially by independent providers, in the behavioral health safety net. In addition, the ESNP category will allow smaller and medium sized safety net providers to access safety net funding.

New and Updated Service Definitions

- Responsible Entity: Health Care Policy & Financing
- Dependencies: None
- Status: In progress with new service definitions starting July 1, 2023

In addition to new statutory and regulatory definitions, the Department is creating new service definitions for crisis services and secure transport. The Department is also updating the service definition for Mobile Crisis services as part of an expansion of the crisis services within the safety net system. This expansion of service definitions and provider types will better align the payment models with actual crisis

services being provided within the community. The Department anticipates an increase in provider engagement within the crisis services. This change aligns with plans for continued integration between the Department and the BHA, including the development of more integrated system technologies. **Updating the provider and services definitions for crisis will increase total available crisis funding by expanding federal match dollars and increasing the services that can be billed for directly, rather than rolled up into the total cost rates.** Direct billing and value-based payments support more equitable and accurate payments to providers.

2. Evaluate appropriate payment methodologies as viable alternatives to the Relative Value Unit payment model

Evaluate Relative Value Weights

- Responsible Entity: HCPF in collaboration with the BHA
- Dependencies: None
- Status: In progress, to be completed by March 31, 2023

The Department has engaged with an outside vendor to evaluate the role of the Relative Value weights associated to service codes in the cost report. The Relative Value weights and the associated Relative Value Units (RVUs) play an integral part in the calculation of safety net rates based on cost reporting. For more background information, please see the Appendix D of the Behavioral Health Rates Report.

Through robust stakeholder engagement with Community Mental Health Centers (CMHCs), Independent Provider Network (IPN) groups, Regional Accountable Entities (RAEs), and the BHA, the Department and its vendor are evaluating if the RVU weights can be rebalanced to reduce inappropriate weighting in the cost reports and therefore reduce disparities in rates**. The outcome of this evaluation, to be completed by March 31, 2023, may result in better balanced weighting and a reduction of skewing within behavioral health safety net rates.** Any changes to the weighting deemed necessary will be implemented in summer 2023.

3. Continue improvement for safety net cost reports

Create Updated Reporting Requirements for Safety Net Providers

- Responsible Entities: Behavioral Health Administration in collaboration with HCPF
- Dependencies: Completion of universal contracting provisions pursuant to HB 22-1278
- Status: In Progress, initial discussions between BHA and HCPF have begun

The BHA, working with the Department, is updating reporting requirements for new safety net providers under the BHA. This includes requirements for cost reporting, financial reporting, submission of claims, and appropriate licensing.

To increase diligence on cost-based rate setting, HCPF released new cost report templates for the safety net providers in May 2022. Those cost reports must be completed by the CMHCs by November 2022. The cost reports and the rate reviews will be posted publicly by March 15, 2023. The Department intends to continue to refine the cost reporting requirements for the safety net providers. **More accurate cost reports create more accurate, accountable, and equitable payments.**

Stakeholder Engagement for Cost Reports

- Responsible Entity: HCPF in collaboration with the BHA
- Dependencies: None
- Status: In progress with continued improvement plans

The Department and the BHA continue to work closely with a multi-stakeholder group to update the safety net cost reporting requirements, as well as the Auditing and Accounting (A&A) guidelines associated with cost reports. This includes adding clarity and better defining "reasonable" with regards to costs. Under HB 22-1278, the definition of the A&A guidelines committee is being expanded to include more external stakeholders including providers and advocates. This stakeholder engagement was used to inform the updated cost reports released May 2022. Additional stakeholder engagement and the expanded A&A guidelines committee engagement will be implemented by March 31, 2023. **The addition of external stakeholders ensures that the cost reporting structure of the safety net providers is robust, effective and transparent.**

4. Expand value-based payment models to larger groups of providers

Explore Alternative Payment Methodologies

- Responsible Entity: HCPF in collaboration with the BHA
- Dependencies: None
- Status: Initial work in progress, additional work forthcoming

HCPF is working with stakeholders and the BHA to develop new reimbursement methodologies for safety net providers that create greater accountability to the community and reward member outcomes. Specifically, the new Alternative Payment Models (APMs) will create sufficient flexibility for providers to meet the needs of the community and members, while the value-based payments (VBP) will better correlate reimbursements with results. The specifics are under development; however, the Department has started modeling different payment methodologies using previous utilization to help inform the development of an initial APM. While these payments will evolve on an iterative basis, the initial APM is anticipated to be effective July 1, 2024, and may require CMS approval for Directed Payments. The Department will draft a plan with the RAEs and providers for implementation of VBP by July 2023.

With the addition of the new safety net provider classification for small and medium providers, the Department and the BHA will work together to evaluate additional payment methodologies that do not rely on cost reports. **The Department expects that these Essential and Comprehensive Safety Net Providers will better engage in the provision of safety net services with limited additional administrative burden, in order to gain access to the higher safety net reimbursement rates for comparable services.** Work on these additional payment models is expected to begin in fall 2023.

Support Safety Net Providers Under New Payment Models

- Responsible Entity: HCPF
- Dependencies: Implementation of updated payment models
- Status: In planning, with initial funding secured

For new safety net providers, the Department will provide additional support to ensure ease of transition and understanding of reporting requirements. This includes

vendor support for the cost reporting requirements for the comprehensive safety net providers. This is in addition to the already standardized Department training and resources available. The Department has already begun contracting for these additional support services. The Department will also be contracting for additional cost report training to begin in spring/summer 2023. **Many small and medium sized providers will benefit if they choose to become a safety net provider, because of the higher reimbursement rates and access to APMs and VBPs.**

Apply for Directed Payment Authority

- Responsible Entity: HCPF
- Dependencies: None
- Status: In planning, application anticipated late 2022 or early 2023

To launch new Alternative Payment Models and value-based payments, the Department may need additional federal approval. Specifically, the Department may need approval for Directed Payments, an allowance for the Department to direct its managed care entities on how to pay for services under very specific rules. The Department is beginning discussions with the Centers for Medicare and Medicaid Services (CMS) to understand the requirements for such authority. The intended outcome is that the Department will be ready with Directed Payment authority when required for new payment models. **Directed Payments, when approved by CMS, can be used to create more standard and more consistent payments and processes across the managed care entities like the RAEs.**

5. Continue to analyze and periodically post publicly rate review and analysis on behavioral health rates, to show changes over time.

Compare IPN Rates to Commercial Insurers

- Responsible Entity: HCPF in collaboration with the Division of Insurance
- Dependencies: Availability and viability of commercial rates for comparison
- Status: Expected start date 2023

The Department is engaging with the Division of Insurance (DOI) to compare the Medicaid Independent Provider Network (IPN) reimbursement rates with those paid by commercial insurance plans. The Behavioral Health Provider Rate Comparison Report

found that the IPN reimbursement rates were not readily comparable to safety net providers as noted in the August 2022 Rates Report. A better – more apples to apples - comparison would be to see how Medicaid rates compare to those of commercial insurers. This requires work and collaboration with DOI. **New insights may inform and support Medicaid behavioral health rate setting targets and opportunities for the IPN, or it may inform the DOI as to commercial reimbursement opportunities.**

Compare SUD Rates to Commercial Insurers

- Responsible Entity: HCPF in collaboration with the Division of Insurance
- Dependencies: Availability and viability of commercial rates for comparison
- Status: Expected start date 2023

The Department is engaging with the Division of Insurance (DOI) to compare the substance use disorder (SUD) reimbursement rates with those paid by commercial insurance plans. The Behavioral Health Provider Rate Comparison Report was unable to directly separate out and compare SUD rates due to restrictions on data. The Department intends to compare the paid Medicaid SUD reimbursement rates with rates paid by commercial insurers. This requires work and collaboration with DOI and is contingent upon compliance with SUD reporting rules. **New insights will inform and support Medicaid behavioral health rate setting targets and opportunities for SUD providers, or it may inform the DOI as to commercial reimbursement opportunities.**

Post Action Plan and Cost Reports

- Responsible Entity: HCPF
- Dependencies: None
- Status: Action Plan and Cost Reports posted by March 15, 2023

The Department will post any subsequent updates to this action plan on its website. In addition, in compliance with HB 22-1268, the Department will post the safety net cost reports. For better transparency and educational purposes, the Department also will post graphics and companion documents to aid readers in understanding the cost report information.