DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2024-25 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 19, 2023

9:00 am – 5:00 pm

9:00-9:15 COMMISSION ON FAMILY MEDICINE

Presenters:
- John McLaughlin, MD: COFM Chair, Congressional District 1 Representative
- Ryan Flint, DO: CAFMR Program Director, St. Anthony's, Colorado Association of Family Medicine Residencies (CAFMR) Board Member
- Ali Rakestraw, MD Resident Physician, Family Medicine Resident, St. Joseph's Program
- Lynne Jones, Executive Director, Colorado Commission on Family Medicine, CO Association of Family Medicine Residencies (COFM/CAFMR)

9:15-9:20 BREAK

9:20-9:35 INTRODUCTION & HEARING OVERVIEW

Presenter: Kim Bimestefer, Executive Director

9-35-9:40 COMMON QUESTIONS FOR DISCUSSION

Main Presenters:
- Kim Bimestefer, Executive Director

Supporting Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Common Questions for Discussion: Page 16, Questions 1-3 in the packet, Slide 16

9:40-10:00 BEHAVIORAL HEALTH QUESTIONS FOR DISCUSSION

Main Presenters:
- Kim Bimestefer, Executive Director
- Cristen Bates, Behavioral Health Initiatives & Coverage Office Director

Topics:
- Behavioral Health: Page 21, HCPF Hearing Questions 1-2 in the packet, Slides 17-21

10:00-10:30 RAEs/ACC PHASE III

Main Presenters:
- Cristen Bates, Behavioral Health Initiatives & Coverage Office Director

Topics:
- RAEs/ACC Phase III: Page 23, Questions 3-4 in the packet, Slide 22-29

10:30-10:45 BREAK

10:45-11:05 PUBLIC HEALTH EMERGENCY UNWIND, COUNTY ADMINISTRATION & APPEALS

Main Presenters:
- Kim Bimestefer, Executive Director
- Rachel Reiter, Policy Communications and Administration Office Director

Topics:
- Public Health Emergency Unwind, County Administration and Appeals: Page 29, Questions 5-22 in the packet, Slides 30-41

11:05-11:20 VALUE BASED PAYMENTS

Main Presenters:
- Kim Bimestefer, Executive Director
- Bettina Schneider, Chief Financial Officer
- Cristen Bates, Behavioral Health Initiatives & Coverage Office Director

Topics:
- Value Based Payments: Page 46, Questions 23-30 in the packet, Slide 42-46

11:20-11:40 PROVIDER RATES

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Provider Rates: Page 58, Questions 31-48 in the packet, Slides 47-54

11:40-11:45 DENVER HEALTH

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Denver Health: Page 72, Questions 49-52 in the packet, Slides 55-56

11:45-11:50 GENERAL FINANCING

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- General Financing: Page 74, Questions 53-58 in the packet, Slides 57-61

11:50-12:00 R12-14 & GENERAL ELIGIBILITY

Main Presenter**s:**
- Bettina Schneider, Chief Financial Officer
- Adela Flores-Brennan, Medicaid Director

Topics:
- R12-14 & General Eligibility, Page 78, Questions 59-67 in the packet, Slide 62

12:00-1:30 LUNCH

1:30-1:45 CHILDRENS HEALTH PLAN *PLUS* BENEFIT

Main Presenters:
- Adela Flores Brennan, Medicaid Director

Topics:
- CHP+: Page 85, Questions 68-70 in the packet, Slides 63-65

1:45-2:00 AUTISM PROVIDERS

Main Presenters:
- Adela Flores Brennan, Medicaid Director

Topics:
- Autism Providers, Page 88, Questions 71-76 in the packet, Slides 66-68

2:00-2:10 BREAK

2:10-4:10 OFFICE OF COMMUNITY LIVING

Main Presenters:
- Bonnie Silva, Office of Community Living Director

Topics:
- Office of Community Living: Page 96, Slides 69-72
- Community-Based Program Growth: Page 96, Questions 77-78 in the packet, Slides 73-74

- LTSS Cost Growth: Page 97, Questions 79-80 in the packet, Slides 75-77
- Third Party Assessor: Page 100, Questions 81-92 in the packet, Slides 78-82
- R-11: Page 108, Questions 93-94 in the packet, Slide 83-86
- Developmental Disabilities Waitlist: Page 112, Questions 95-99, Slides 87-91
- Care and Case Management System: Page 118, Questions 100-102, Slides 92-93

4:10-4:30 CLOSING REMARKS

Main Presenters

- Kim Bimestefer, Executive Director

COMMON QUESTIONS, FOR WRITTEN RESPONSES ONLY

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COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Colorado Commission on Family Medicine
Report to the Joint Budget Committee, December 2023
Training Family Physicians for the State's Health Care Needs since 1977

Presenters:

- ***John McLaughlin, MD: COFM Chair***
  Congressional District 1 Representative
- ***Ryan Flint, DO: CAFMR*** Program Director, St. Anthony's, Colorado Association of Family Medicine Residencies (CAFMR) Board Member
- ***Ali Rakestraw, MD Resident Physician***
  Family Medicine Resident, St. Joseph's Program
- ***Lynne Jones***
  Executive Director, Colorado Commission on Family Medicine, CO Association of Family Medicine Residencies (COFM/CAFMR)

***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.

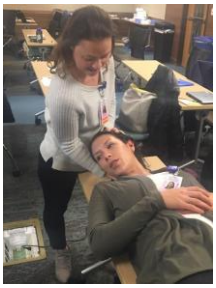
Our mission: to convene key leaders and stakeholders who support family medicine training to:

- 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.

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 102,000 individual patients annually, 67+% of whom are uninsured or Medicaid/Medicare beneficiaries.
- Physicians who train in Colorado tend to remain in the state (44+%).
- COFM is a unique collaborative vs. competitive model of recruiting new physicians to the state.






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 Alamosa, Brush, Fruita, Granby, LaJunta, Meeker, Pagosa Springs, Yuma, 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 (Clinica, Pueblo Community Health, Peak Vista, Salud, STRIDE, Sunrise, and others).

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Addressing health disparities and inequities

-64,675 of the 102,000 individual patients treated are uninsured, or Medicaid/Medicare beneficiaries.
-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.
-Engagement with schools/other educational institutions to 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 likely to practice 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.

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

Colorado continues to increase the average number of physicians practicing in rural communities with time. From 2012 -2014, prior to the establishment of the rural training tracks, an average of about 10% of residents remaining in Colorado chose to practice in rural areas where in the past 3 years it is approximately 21%. Underserved community choice was 27% in 2022.

2012 – 2023

FM Resident Graduates who stayed Colorado to Practice

Resident Graduate Years	Number of Residency Programs	Total Number of Graduating Residents	Resident Graduates Staying in Colorado	% of Resident Graduates staying in CO	Resident Grads Practicing in Rural Colorado	% of Resident Grads Practicing in Rural Colorado	Resident Grads practicing in Urban Underserved Colorado	% of Resident Grads practicing in Urban Underserved Colorado	Resident Grads joining Colorado FMR Faculty	% of Resident Grads joining Colorado FMR Faculty	Colorado Fellowship	% of Resident Graduates staying in CO Fellowships
2023	10	83	51	61%	8	16%	11	22%	10	20%	7	14%
2022	10	83	38	46%	8	21%	8	21%	5	13%	11	29%
2021	10	81	48	59%	9	19%	13	27%	4	8%	5	10%
2020	10	88	55	63%	8	15%	12	22%	5	9%	9	16%
2019	10	86	49	57%	12	24%	10	20%	9	18%	11	22%
2018	9	65	46	71%	6	13%	10	22%	7	15%	6	13%
2017	9	68	49	72%	11	22%	11	22%	7	14%	6	12%
2016	9	66	33	50%	7	21%	9	27%	4	12%	5	15%
2015	9	68	38	56%	7	18%	11	29%	2	5%	6	16%
2014	9	62	35	56%	7	20%	11	29%	6	17%	6	17%
2013	9	66	38	58%	6	15%	10	26%	1	3%	7	18%
2012	9	65	36	55%	3	8%	8	22%	2	6%	2	5%

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

REDUCTION IN FAMILY MEDICINE RESIDENCY PROGRAMS

The Peak Vista Family Medicine Residency Program will close its doors June 30, 2024, due to financial challenges with the program. As a federally qualified health center hosted program not affiliated with a hospital system, supporting a program can be a considerable financial challenge without the support of federal grant funding. Initiated in 2016, the program will have graduated 23 family physicians, 68% of whom remained in Colorado to practice.

COFM on behalf of CAFMR FUNDING REQUEST

CAFMR is asking for continuation funding for the three funding categories for the residency programs:

- Base total funding: $3,340, 168 (50/50 GF/FF); supports recruitment, rural practice exposure, professional development, care coordination and collaboration among the state residency programs.
- Rural Training Track funds: $3,000,000 (50/50 GF/FF); supports rural residency training in four communities in Colorado.
- Additional Resident Training Position funds: $2,700,000 (50/50 GF/FF); supports five additional residents with a commitment to practice for 3 years in state defined rural and underserved areas upon graduation.

CAFMR is working diligently to pursue another residency program in the Pikes Peak region as El Paso County is the most largely populated county in the state and continues to be challenged by primary care access. COFM consulted with HCPF regarding the base funding that Peak Vista currently receives and is proposing that COFM retain the $167,084 in general funds and $167,084 in federal match for a total of $334,168. These funds will be distributed to each of the nine remaining residency programs in the amount of $37,130 ($18,565 general fund) for a new base funding total of $371,298.

These funds are valuable to the overall success of the Commission and will allow the programs to enhance their efforts toward meeting statutory requirements and the mission of the Commission through: Supplementing current state support for training family physicians which will help alleviate some of the burden to sponsoring institutions and systems of training residents.

• Supplementing support for recruiting costs which have increased in the form of travel to medical school residency recruiting events, hosting activities and events, and promotional activity including sponsorship and exhibits.

• The current cost of training residents has increased from $150,000 to approximately $180,000 each since COFM funding first received state support (https://journals.stfm.org/familymedicine/2018/february/pauwels-2017-0230/) Although it was never the intent that the state would fully support these programs (the state annually contributes between three and four percent of the cost of training), funding provided helps defray costs to sponsoring institutions, which typically experience a loss, in training family medicine residents.

For example, one program has received permission to increase by 3 (14%) the number of family medicine resident physicians trained each year. These funds will assist to defray the cost of training those new residents.

This is a cost neutral request as the appropriation will remain the same and this request does not require additional general funds or legislation.

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+%.

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

Training Family Medicine residents in the rural community of Fort Morgan would be impossible without the Colorado Commission on Family Medicine. The federal funding that the program receives is simply not enough to pay resident salaries and operational costs. The direct funding from COFM is vital. COFM's ability to foster collaboration among all the programs in Colorado is also extremely valuable. We collaborate on recruitment and bring medical students from across the nation to Colorado. We also collaborate on curriculum development, faculty development and sharing best practices on innovations of care delivery. Family Medicine educators from across the country are envious Colorado's ability to bring competing programs and healthcare systems together to collaborate on these projects which enhance quality in education and patient care. This collaboration simply would not happen without the infrastructure that the commission provides.

-Dan Burke, MD, Program Director, Fort Morgan Rural Training Track

- 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 currently 10 family medicine residency programs in Colorado, there will be nine in 2024-25.
- Programs are independent of one another but collaborate through the Commission on Family Medicine (COFM).
- Historically from 2010 through 2022 about 20% of family medicine resident physicians come from Colorado medical schools (University of Colorado and Rocky Vista University) and over 50% stay to practice in Colorado.
- Over 40% of graduates who stay in the state practice in rural or underserved areas, it was 54% in 2022 with 27% each in rural and urban underserved.
- The residency clinics are part of Colorado's health care safety net. In 2022:
  - Over 102,000 Coloradans received health care in family medicine clinics.
  - 67+% of patients were Medicaid (44%) or Medicare (16%) or uninsured (7%).

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. These funds are critical to the success of the Commission as they supplement the sponsoring institution support, show state investment in addressing access issues, and allow for investment in enhancing programs not otherwise available to them.
- State funds are matched by federal Medicaid dollars, effectively doubling the investment.

COLORADO COMMISSION ON FAMILY MEDICINE

Colorado Family Medicine Residencies

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 (67+% 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

Program Expansion and Success
The Fort Collins Family Medicine Residency:

- Two graduates over last 2 years practicing in Yuma, CO
- Program expanded number of residents in training from 18 to 24 since 2017.

- 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

- 83 total graduates in 2023.
- 61% of this year's graduates stayed in Colorado.
- 54% of those in Colorado practice in rural/underserved areas.
- Since 1972 (1st graduating classes of FPs), 52% of graduates have active licenses in CO.

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

CO Residency Program Base Support	2018/19	2019/20	2020/21	2021/22	2022/23
Total # of Residents*	252	247	265	258	**260**
Total # of Graduates*	83	82	81	85	**83**
Cost per Resident**	$342,711	$359,387	$366,346	368,911	**384,383**
State Support per Resident***	$13,254	$13,523	$18,758	$12,946	**12,847**
% Support from State***	4.10%	3.7%	3.6%	3.5%	**3.3%**

*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 260, 87 of whom are expected to graduate in June of 2024.

**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 2022-23, the residency programs reported spending 99,939,559 for training 260 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*.

Benefits of the Commission

The Commission fosters collaboration among the independent programs:

- Increases the placement of graduates in rural and underserved locations.
- 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.

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 family medicine specialty:

- Fewer 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.
- Fewer 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.

NOTE: the federal Department of Health and Human Services recently published an issue brief describing the value of and challenges in the US primary care role
https://www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf

Rural Training Tracks

The resident physicians who are trained in Colorado and whose programs participate with the Commission on Family Medicine continue to choose to 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.

Physician Workforce Pipeline in Action:
On the eastern plains, four rural training track trained physicians are practicing Brush, Wray and Sterling after completing their residencies; evolving the rural practice pipeline for that region of the state.

-Information from Jeff Bacon, MD
-Chief Medical Officer, Sterling, CO

Colorado proudly hosts 4 rural training tracks:

☆Wray ☆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 (one of oldest in country) 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 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 – GF and FF through Medicaid Graduate Medical Education funds) This state funding support is crucial to the sustainability of the quality and comprehensive scope of the residency programs in Colorado to train family physicians (allocated to the Commission on Family Medicine) and falls into three categories noted below:

Base Funding ($1,670,084)	Rural Training Track ($1,500,000)	Added Resident Positions ($1,350,000)
• Distributed from HCPF to residency programs • Supplements Medicare GME and other funding sources & patient revenue to defray expense of resident training • Recruitment of medical students into residency programs • Support resident exposure to rural practice experience • Enhance faculty and program leadership professional development • Provide collaboration, training and sharing of best practice among all residency programs • Supports care coordination and integrated care delivery across residency programs	• 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 development expansion work	• 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

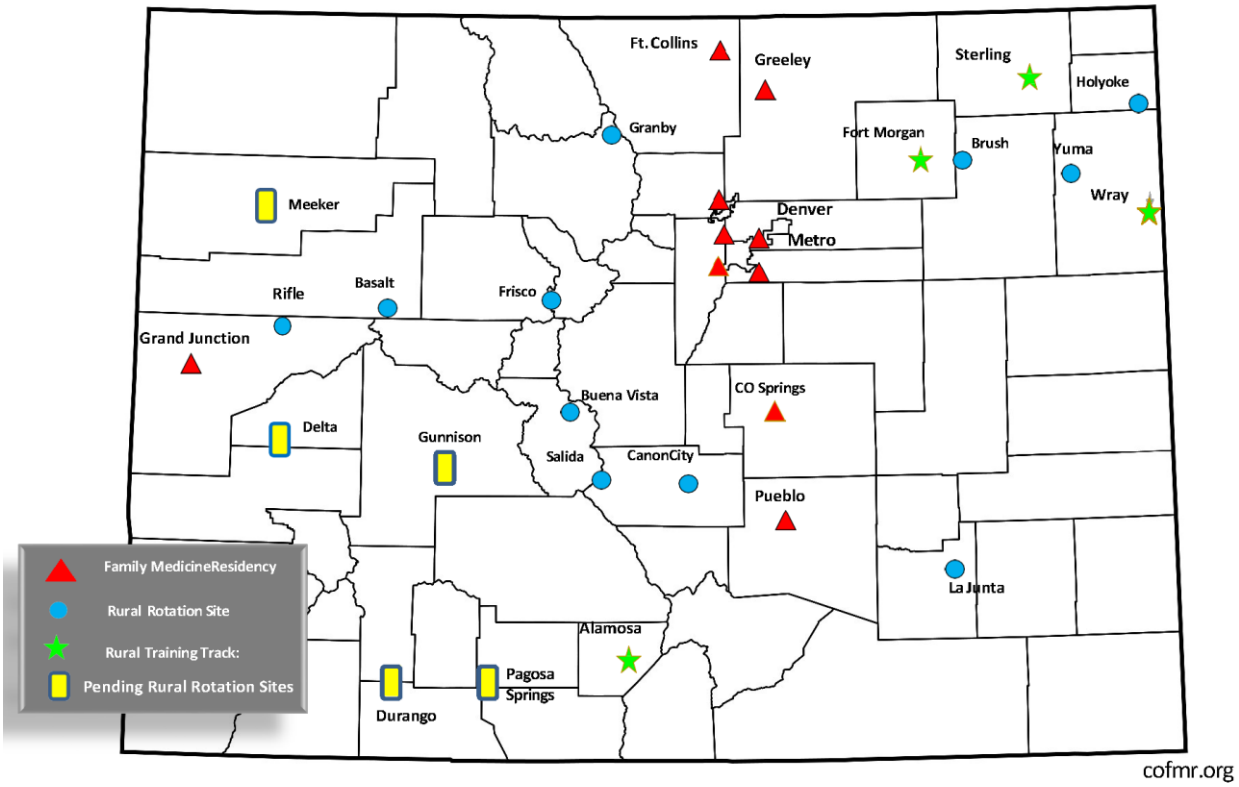
Benefits of the Commission's work to rural Colorado are multiple. Close to ¾ of the Commission's funding impacts rural primary care practice either directly or indirectly through training and practice with our rural training tracks (RTT) and rural rotation sites.; the broad spectrum training the resident 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 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



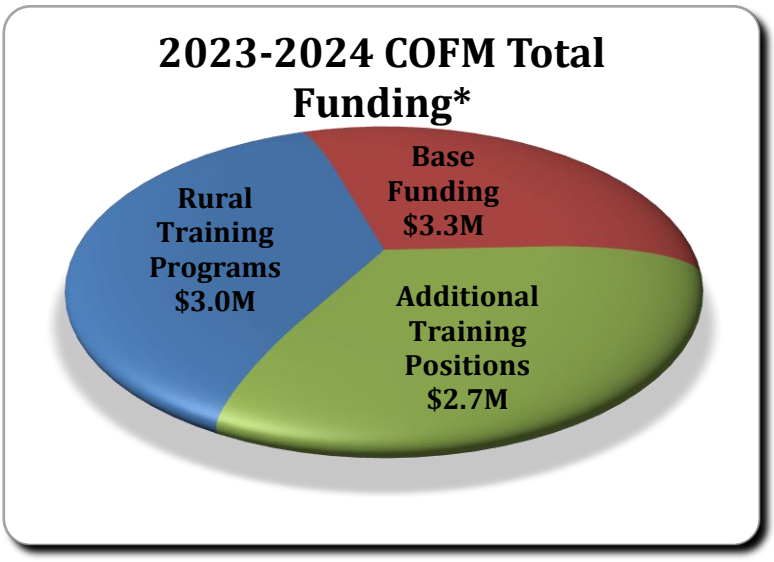
RTT resident physicians see:

- 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



*State general funds ($4,745,085) are matched by federal Medicaid funds ($4,745,085) for $9,490,170 in total funds.

COMMON QUESTIONS FOR DISCUSSION

1. **Please describe one-time state and federal stimulus funds that have been allocated to the Department but are not expended as of September, 30, 2023, by bill, budget action, executive action, or other source that allocated funds. The description should include but are not limited to funds that originate from one-time or term-limited General Fund or federal funds originating from the American Rescue Plan Act (ARPA)/State and Local Fiscal Recovery Funds/Revenue Loss Restoration Cash Fund. Please describe the Department's plan to obligate or expend all allocated funds that originate from ARPA by December 2024.**

   Please further describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information: Original fund source (General Fund, ARPA, other), amount, and FTE;

   a. **Original program time frame;**

   b. **Original authorization (budget decision, legislation, other);**

   c. **Requested ongoing fund source, amount, and FTE; and**

   d. **Requested time frame (one-time extension or ongoing).**

RESPONSE

HCPF has received the following one-time state and federal stimulus funds that have not been fully expended by Sept. 30, 2023[1]:

- American Rescue Plan Act Section 9817 Home and Community Based Services: This provision in ARPA provided a 10-percentage point increase in the federal match rate for certain Medicaid services for one year, with the requirement to use the freed-up state funds to enhance, expand, and strengthen home and community-based services. Per SB 21-286, the freed-up state funds were transferred to the Home and Community Based Services Improvement Fund to use as the state share for projects implemented through the spending plan, many of which also receive Medicaid federal financial participation (FFP).
- State and Local Fiscal Recovery Fund
  - HB 22-1302 "Primary Care and Behavioral Health Statewide Integration Grant Program": This is a program administered by HCPF to provide grants to physical and behavioral health care providers for implementation of evidence-based clinical integration care models.
  - SB 22-200 "Rural Provider Stimulus Grant Program": This is a program administered by HCPF to provide grants to qualified rural health care providers

[1] For a complete list of all funds received, see the spending breakdown: https://coforward.colorado.gov/data/agency-spending-data/dept-of-health-care-policy-financing-hcpf

to improve health care services in rural communities through modernization of information technology infrastructure and expanded access to health care.

- Vaccine Analyst: HCPF has an interagency agreement with the Governor's Office to fund one FTE to support vaccine outreach. Utilizing SLFRF to support the position, the FTE is responsible for leading the effort to increase the number of Medicaid members fully immunized for COVID-19 and other critical vaccines. The position is funded through June 2024.

The spending for these stimulus funds is in various states of progress. The ARPA HCBS stimulus funds expire March 31, 2025, per guidance from the Centers for Medicare & Medicaid Services. HCPF submits a quarterly report to the JBC describing how HCPF intends to fully expend this funding. The Healthcare Practice Transformation & Integration grant program funding must be obligated by Dec. 31, 2024, with grantees spending of that funding by Dec. 31, 2026. HCPF is currently setting up the grant agreements that will be fully encumbered by Dec. 31, 2023. The Rural Provider Stimulus Grant Program is currently funded through July 1, 2024, and HCPF is requesting to extend the deadline until Dec. 31, 2024, to expend or encumber the funding. HCPF has adopted program guidelines, including grant application procedures, timelines, eligibility, funding amounts and reporting requirements. HCPF is currently setting up grant agreements with awardees, with seven of 24 agreements fully executed, eight in final approval stages, and drafting underway with nine awardees. HCPF communicates with all awardees regularly.

The following table shows the total stimulus funding, amount spent as of Sept. 30, 2023, the amount remaining per program, the total FTE allocated, and a summary narrative of the spending plan.

Stimulus Fund Source	Amount Allocated	Amount Spent as of Sept.30, 2023	Amount Remaining	FTE	Spending Plan
ARPA HCBS	$304,257,346	$144,126,581	$160,130,764	58.5	Plan to spend total amount by March 31, 2025. Spending plan published quarterly.[2]
SLFRF – HB 22-1302 Grants	$34,750,000	$1,372,385	$33,377,615	5.0	HCPF has set up contracts to create the grant program. 81 grants currently being set up with 47 already signed.

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

SLFRF – SB 22-200 Grants	$10,000,000	$35,980	$9,964,020	1.5	HCPF has set up contracts to create the grant program, with 24 grants currently being set up and 7 already signed.
SLFRF - Vaccine Analyst	$278,886	$208,655	$70,231	1.0	HCPF has hired this position through an IA with the Governor's Office. This is funded through June 2024.

The following budget requests include items that replace one-time General Fund or ARPA funded programs.

Request	Original Fund Source	Original Authorization and Original Time Frame	Requested Ongoing Fund Source	Amount	FTE	Request Time Frame
FY 2024-25 R-6 "Provider Rate Adjustments"	HCSI cash fund and FFP	New Request	General Fund and FFP	$13,322,439	0.0	Requesting HCBS base wage rate increases to be paid through General Fund as the state share starting Jan. 1, 2025, and ongoing
FY 2024-25 R-7 "Behavioral Health Continuum"	HCSI cash fund and FFP	FY 2021-22 BA-10 "HCBS ARPA Spending Authority" funded through ARPA through Dec. 31, 2024	General Fund and FFP	$71,697	1.0	Requesting to continue the Statewide Supportive Housing Expansion (SWSHE) Pilot program starting Jan. 1, 2025, and ongoing
FY 2024-25 R-9 "Access to Benefits"	HCSI cash fund and FFP	FY 2021-22 BA-10 "HCBS ARPA Spending Authority" funded through ARPA	General Fund and FFP	$125,000	0.0	Requesting to continue the Centers of Excellence in Pain Management pilot program starting

		through Dec. 31, 2024				Jan. 1, 2025, and ongoing
FY 2024-25 R-11 "Program Support"	HCSI cash fund and FFP	FY 2021-22 BA-10 "HCBS ARPA Spending Authority" funded through ARPA through Dec. 31, 2024	General Fund and FFP	$336,333	3.8	Requesting to continue the HCBS systems support and Direct Care Workforce Unit starting Jan. 1, 2025.
FY 2024-25 R-11 "Program Support"	SLFRF	§ 24-75-226 (4) (a), C.R.S.	General Fund and FFP	$45,435	0.9	Requesting to hire a new Preventive Care Analyst with an expanded role July 1, 2024, and ongoing.
FY 2024-25 Base Budget	HCSI cash fund and FFP	FY 2023-24 R-7 "Provider Rate Adjustments" funded through ARPA through Oct. 31, 2023	General Fund and FFP	$40,446,608	0.0	HCBS base wage rate increases, GRSS Budget Neutrality Adjustment, and NMT Rate Increase were approved to continue with General Fund starting Nov. 1, 2023, and ongoing
FY 2024-25 Base Budget	HCSI cash fund and FFP	FY 2023-24 R-10 "Children and Youth with Complex & Co-Occurring Needs" funded through ARPA through Dec. 31, 2024	General Fund and FFP	$1,769,429	0.0	Adding Skilled and Therapeutic Respite Services to the CES and CHRP Waivers were approved to continue with General Fund starting Jan. 1, 2025, and ongoing
FY 2024-25 Base Budget	HCSI cash fund and FFP	FY 2023-24 R-13 "Case Management Redesign" funded through ARPA for a partial	General Fund and FFP	$12,828,805	0.0	Increasing Case Management Rates, providing ongoing training and system support were approved to continue with

		year in FY 2023-24				General Fund starting July 1, 2024, and ongoing
FY 2024-25 Base Budget	HCSI cash fund and FFP	FY 2023-24 BA-7 "Community Based Access to Services" funded through ARPA through June 30, 2024	General Fund and FFP	$2,974,232	0.0	Providing funding to prevent unnecessary institutionalization, providing effective transition services, expanding access to Colorado's Community-Based Service System, and increasing access to integrated community-based housing were approved to continue with General Fund starting July 1, 2024, and ongoing
FY 2024-25 Base Budget	HCSI cash fund and FFP	FY 2021-22 S-10, BA-10 "American Rescue Plan Act Spending Authority" funded through ARPA through April 15, 2023	General Fund and FFP	$79,920,605	0.0	HCBS base wage rate increases were approved to continue with General Fund starting April 16, 2023, and ongoing

2. **Please provide a description, calculation, and the assumptions for the fiscal impact of implementing compensation provisions of the Partnership Agreement, as well as a <u>qualitative description</u> of any changes to annual, medical, holiday, or paid family leave as part of the Agreement. Please also describe any compensation and leave changes for employees exempt from the Agreement if applicable.**

RESPONSE

In FY 2022-23, HCPF's budget included a salary survey appropriation of $1.74 million total funds. In FY 2023-24, HCPF's budget included an appropriation of $3.67 million total funds.

These amounts are attributable to the Partnership Agreement. The agency has also followed the Partnership Agreement as it pertains to pay ranges and minimum wage.

HCPF had two union stewards during FY 2022-23. During this period, the employees' hours were tracked, and the reimbursements were processed appropriately and timely. This included 163.5 hours and $7,297.87 in total costs for the year.

The costs to departments for employees using the paid family medical leave were requested and approved last year through DPA's R-2 request. For FY 2023-24, the cost is part of the common policy 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. If HCPF experiences increased costs related to the Partnership Agreement beyond current appropriations, it will work through the regular budget process to request additional resources.

3. **Provide a prioritized list of budget reductions the Department would propose if 10.0 percent General Fund appropriation reductions were required of every Department.**

RESPONSE

We appreciate the question and the desire to partner with HCPF on identifying reductions. On Nov. 1, the Governor submitted a balanced budget that provided decision items for increases and reductions that we spent over a half a year to identify and prioritize across the entire Executive Branch. The proposed budget is balanced, maintains a reserve of 15%, and does not require a 10.0% reduction in the General Fund to balance. If the economic conditions change, the Governor will take actions to propose reduced expenditures and submit a plan to address the shortfall to the General Assembly. If the Joint Budget Committee wants feedback on specific reduction proposals, we welcome the opportunity to work with JBC staff on estimating the impacts and tradeoffs of those proposals.

DEPARTMENT DISCUSSION QUESTIONS

BEHAVIORAL HEALTH

1. **[Rep. Bird] Please share additional data on the length of stay for IMD patients. Does the Department have data on the number of patients that would have benefited from a stay longer than 15 days?**

RESPONSE

The federal IMD exclusion rule places significant limits on state's ability to cover inpatient mental health services. HCPF has studied the issue in to improve access to care, especially for

individuals with serious mental illness and those who need more than 15 days inpatient care to be stabilized. In the IMD Implementation Plan Report prepared for HCPF, Health Management Associates reported that between October 2019 through November 2022, 783 stays, or an average of 2.7%, in IMDs exceeded 15 days. For the same time, period 97.2% of total IMD stays were less than 15 days.

Between October 2019 through August 2023, 1,728 members, or approximately 12%, who received care in a freestanding inpatient psychiatric hospital had a second episode in an IMD in the same calendar month. This suggests a member was potentially not fully stabilized when discharged from the first IMD.

If a member stays in an IMD for more than 15 days in a calendar month, whether from a single visit or as a combination of total days from multiple visits, a provider (or multiple providers) receives no payment for care they provide. Multiple stays in a calendar month that totaled more than 15 days happened 730 times, with an average of 15 times per month over the last four years.

2. **[Rep. Bird] What waivers are available from the federal government that could allow for stays longer than 15 days? Why is the Department not considering a 30 or 60 day IMD waiver as part of the request?**

RESPONSE

The Centers for Medicare & Medicaid Services (CMS) offers a Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) 1115 Waiver opportunity to states. This waiver allows states to pay for member stays in an IMD for up to 60 days, provided the state's average IMD length of stay does not exceed 30 days. This is the only waiver option that allows states to cover up to 60 days for individual member stays. This waiver authority does not limit the number of stays a member can have annually or through a lifetime benefit.

Health Management Associates worked with HCPF to estimate the fiscal impact of pursuing an SMI/SED 1115 Waiver. This fiscal analysis is laid out in the IMD Implementation Plan Report published on HCPF's website. Reimbursement for the first 15 days of a stay in an IMD when the stay exceeds 15 days would cost $2,450,304, with a General Fund cost of $582,769. This amount is reflected in HCPF's R-7 budget request.

For calendar years 2021 and 2022, the average length of stay for members who exceeded 15 days in an IMD was 33.44 days. To pay for 30 days in an IMD for all members whose stays exceeded 15 days would cost an estimated $7.2 million, with a General Fund cost of $1.8 million. This includes the $2,450,304 for the first 15 days of a stay, in addition to reimbursement for stays up to 60 days for some members, with a requirement that the state maintain an average length of 30 days.

In 2023, 18 members required stays of 60 days or more and the additional cost to cover these stays would be approximately $16,335 in total for days that are over 60 days. This cost would covered entirely by General Fund and covering these medically necessary stays is a condition of the waiver.

HCPF's request to seek authority to pay for the first 15 days addresses a critical gap in reimbursement for these services while keeping within the constraints of the funding available in the state's budget.

REGIONAL ACCOUNTABLE ENTITIES

3. ***[Rep.Bird]*** **Describe Department oversight of the RAEs, including the following components.**
   1. How does the Department collect and consider feedback from providers regarding RAE performance?
   2. How does provider feedback inform oversight and accountability of the RAEs?
   3. How is the Department working to make sure that all RAEs are treating providers similarly across the state?
   4. How does the Department work with RAEs to ensure RAEs incentivize and create an environment where providers want to serve Medicaid members?

RESPONSE

Related to providers, the RAEs have contracts with Primary Care Physicians, known under the Medicaid program as PCMPs – Primary Care Medical Providers. They also have contracts with Behavioral Health providers. All providers, including these providers, are formally enrolled by HCPF into the Medicaid network and execute a standard provider agreement with HCPF to ensure consistent contractual compliance. Because the question came from the Behavioral Health JBC Analyst briefing, the answer below is largely from the behavioral health perspective.

HCPF oversight of the RAEs

HCPF oversight of the Regional Accountable Entities (RAE) begins by ensuring contract requirements comply with extensive federal and state statutes and regulations. All RAE contract language must be approved by the Centers for Medicaid and Medicare Services (CMS). The contracts include stringent Statements of Work and are amended biannually to adjust for environmental changes, operational realities, and new state priorities, including those identified by providers and members. HCPF reviews comprehensive deliverables submitted by the RAEs that document operational and financial performance, program strategies, network performance and governance structures. HCPF uses robust data analytics to measure RAE and provider performance in accordance with quality performance metrics, formal stakeholder feedback processes, customer service standards, and independent auditing requirements. HCPF enforces all of this via a thorough contract remedy process to address deficiencies in RAE contract performance. When RAEs are not meeting contract elements, they are placed on action monitoring plans or corrective action plans. HCPF also uses a set of incentive payment programs that help improve statewide service quality and access.

Every RAE and MCO is also required to have a grievance and appeal system to handle grievances about any matter related to their contract. HCPF may review any of the documented solutions and if HCPF determines the solution to be insufficient or otherwise unacceptable, it may direct the RAE or MCO to find a different solution. The RAEs and MCOs

must submit quarterly grievance and appeals reports to HCPF. In addition, in accordance with C.R.S. 25.5-5-406.1(n)(III)(C), Colorado has an independent Managed Care Ombudsman. The role of the Managed Care Ombudsman includes: helping Medicaid members resolve concerns at the lowest level resulting in the expedited delivery of service when issues about health care benefits arise; advising members of their rights and procedures for accessing a fair hearing with the Colorado Office of Administrative Courts; working with HCPF on patient safety and access issues; and overseeing complaint resolution.

1. **How does the Department collect and consider feedback from providers regarding RAE performance?**

HCPF uses multiple mechanisms to collect and consider stakeholder feedback about RAE performance, including:

- **Managed care provider complaint form** – HCPF's managed care and CHP+ provider complaint form allows individual providers to escalate complaints about RAEs, Managed Care Organizations (MCOs) and CHP+ plans directly to HCPF contract management teams. These complaints are tracked for direct resolution, but also the trends provided in these forms can result in broader HCPF activity including corrective actions against a specific RAE or MCO, programmatic policy guidance, or contract amendments.
- **Program Improvement Advisory Committees (PIAC)** – HCPF's Accountable Care Collaborative (ACC) holds a monthly statewide Program Improvement Advisory Committee (PIAC). Each region also contractually required to have their own local PIAC to inform programmatic decisions and identify community needs, which must include BH providers. The statewide PIAC includes voting members who represent providers, advocacy organizations, Medicaid members and other community stakeholders. The PIAC considers actions related to the ACC and provides formal recommendations to HCPF for program improvement. PIAC subcommittees, including a Provider and Community Experience committee, help examine specific issues and develop recommendations for HCPF. Neither the statewide PIAC nor the PIAC subcommittees include RAE or MCO representatives among their voting membership.
- **Stakeholder meetings** – HCPF routinely meets with stakeholder groups to receive feedback about the ACC program. This includes regular meetings with specific provider trade groups or organizations representing safety net providers, the independent provider network (IPN), freestanding psychiatric hospitals, state mental health hospitals, hospitals, substance use disorder providers, psychiatric testing providers, and county human service departments. In addition, HCPF convenes several provider-focused forums including a coding committee and the Institutes for Mental Disease (IMD), Hospital, IPN, SUD, and Safety Net forums.
- **Targeted engagement with the Independent Provider Network (IPN)** – With the assistance of a third-party facilitator, HCPF and IPN providers identified potential barriers and created mutually agreeable action plans to address credentialing and contracting, billing and coding, reimbursement, service quality and communications. HCPF launched a quarterly IPN Collaboration to help providers stay informed about key changes that directly impact the IPN community. HCPF continues to meet monthly with representatives from the IPN to move these recommendations forward and provide ongoing space for collaboration. IPN providers had the opportunity to give feedback about HCPF and the RAEs through an IPN satisfaction survey. Overall, the results indicate improvement in satisfaction and service quality; survey respondents

indicated they are more satisfied with being a Medicaid provider and their relationships with the RAE improved in the one-year collaboration period. These survey results are provided in the IPN, RAE, HCPF Collaboration Project Phase II Final Report.

- The Executive Director also conducts a multitude of productive, collaborative, annual on-site visits with providers, such as Federally Qualified Health Centers (FQHCs), hospitals, Community Mental Health Centers (CMHCs) and more. In all meetings, she inquires about their working relationship with the RAE and opportunities for improvement to help inform and evolve needed RAE attributes as well as RAE and provider accountability to serving Medicaid members.

2. **How does provider feedback inform oversight and accountability of the RAEs?**

Providers are critical stakeholders that are necessary for ACC program management and success. Provider feedback, whether received through the formal mechanisms described in Question 1 or through less formal communications, significantly informs HCPF's oversight and accountability of the RAEs. Feedback has frequently helped HCPF both troubleshoot unique issues related to specific providers or individual Medicaid members and identify broader systemic challenges that affect many providers and members. Provider insights often help HCPF better manage RAE performance and to develop longer term solutions and RAE contract amendments. As an example, provider feedback resulted in contract amendments to hold RAEs accountable to contract and credential new providers within 90 days.

Provider feedback also propelled the creation of a HCPF 2023 report that studied, reported, and explained the difference between the roles and related reimbursements to Medicaid independent providers compared to the Community Mental Health Centers.

3. **How is the Department working to make sure that all RAEs are treating providers similarly across the state?**

The ACC Program strikes a balance between regional flexibility and responsiveness as well as uniform statewide program parameters. The following program components ensure that RAEs are treating providers similarly across the state:

- **Identical contracts** - Although HCPF pays different behavioral health capitation rates to each of the RAEs to account for regional variations that affect the costs for health care services, RAE contracts are otherwise identical for all seven regions.
- **RAE deliverables** - HCPF collects approximately 120 deliverables annually to monitor RAE performance, track customer service issues, identify potential problems, ensure consistency from region to region, and take remedial action if necessary.
- **Independent audits** - HCPF uses independent third parties to monitor RAEs on: network adequacy, program compliance, and RAE financial performance for accuracy and consistency.
- **Quality metrics** - HCPF uses statewide health quality performance indicators to measure health outcomes, monitor RAE performance, and ensure providers across regions are working towards improving the same measures. The incentives and metrics are publicly reported by the RAEs and posted on the HCPF website to encourage transparency and accountability.
- **Directed payments** – Directed payments are CMS-approved standards that state Medicaid agencies impose on managed care organizations to support statewide access

to care, appropriate payments to providers, or certain payment methodologies. In July 2023, HCPF established a directed payment policy and fee schedule to set minimum rates for certain high need services, and will be using directed payments to implement value based payments. HCPF prepared a report on this topic, submitted to the General Assembly in December 2023.

- **Universal contracting provisions** – HCPF is collaborating with the BHA to develop and implement standard contract provisions for all contracts between managed care entities and providers. These provisions help ease administrative burden for providers, standardize processes and procedures and improves accountability for RAEs, providers, and the state.

In developing ACC Phase III, HCPF continues to incorporate feedback from providers, members, and community partners about the importance of reducing the complexity and administrative burden of delivering and accessing care. HCPF focused on simplifying systems, creating more consistency and standardization across the program, and centralizing some elements to improve the member and provider experience. A few examples of these proposed changes are the standardized child benefit and the centralized provider credentialing process discussed in the ACC Phase III Concept Paper.

4. **How does the Department work with RAEs to ensure RAEs incentivize and create an environment where providers want to serve Medicaid members?**

Developing a robust network of quality providers is essential to HCPF and the RAEs' ability to administer the Medicaid program. HCPF monitors the number of behavioral health providers that hold contracts with the RAEs and works closely with providers and RAEs to expand the Medicaid provider network. Medicaid is the largest payer of behavioral health services in the state and has a number of beneficial policies for BH providers. This includes no co-pay, no deductibles, no authorization required for most outpatient services like psychotherapy, and the most comprehensive coverage package of services in the state. In fact, HCPF worked with DORA to release a letter to all licensed behavioral health providers in the state who were not contracted under the Medicaid program communicating these Colorado Medicaid advantages – no premiums, no deductibles, no co-pays – as they are not co-occurring with commercial coverage. We are also planning another similar Medicaid behavioral health education and differentiation campaign for early 2024.

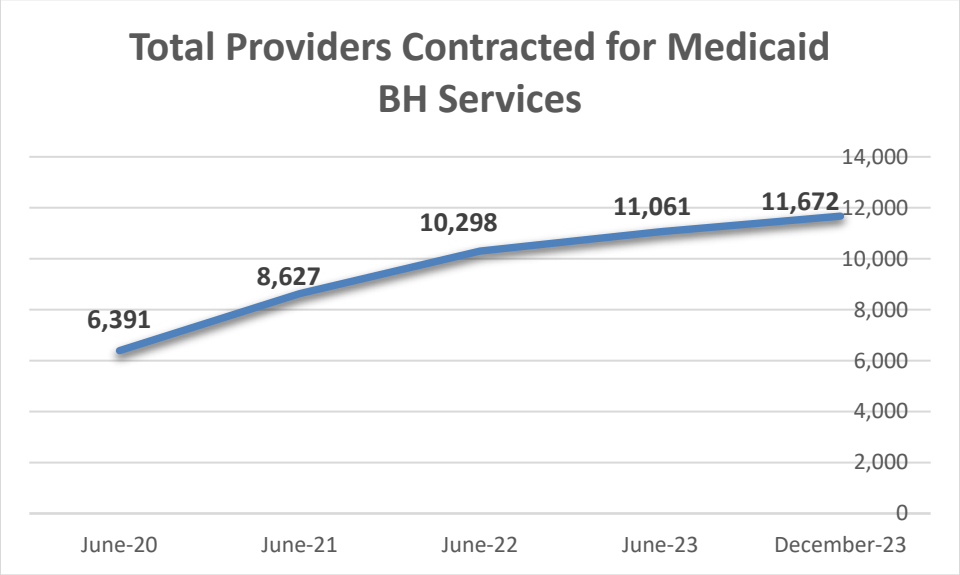
The transformation of the BH safety net, as developed by the Behavioral Health Task Force and multiple legislative actions was designed to improve provider and patient experience with publicly funded behavioral health system by expanding provider types, modernizing definitions of safety net services, streamlining processes, and developing an enhanced and flexible payment model for providers that meet a higher standard of care and serve priority populations.

In FY 2022-23, all RAEs increased reimbursement rates for behavioral health providers, with a specific focus on expanding the independent provider network. In addition, HCPF and the RAEs expanded the use of pre-licensed clinicians working under supervision as Medicaid providers. Over the last three years, all RAEs added contracted behavioral health practitioners to their networks.

Total Number of RAE Contracted Behavioral Health Providers by Fiscal Year

	FY 21/22	FY 22/23	FY 23/24
RAE 1	3,293	3,361	6,248
RAE 2	3,100	3,298	4,175
RAE 3	6,118	5,662	8,405
RAE 4	3,097	3,297	4,176
*RAE 5	6,211	6,742	8,408
RAE 6	3,921	5,999	8,103
RAE 7	3,921	5,999	8,103

*Includes Denver Health Behavioral Health



While the charts above illustrate significant growth in Medicaid behavioral health provider access, there is significant overlap in the counting and tracking of providers below. The ACC3.0 concept paper includes a single process for credentialling providers, and a more streamlined contracting process as well.

HCPF has also targeted specific services in recruiting providers including high intensity outpatient services, peer services, and residential SUD.

- **High-Intensity Outpatient Service Providers** - In FY 2022-23, HCPF used ARPA funding for the RAEs to build network capacity to address gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care. Each RAE was contracted to increase access to high intensity outpatient care and support by expanding what services are offered by existing providers and by bringing new providers into their networks. So far, RAEs have used more than $11M to expand high-intensity services with more than 55 behavioral health providers, with another $13M to contracted to be spent by December 2024.

- **Peer Support Service Providers** - Peer support services provide effective and relatable recovery interventions for members that is a cost-effective workforce for

providers. Historically, HCPF has only paid for these services within community mental health center settings. HCPF worked with the BHA to create a specific Peer Support License and Enrollment Type in August of 2022: the Recovery Support Services Organization (RSSO). These organizations employ peers and can bill Medicaid for peer services. As of June 2023, two of these organizations have enrolled as Medicaid providers and contracted with one or more RAEs. In FY 2023-24, the ACC plans to expand the peer services network further by including housing support peers.

- **Residential Substance Use Disorder (SUD) Service Providers** - Since the 1115 SUD Demonstration began in January of 2021, the number of members served and the number of SUD providers continues to grow. From January to December 2022, more than 8,000 members received residential SUD treatment services, an increase from about 5,000 members served the year before. Effective July 2023, payments have been increased for adolescent SUD residential providers in hopes of increasing provider participation in offering these services.

Year	Number of Unique Providers	Providers offering ASAM 3.2 Withdrawal Management	Providers offering ASAM 3.7 Withdrawal Management	Providers offering ASAM 3.1	Providers offering ASAM 3.3	Providers offering ASAM 3.5	Providers offering ASAM 3.7
2021	56	18	4	20	2	27	11
2022	61	21	5	26	3	37	11
2023*	74	21	10	27	4	39	14

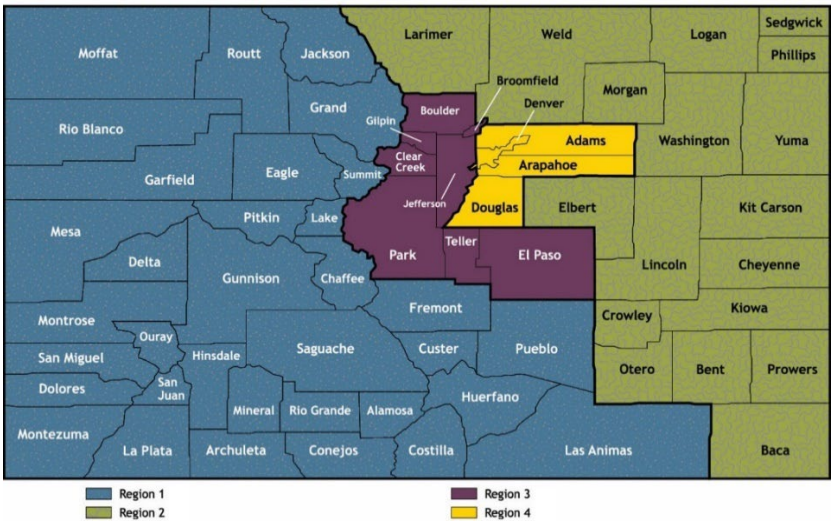
*as of Nov. 30, 2023

4. ***[Sen. Kirkmeyer]*** **Is the Department considering changing RAE boundaries and/or the total number of RAEs? How is the Department soliciting stakeholder feedback on any potential changes.**

RESPONSE

Yes, HCPF is changing both the RAE boundaries and the total number of RAE regions in ACC Phase III. Over the past six months, HCPF has held 20 meetings with more than 1,000 attendees to discuss six possible RAE maps for Phase III. The final map will be the one proposed in the ACC Phase III Concept Paper and includes four regions instead of the current seven-region map. HCPF worked closely with the Behavioral Health Administration, which is also procuring a set of state contracts for the Behavioral Health Administrative Service Organizations (BHASOs), on making this determination. Together, we analyzed care patterns, specifically looking at the counties where people live compared to where they seek care. We reviewed multiple different map options using a set of 28 metrics, including population, demographics, income and eligibility for Health First Colorado or BHA funding, and behavioral health needs. HCPF published a fact sheet on this topic on Dec. 6, 2023, summarizing the issues and the stakeholder process.

ACC Phase III RAE Map:



PUBLIC HEALTH EMERGENCY UNWIND, COUNTY ADMINISTRATION, AND APPEALS

5. ***[Rep. Bird]*** **Please show Medicaid enrollment as a percentage of the state population over time. How does Medicaid enrollment as a percentage of the population vary by county?**

RESPONSE

HCPF compared Medicaid members to the State of Colorado population during two times of significant change; before and after ACA expansion and before and after the pandemic. The difference between the ACA expansion years was an increase of 11 percentage points and the difference between the pandemic years was 7 percentage points.

Change in Medicaid Population before and after ACA Expansion:

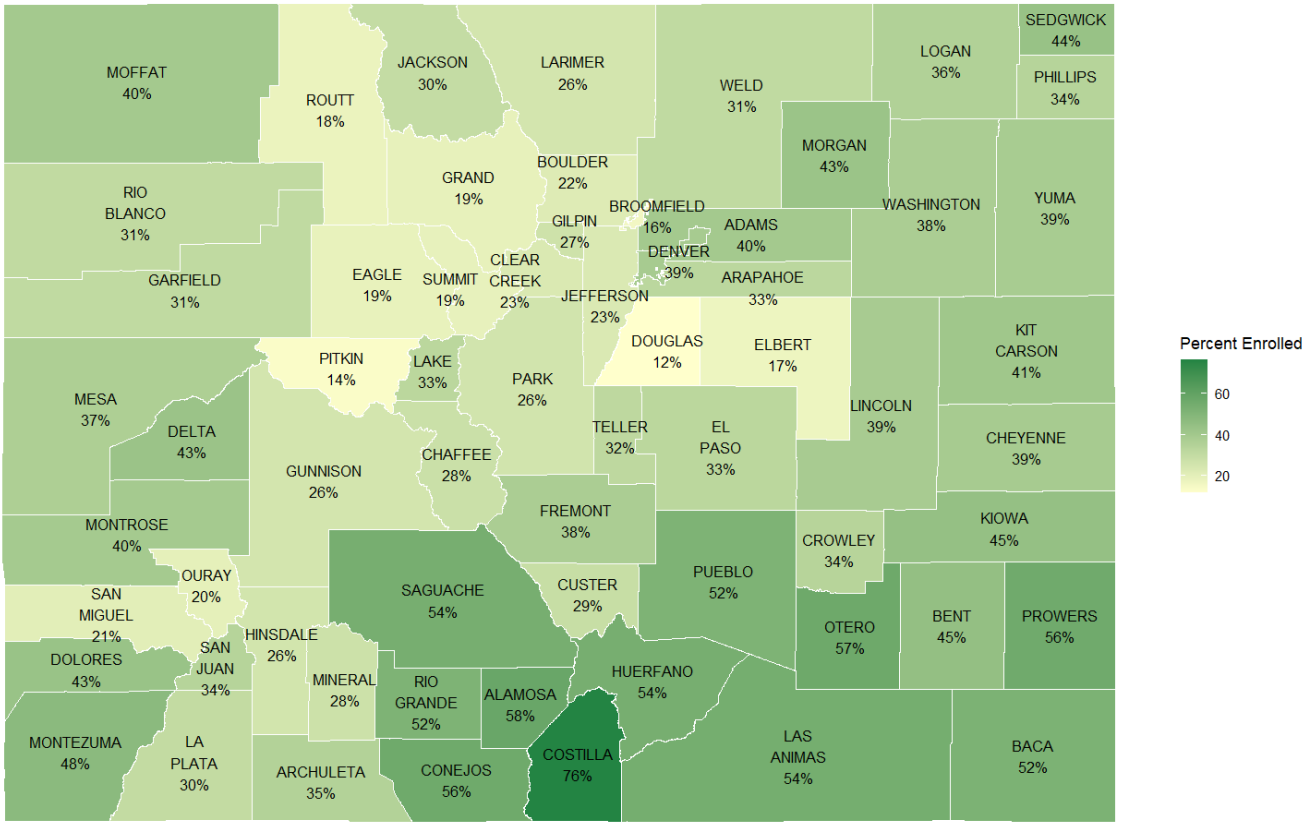
Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2012-13	682,994	5,194,662	13%
2015-16	1,296,986	5,446,593	24%

Change in Medicaid Population before and after the Pandemic:

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2018-19	1,261,365	5,676,913	22%
2022-23	1,719,393	5,838,736	29%

HCPF mapped the percentages of Medicaid members by county population below for 2022. The lighter the color on the map, the lower the percentage. Percentages vary from a low of 12% in Douglas County to a high of 76% in Costilla County. The median percentage of all 64 counties is 34%.

Medicaid enrollment as a percentage of county populations, 2022



6. ***[Rep. Bird, Sen. Kirkmeyer]*** **What is the Department doing to minimize disenrollments due to administrative issues? What is the Department doing to ensure that the most vulnerable populations, including people with disabilities, are able to successfully navigate the enrollment process?**

RESPONSE

HCPF has been actively monitoring the disenrollments statewide and engaging with the community to understand the pain points that may lead to disenrollments and identifying initiatives to mitigate them. Since the summer, HCPF has been meeting on a regular basis with disability advocates and stakeholders to gather their experience, perspective, and examples on disenrollments. HCPF also created an internal workgroup that meets weekly to gather subject matter experts (SMEs) from various areas of HCPF to identify ways to minimize disenrollments. We have further leveraged partnerships with our federal partners and other states for additional flexibilities and ideas to address disenrollments.

Outreach

HCPF developed four messaging toolkits with advocate and member feedback to educate and outreach members during the renewal process. These toolkits have been translated into the top 11 languages spoken by our members and distributed statewide to partners to assist us in reminding members to update their contact information, take action on their renewal and how to transition to other coverage, if needed. Additionally, HCPF and each of its regional accountable entities (RAEs) is doing coordinated, direct-to-member outreach before, during, and after a member's renewal period. This outreach involves texting, email, automated and live calls, and traditional mail in addition to a PSA campaign being run in partnership with Connect for Health Colorado.

Additional Implemented Measures for All Members

HCPF also implemented a renewal packet redesign after receiving feedback that renewal packets were too long, had too many blanks, and the envelopes made them look like junk mail. The packets were shortened by 33%, and a Colorado State seal was added to the renewal packet envelope window to help prevent it from being mistaken for junk mail.

The online member portal, PEAK, has undergone a significant number of improvements for members to respond to their renewal packet and potentially mitigate disenrollments. Some of the improvements include: a member to-do list to guide members, enhanced document uploading capabilities, improved interface for mobile/smartphone accessibility, and additional plain language updates.

Ex Parte Change

All states received guidance from the Centers for Medicare and Medicaid Services (CMS) on Aug. 30, 2023, that requires a change to the ex parte (automation) process for renewals aimed at reducing procedural denials. Instead of renewing members with ex parte at the household level (all members of a household receiving Health First Colorado or CHP+ benefits reviewed for eligibility at the same time), as has been done in the past, CMS is requiring states to perform ex parte automation reviews on an individual basis, meaning each person in

the household is reviewed and approved separately. HCPF implemented a system change in October to evaluate eligibility at the individual level during ex parte and retroactively reinstated 7,510 members in November as a result of this guidance. This change will benefit members and reduce procedural denials by keeping members on coverage who would have otherwise been terminated because their household did not complete or return their renewal packet.

The following are specific actions taken to help the most vulnerable populations:

Extension for Long-Term Care (LTC) Members

This CMS flexibility allows LTC members to have an additional 60 calendar days to return their renewal packet for it to be processed by the county for cases that are past due. HCPF is doing additional outreach through an Outbound Contact Center during the extension period to remind these members to complete their renewal and connect them to resources if they need help. Contracts have been executed with medical assistance sites to process renewals for counties that are backlogged or in need of additional support to help these members. In addition, HCPF is connecting specifically with nursing facilities to provide data on their members that need additional support with the enrollment process to mitigate disenrollments.

Streamlined Escalation Process

In order to have a holistic understanding of the issues presented by members and stakeholders, HCPF redesigned and streamlined its escalation process to include both financial and functional eligibility escalations. A centralized online escalation form was implemented and shared widely with partners, advocates, stakeholders, and more importantly made accessible to members. Internally, additional collaboration and coordination occurred to address the escalations in a timely, thorough manner. Additional temporary staff will have a dedicated focus on escalations for LTC members.

7. ***[Sen. Bridges]*** **How many pages of documentation are required to reapply for Medicaid and how does this compare to other states? Please explain any differences in the typical volume of documentation required in Colorado versus other states. What is Colorado doing to keep the reapplication process as simple as possible? The JBC has heard reports that Colorado Medicaid clients need to present 60 pages of documentation to reapply for Medicaid, compared to as little as 2 pages in many other states.**

RESPONSE

There is not a required number of pages to reapply for Medicaid. Our application and renewal packets go through an approval process with our Federal partners, ensuring we are not asking questions not needed to make a Medicaid determination. When an individual is reapplying for Medical Assistance, the number of questions can vary depending on individual circumstances and medical needs. Responses help us determine what criteria must be met for the individual to be determined for a Medicaid category. Some Medicaid categories require minimal information such as SSN, citizenship, income, and, if applicable, legal immigration status.

Medicaid categories for aged, blind, and disabled populations also require asset information, disability information and, depending on category, information about help needed with self-care activities (such as bathing, dressing, eating, using the bathroom). Every state can elect different optional Medicaid categories which influences different requirements and documentation when it comes to the application and renewal process.

HCPF is monitoring the ex parte (auto renewal) process to find opportunities to increase the number of members that are automatically approved. This keeps the renewal process simple for those members by only sending out an approval letter (no further action needed by the member). Those who are not approved at ex parte receive a renewal packet which HCPF redesigned in October 2023. At the beginning of PHE Unwind we heard that renewal packets were too long, had too many blanks, and the envelopes made them look like junk mail. The packets were shortened by 33%, and a color Colorado State seal was added to the renewal packet envelope to help prevent it from being mistaken for junk mail. In a recent meeting with the White House, they stated that they hold up the Colorado renewal packet as best practice. This was great news to hear given that our members through the Member Experience Advisory Council (MEAC) and eligibility workers approved and are excited about the structure and decreased number of pages on the renewal packet.

8. ***[Sen. Bridges]*** **The JBC has heard reports that Colorado has a disenrollment error rate of 9.0 percent. What does that mean? How is an error being defined? How does that compare to other states? One of the reasons provided for the high error rate is that HCPF is looking at the individual rather than the family. How is that happening and why hasn't the issue been fixed? Please provide an overview of the entire disenrollment process, including what needs improving.**

RESPONSE

During the public health emergency, Colorado made it a top priority to get people who lost their jobs and related employer-sponsored coverage due to the pandemic-induced economic downturn, enrolled in Health First Colorado and Child Health Plan *Plus* (CHP+) in order to mitigate the devastating consequences of a rising uninsured rate to Coloradans, care providers and our economy as a whole.

Regarding the end of the Public Health Emergency ("PHE Unwind"), direct comparisons with other states are difficult because they are not apples to apples; states clearly approached the unwind of the continuous coverage requirement differently. Some states tried to return to normal operations very quickly, like Arkansas, while Colorado chose to take the full 12 months (14 months including noticing members) to return to normal operations. Still, as Colorado returned to regular renewal processes after the PHE, we anticipated that more individuals would be disenrolled from our programs compared to national norms for at least two reasons:

- **Greater Comparative Medicaid Enrollment**. First, we all worked together - HCPF, providers, counties, advocates, and all stakeholders - to help Coloradans secure Medicaid coverage as they lost their jobs and employer-sponsored coverage. Those efforts are reflected in the chart below, which shows Medicaid enrollment growth in January 2023 of more than 40% in Colorado compared to national growth of about 31% - *a 30% favorable difference*.
- **Lower Comparative Unemployment Rate**. Second, Colorado's economy has rebounded significantly. As of October 2023, the state's unemployment rate is similar

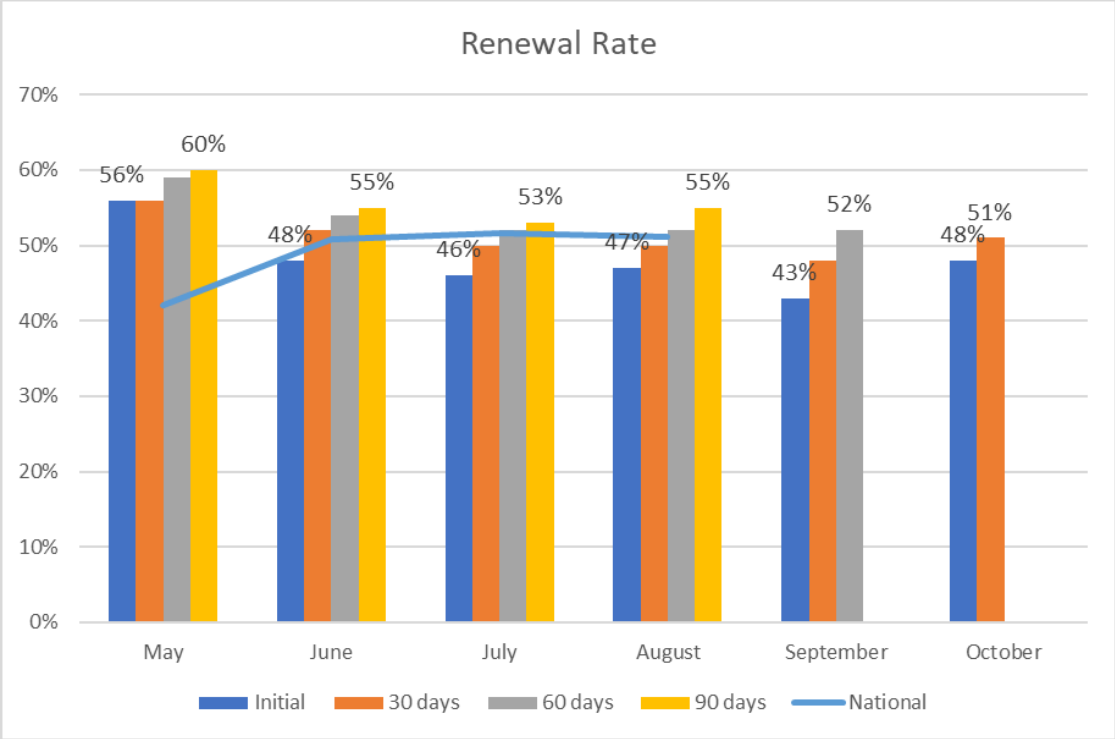
to pre-pandemic levels, at 3.3%. This is lower - or better than - the national unemployment rate of 3.9%. Colorado's lower unemployment rate compared to other states means that many Coloradans may have secured jobs and related employer-sponsored coverage, rising out of crisis after the COVID-induced economic downturn. These individuals no longer need Medicaid coverage.

We expect to see higher Colorado Medicaid disenrollment during the PHE Unwind due to these two factors - our state's greater Medicaid enrollment performance combined with our stronger economy, as noted in the chart below, which tracks both factors from January 2020 through July 2023, in six-month measures.

Date	National (In Millions)	% Change month	% Change aggregated	National Unemployment Rate	HCPF (In Millions)	% Change month	% Change aggregated	CO Unemploy-ment Rate
Jan-20	70.97			3.5%	1.28			3.0%
Jul-20	75.72	6.69%	6.7%	10.2%	1.37	7.64%	7.6%	6.4%
Jan-21	80.59	6.43%	13.6%	6.3%	1.49	8.46%	16.7%	6.3%
Jul-21	83.77	3.95%	18.0%	5.4%	1.56	4.62%	22.1%	5.6%
Jan-22	86.98	3.83%	22.6%	4.0%	1.62	4.22%	27.3%	4.0%
Jul-22	89.82	3.27%	26.6%	3.5%	1.70	4.71%	33.3%	2.7%
Jan-23	92.97	3.51%	31.0%	3.4%	1.79	5.34%	40.4%	2.8%
Jul-23	91.51	-1.57%	28.9%	3.5%	1.72	-3.85%	35.0%	2.9%

To track the state's renewal and disenrollment performance, HCPF has created a variety of dashboards that are posted on our Continuous Coverage Unwind Data Reporting webpage. We leverage this transparent reporting in collaboration with all stakeholders – care providers, advocates, counties, etc. - to address emerging findings to achieve our shared goal to Keep Coloradans Covered.

Most notably, Colorado's 57% pre-pandemic average renewal rate closely aligns with Colorado's post-PHE average renewal rate of about 55% based on May through August available data, including the 90-day reconsideration period. Colorado's 49% average point-in-time renewal rate is below the national average upon the initial measure (measured 10 days after each respective month), though its 55% average renewal rate post the 90-day reconsideration period is better than the national average. Again, we expected our stronger economy, measured by the more favorable unemployment rate, to impact this renewal rate.



Looking at pre-pandemic data (calendar year 2018 and 2019), about 41% of individuals lost Medicaid coverage on average each year. This compares to 43.2% during the PHE Unwind (May 2023 through August 2023), including the 90-day reconsideration period. We are closely monitoring two types of denials, including "eligibility denials" for reasons such as being over income, moving out of state and no longer meeting program criteria, and "procedural denials" which include individuals who we cannot reach due to incorrect contact information, individuals who we do reach but who do not complete the renewal process, individuals who ask to disenroll as they no longer need coverage, and those who may have turned in renewals but are missing critical documentation. Historically or pre-pandemic (calendar year 2018 and 2019), eligibility denials averaged 29%, compared to 15% during the PHE Unwind period May 2023 through August 2023. This figure is lower (better) now only because individuals have not turned in their renewal information. Accordingly, the procedural denials are higher, at 25% (using the 90-day reconsideration period) compared to 12% pre-pandemic.

Procedural denials decline (improve) significantly through the 90-day reconsideration period, decreasing by about 9 points from 36% to 25%. Compared to national performance, Colorado's procedural denials will also be higher because our pending cases (not yet completed) are so much lower – around 2% historically, and 6% more recently, compared to the national 20-25% average. We highlight and appreciate Colorado counties' performance, accordingly.

As part of our focus on innovations to assist the counties in processing Medicaid eligibility applications, HCPF has worked to automate the renewal process. This is called ex parte. For years, Colorado Medicaid and other states have determined eligibility for Medicaid by household (household income). More recently, the federal Centers for Medicare and Medicaid Services (CMS) directed states to determine eligibility through the ex parte, automated process based on each enrolled individual, not based on the household. HCPF implemented

this CMS directive in October for all ex parte cases starting with September renewals and going forward. HCPF also applied this new directive to all cases redetermined through the ex parte process retroactively starting with May renewals. This resulted in the re-instatement of 7,510 individuals.

We are uncertain of the origins of the 9% referenced figure in this question. However, we continue to work with stakeholders to reduce procedural terminations. In addition to the change in ex parte, as noted above, we have also significantly reduced "whereabouts unknown" from 26% to 6% through eligibility system processing improvements, the implementation of a consolidated Return Mail Center, and collaboration with key partners.

Other Improvements Designed to Keep Coloradans Covered

HCPF's top priority is to Keep Coloradans Covered, which is why we have closely monitored the data and made improvements. Other improvements designed to Keep Coloradans Covered include:

- Outreach to members to remind them to update their addresses so we can reach them with renewal information, which resulted in a 34% increase in emails and text sign ups.
- Maximizing auto-renewals at around 30% of members.
- Auto enrolling eligible children into CHP+.
- Reminding members to renew by using communications toolkits developed with members and advocates and translated into the top 11 languages used by members, and which are being leveraged by stakeholders.
- Reminding members to renew by conducting a statewide PSA campaign in partnership with Connect for Health Colorado.
- Reminding members who have not yet completed the renewal process with targeted outreach from Regional Accountable Entities.
- Created a new Outbound Contact Center.
- Redesigned renewal packets to be 33% shorter and include the Colorado State seal, which resulted in an increase in the packet return rate for non-Modified Adjusted Gross Income (MAGI) members since the start of the PHE unwind from 46% to 65%.
- Created a 60-day extension for vulnerable populations through June 2024 (long-term care, members on waivered services, buy-in).
- Streamlined the escalation process.
- Created resources for vulnerable populations, including a website with Long-Term Services and Supports (LTSS) specific resources that contains an LTSS FAQ page and an LTSS one-pager.
- Improved our digital tool (PEAK) and continuing correspondence improvement projects.
- Contracting with Medical Assistance sites to work renewal backlogs and support counties.
- Working with nursing facilities to provide data on members needing additional support.

The above is not an all-inclusive list as HCPF continues to partner with health plans, providers, counties and many other stakeholders to help our members through the renewals process.

9. ***[Rep. Bird]*** **What do we know about the population being disenrolled from Medicaid? What percentage are disenrolled for procedural reasons? Are they getting coverage elsewhere? The Department had predicted that a large portion of the disenrolled population would find coverage through the healthcare exchange. Is that happening?**

RESPONSE

We are not seeing disparities among groups when looking at baseline and post renewal data. When comparing to the Medicaid population prior to the start of Unwind, we are not seeing disparities among different races, ages, or regions. The population being disenrolled is generally consistent with our baseline.

When allowing for the 90-day reconsideration period (which is the period following the renewal due date, used by members to submit late renewal packets or required documentation) a clearer picture of renewals outcomes can be seen. The renewal rate averages 56% and the disenrollment rate averages 43% (compared to pre-PHE rates of 57% and 41% respectively). Of the disenrollments, 18% are due to no longer meeting eligibility requirements and 25% are for procedural reasons.

HCPF is leveraging data from Connect for Health Colorado and the state's All Payers Claims Database (APCD) to better understand what health care coverage people are obtaining once they disenroll from Medicaid. Connect for Health Colorado is reporting that 6,828 individuals who lost Medicaid coverage have obtained coverage through a Qualified Health Plan (data for plans starting in June 2023 through January 2024 as of Dec. 6, 2023). Approximately 6% of individuals referred to Connect for Health Colorado are enrolling in a Qualified Health Plan. HCPF and Connect for Health Colorado have a coordinated outreach plan that utilizes mailers, emails, and phone calls to help inform individuals of their options to enroll in the Qualified Health Plan. HCPF and Connect for Health Colorado expect enrollment in Qualified Health Plans to continue to increase even after the Connect for Health Colorado's open enrollment ends in January, as members who have been disenrolled from Medicaid have a special open enrollment period that lasts until July 31, 2024.

By utilizing data from state's APCD and available coverage reported directly to HCPF, we are examining data on what coverage the individual had prior to and after being disenrolled from Medicaid and CHP+. However, the data is preliminary and only covers health plan enrollments reported to the APCD and HCPF between May and August 2023. Individuals may enroll in coverage several months after being disenrolled from Medicaid and information submitted by payers into the APCD can be updated retroactively. In addition, not all payers are required to submit information to the APCD. Employee Retirement Income Security Act of 1974 (ERISA) covered employers who provide self-funded health coverage do not have to report data into the APCD and they account for approximately 1/3 of individuals covered by employer sponsored health plans in Colorado. In addition, Medicare Fee-for-Service coverage for CY 2023 is not currently available through the APCD. Once HCPF receives additional data from

the APCD that includes enrollment data beyond August 2023 and when the CY 2023 Medicaid Fee-for-Service enrollment become available, we expect the data to show that most individuals have acquired health coverage following their Medicaid disenrollment. However, it will be several months after the renewal process is complete in April 2023 that we can provide a comprehensive examination of what other health care coverage individuals selected following their Medicaid disenrollment.

10. ***[Sen. Kirkmeyer]*** **The request has funding for County Administration decreasing from $132.2 million down to $112.7 million. Why? How much of the change is attributable to the end of one-time funding for the unwind of continuous eligibility versus the provider rate increase versus other changes?**

RESPONSE

For the past several years, the only decrease in funding in the County Administration line item has been due to annualizations for the various Public Health Emergency (PHE) budget requests the General Assembly has approved. The PHE funding was requested and approved as one-time only funding to support the counties in addressing the PHE unwind. Outside of the PHE funding, since FY 2021-22, the County Administration appropriation has increased by $20,007,300 total funds due to special bill appropriations and provider rate increases.

The decrease in funding requested in HCPF's Nov. 1 budget submission for the County Administration line item is solely based on annualizing out one-time funding from the FY 2023-24 BA-06 PHE Funding budget request that HCPF submitted last year. At the time HCPF submitted that budget request, it was assumed that the PHE Unwind period would be mostly concluded by the end of FY 2023-24, and therefore, the corresponding funding reduced as well for FY 2024-25.

HCPF is in the process of assessing the overall status and timelines of the PHE Unwind and will make any budget adjustments necessary through the Supplemental process.

11. ***[Sen. Kirkmeyer]*** **Does the Department believe the funding for County Administration is adequate? What are the biggest funding and performance issues the Department sees with County Administration?**

RESPONSE

Historically, HCPF's county administration line has overexpended what has been approved by the General Assembly in the state share appropriation of dollars. From FY 2015-16 to FY 2021-22, the appropriation of state funds was fully expended; when this occurs, county dollars are used to supplement the state share that was expended. At that time, HCPF heard numerous concerns from county partners about this lack of state funding, including impacts to counties beyond HCPF programs. These costs were then covered by local funds, which put a strain on county human services programs and other county departments.

In the FY 2022-23 budget cycle, the General Assembly approved HCPF's R-08 County Administration, Oversight and Accountability request, which increased the state appropriation of dollars, with the goal of reducing the state overexpenditure. This request has provided

some near-term relief to county budgets. Additionally, since the Public Health Emergency (PHE), HCPF has been approved for additional term-limited County Administration funds for eligibility redeterminations and appeals to manage the specific workload resulting from the end of PHE Continuous Coverage. During the PHE, members were "locked into" coverage resulting in record levels of enrollment and record levels of renewals for counties to process. The temporary funding has resulted in the shifting of some costs from regular county administration funding to the term-limited funding associated with the PHE.

Once the additional county funding for the PHE ends, HCPF is concerned that the shift of costs from regular county administration to the PHE term-limited funding may reverse, causing the overall spending in the standard county administration allocation to increase. If this were to occur, another state overexpenditure issue would result.

Currently, HCPF sees challenges in county performance related to the end of PHE Continuous Coverage: redetermination backlogs in some counties continue to increase, some members are unable to get through to their counties when calling for assistance, and long-term care members need additional support to complete their redeterminations. In addition, HCPF believes it's critical to ensure adequate, ongoing fiscal oversight of funding provided to counties, to ensure funding is being used effectively and efficiently to manage the challenges identified.

12. ***[Sen. Kirkmeyer]*** **Has the County Administration funding kept pace with the increases in workload for Medicaid, SNAP, and other state public assistance programs?**

RESPONSE

In July 2016, medical assistance program enrollment was 1,327,920; by July 2023, representing the beginning of the unwind of Continuous Coverage, the overall enrollment had grown to 1,721,590, representing an increase of 24%. During that time, the overall appropriation of state funds for the annual county administration allocation remained relatively steady until it was increased by approximately $2.5 million in the FY 2022-23 R-08 County Administration, Oversight, and Accountability request, representing a 21.5% increase. That increase included new performance expectations for county call centers, accuracy and customer service. Understanding that during that timeframe state funding may not have kept up with workload increases, the JBC's support of the R-08 request was greatly appreciated. HCPF is committed to the additional work that remains to be done, through SB 22-235 County Administration of Public and Medical Assistance Programs, to create a sustainable funding methodology.

While additional efficiencies were gained through automation of certain Medicaid processes and centralized support services, like the Returned Mail Center or ex parte automation for renewals, feedback from county partners has indicated that funding may not be sufficient to keep up with market competitive wages, total workloads, and performance expectations. HCPF is evaluating the funding model needed to support the necessary number of staff required to meet federal and state requirements through the SB 22-235 workload study and will request any needed adjustments through the regular budget process.

13. ***[Sen. Kirkmeyer]*** **The Department is proposing a reduction in County Administration at the same time that the Department of Human Services is proposing a reduction. With counties struggling with timely processing of SNAP, how does the executive branch expect the counties to improve performance in the light of decreasing funding?**

RESPONSE

The change in appropriation from FY 2022-23 to FY 2023-24 solely represents the term-limited funding for the PHE coming to an end. HCPF did not request a decrease in the regular county administration appropriation that supports work outside of Continuous Coverage. As HCPF is continuously monitoring the progress of the PHE unwind, any changes necessary for the PHE term-limited funding may be addressed through the regular budget process.

The year 1 study authorized by County Administration of Public Assistance Programs (SB 22-235) found HCPF programs administered by counties to have high performance overall, and any decrease in funding may have an impact to that performance. HCPF is coordinating with CDHS leadership to determine and measure any impact to our programs' performance resulting from any decrease in CDHS county administration. HCPF is also working with CDHS to create a longer-term strategic plan to more comprehensively address the current and future needs of our county partners.

14. ***[Sen. Kirkmeyer]*** **Please provide an update on the S.B. 22-235 workload study.**

RESPONSE:

County Administration of Public Assistance Programs (SB 22-235) required two deliverables from CDHS and HCPF: the completion of an assessment of best practices in counties to be completed by July 2023 and the completion of a funding model that creates a methodology to determine the true need for county administration funding, based on federal and state requirements and accounting for individual changes that counties have operationalized. The assessment of best practices was completed and the final report was submitted to the JBC by CDHS on Nov. 1, 2023.

The procurement process for the funding model methodology was completed and the contract was signed in December 2023. The kickoff of the study will be held in December 2023, with representatives from CDHS, HCPF and counties as members of the kickoff committee. County members of the committee were selected by the Colorado Human Services Directors Association (CHSDA).

CDHS and HCPF expect the study to be concluded by June 2024, with the final report submitted to the JBC by Nov. 1, 2024, for the JBC to consider in their budgeting process.

15. ***[Sen. Kirkmeyer]*** **When the Colorado annual compensation report is recommending a 3.0 percent increase for state employees, why is the Department proposing only**

a 1.0 percent increase for County Administration? How will counties be able to recruit, motivate, and retain a qualified workforce in a competitive market with insufficient funding?

RESPONSE

As part of the County Administration of Public Assistance Programs (SB 22-235) final report response, HCPF indicated its agreement with the findings of the SB 22-235 assessment of best practices. As part of these findings, HCPF agreed that county performance is highly influenced by the ability of county departments to recruit, motivate and retain a qualified workforce. HCPF expects to use the funding model methodology created in year 2 to help determine the true need for funding, at a level that supports county workforces, as they return to normal operations post-pandemic. Because of budget constraints and the pending completion of the SB 22-235 funding model, which is due to the JBC in November 2024, HCPF did not include county administration in targeted provider rate increases, resulting in the 1% rate increase for counties this fiscal year.

16. ***[Rep. Bird]*** **How much is the Department currently spending on oversight of county administration? What is the optimal balance between state oversight and county workload and how do we know when we reach that point? Does the threat of mismanagement and inappropriate expenditure justify the proposed level of state oversight and the increased workload for counties?**

RESPONSE

The federal government requires pass-through entities to undertake two types of oversight of their subrecipients: programmatic oversight and fiscal oversight. HCPF's accountability programs for counties include compliance reviews, performance monitoring, quality assurance reviews and formal non-compliance processes. Most of HCPF's resources for oversight are focused on programmatic activities to determine, for example, whether eligibility determinations are done timely, whether a member has a discrimination concern, or ensuring counties are adequately staffing call lines. Currently, HCPF only has 1.0 FTE dedicated to fiscal oversight, which is federally required. This level of oversight is insufficient to meet federal requirements, such as the periodic review of certain expenditure types prior to payment, and is lower than other resources dedicated to county fiscal oversight in other public assistance programs. HCPF continuously strives to balance oversight through collaboration with counties and has adjusted course in its accountability programs based on county feedback.

The potential threat of mismanagement and inappropriate expenditures are very real and documented in recent audits. The federal Payment Error Rate Program (PERM) requires the state to pay the federal government for any claims paid on behalf of members where eligibility was determined incorrectly, above a 3% threshold. In the 2018 Office of State Auditor single statewide audit, the OSA auditors found an eligibility error rate of 26%, based on cases reviewed. Once extrapolated across the entire caseload, OSA determined that HCPF may have a potential federal disallowance of around $300 million, all of which would have to be paid for with state funds. Had the PERM review found the same error rate as OSA, the

state would be required to repay the federal government for all errors above the 3% threshold, impacting millions of dollars in the state budget.

While oversight of counties can increase administrative work, it is essential that the state ensure adequate programmatic and fiscal oversight of counties as subrecipients, both to meet federal requirements, and to protect the state budget from potential federal disallowances.

17. ***[Sen. Kirkmeyer]*** **What are the 12 counties that were reviewed in the last two quarters and are they really representative of the issues statewide? How serious were the 52 findings and the 22 unallowable costs? How much money are we talking about? Were there any potential harms to Medicaid clients?**

RESPONSE

The approach of HCPF's accountability programs is to cast a wide net to catch potential issues that may not surface in data or expenditure reviews. As a result, the 12 counties reviewed include large, medium and small counties, and include both frontier, rural and urban counties. In addition, the counties reviewed represent a wide variety in terms of resources available. While some of the findings are minor, many of the findings represent material deficiencies in fiscal internal controls which are required per 2 CFR Part 200, the Uniform Guidance. In these findings, the county was found to not have adequate processes to ensure accounting controls are in place; that the county did not have controls over procurement cards and advance payments; or that the county did not meet contracting requirements to be eligible for federal and state funds. This is not an exhaustive list, but the findings represent state financial risk associated with inappropriate federal or state expenditures. The unallowable costs vary but represent several hundreds to several thousands of dollars.

HCPF considers it a priority to work collaboratively with counties to cure any issues when they are found, so the issue is fixed going forward. This approach mitigates potential federal audit findings and associated disallowances for the state. In many cases, counties have cured findings immediately after being informed. HCPF works with county partners to cure findings through a collaborative process and provides templates or other resources to assist counties to coming into compliance.

Because claims payments for Medicaid members are paid through HCPF's interChange claims payment system, there was no material impact to members, with the impact primarily being that funding that went to unallowable costs could be better utilized for county staffing to support workload.

The twelve counties reviewed in the last two calendar quarters are:

- Fremont
- Garfield
- Rio Blanco
- Mesa
- Cheyenne
- El Paso
- Archuleta

- Arapahoe
- Washington
- Lincoln
- Clear Creek
- Dolores

18. ***[Sen. Kirkmeyer]*** **Why is increased county oversight a priority when the Department is not providing sufficient information technology infrastructure and county administration funding?**

RESPONSE

As demonstrated by the findings of the best practices assessment in SB 22-235, HCPF's approach to county oversight has resulted in high performance by counties in Medical Assistance administration. The approach has had an impact on accuracy rates, with the most recent Payment Error Rate Measurement (PERM) having a single digit error rate, in comparison to the 26% error rate found in the 2018 Office of State Auditor review. Program outcomes have greatly improved because of HCPF's accountability programs and the collaboration of county partners who are committed to continuous improvement.

As also demonstrated in the SB 22-235 assessment, addressing information technology infrastructure and creating a sustainable funding model for county administration are HCPF imperatives. HCPF is fully committed to the Joint Agency Interoperability (JAI) project, through which the Unified County Auxiliary System (UCAS) is being procured. This next generation workload and document management system will roll out to all counties, for all public and medical assistance programs, to provide a basis for administrative efficiencies, reduced county manual work, improved member experience and the sharing of work across county lines. The UCAS is being procured in partnership with CDHS, CDEC and counties. In addition, HCPF's commitment to the SB 22-235 funding model methodology is indicative of the importance HCPF places on ensuring counties are adequately resourced with a qualified, trained workforce. HCPF will continue to work in the coming years with counties and the General Assembly to assure county funding is adequate and IT systems support counties and their work.

19. ***[Sen. Kirkmeyer]*** **Please describe the appeal process from start to finish and the average time required for each step.**

RESPONSE

When a Medicaid member submits an application and is denied or receives a notice of adverse action (such as an upcoming disenrollment or reduction of benefits), they have a legal right to file an appeal. A member can request a state appeal within 60 of days of the date on the denial letter or notice of adverse action. This process involves the Office of Administrative Courts (OAC) (part of the Department of Personnel and Administration) opening a case file, scheduling the matter for a hearing, and conducting an evidentiary hearing by an Administrative Law Judge (ALJ), who issues an Initial Decision within 20 days of the hearing. During the Public Health Emergency unwind, OAC has accelerated hearings and typically schedules them to take place within 25 days of the receipt of the appeal request.

Concurrently, a hearing notice for all appeals (benefits, eligibility) is sent to HCPF to track all actions (Expedited hearing requests, Initial Decision, Final Decision) that occur during the hearing process. For expedited appeal requests, HCPF's Appeals Officer or internal ALJ reviews the request to determine whether the request meets HCPF's criteria for these appeals (where the typical timeframe for an appeal "may seriously jeopardize the applicant/recipient's life, health or ability to regain, attain, and maintain maximum function"), which HCPF must complete within three (3) business days. For standard appeals, three (3) HCPF staff represent HCPF before the OAC for all fee-for-service benefit hearings (home health, durable medical equipment, oral health, imaging, pharmacy, and other prior-authorized physical health services).

HCPF coordinates all hearing notices and decisions in order to track, research and establish if continued benefits criteria have been met to reopen a case during the appeals process, works with eligibility sites on hearing packets and hearing processes, files motions to dismiss appeals when necessary, reviews the Initial Decision by OAC, prepares exceptions or works with eligibility sites to file exceptions to Initial Decisions as appropriate. Parties have 18 days to submit exceptions to OAC's Initial Decision, although sometimes it may take longer depending on whether a party requests a transcript or submits additional evidence. HCPF's Office of Appeals issues all Final Agency Decisions – affirming the ALJ's Initial Decision, modifying the decision, or overturning the decision. Final Agency Decisions are typically issued within 15 days for cases where exceptions have not been submitted. When exceptions have been filed, the Final Agency Decision is typically issued within 30 days after all deadlines have passed (which may include extensions of time for transcript preparation). HCPF works with eligibility sites and utilization management vendors on Final Agency Decisions. If a member or applicant, or HCPF, disagrees with the Final Agency Decision, the party may file a judicial review in Denver District Court and, to the extent necessary, pursue the process up through the state court appeals process. Judicial reviews can take up to a year on average to resolve, and longer if a party takes the case up to the Colorado appeals court or the supreme court. A tiny number of appeals go up on judicial review yearly (sometimes up to 4 or 5, sometimes none).

20. [Rep. Kirkmeyer] How does the Department's request for additional resources to manage appeals impact county workloads?

RESPONSE

There is almost no direct impact on county workloads. Indirectly, more timely appeals could reduce calls from members to counties asking for the status of their case. Upon request from a member or applicant, counties are required to hold an eligibility dispute resolution conference pursuant to C.R.S. 25.5-4-207. Counties also staff most eligibility appeals. Counties have no role in benefits appeals.

The FY 2024-25 R-8, "Eligibility Compliance" request is a request for permanent staffing of one additional FTE to right-size HCPF's Office of Appeals. Since before Colorado's Medicaid expansion under the Affordable Care Act, the Office of Appeals has had only two staff, one Appeals Officer and one administrative staff member. Medicaid expansion has more than tripled the number of Medicaid members in Colorado, and similarly increased the number appeals, with no commensurate increase in appeals staff.

21. ***[Rep. Bird]*** **How has the Department's timeliness in responding to appeals changed over time?**

RESPONSE

Since before Colorado's Medicaid expansion under the Affordable Care Act, the Office of Appeals has had only two staff, one Appeals Officer and one administrative staff member. The benefits appeals team has remained constant at three staff. The Office of Administrative Courts at the Colorado Department of Personnel and Administration has seen a modest growth in staffing, but a larger growth in the number of appeals it handles from HCPF and other state agencies, including the Colorado Department of Human Services, the Colorado Department of Public Health and Environment, and the Colorado Department of Labor and Employment, among others. Medicaid expansion – and the growth of Colorado's overall population - has more than tripled the number of Medicaid members, and similarly increased the number appeals, with no commensurate increase in appeals staff. Historically, this has negatively impacted HCPF's ability to comply with the federal 90-day deadline to complete most Medicaid appeals.

With the General Assembly's temporary funding of Public Health Emergency (PHE) unwind staffing, appeals are becoming more timely. Despite an early surge in the number of untimely appeals at the beginning of the PHE unwind, we are now seeing a decrease in appeals that are past due, from a high of 413 appeals in August 2023, to a 10-month low of 254 in November 2023. These totals also include cases beyond the 90-day limit due to member-initiated continuances (which constitute an exception to CMS's 90-day limit).

22. ***[Rep. Bird and Rep. Sirota]*** **How much is the Department currently spending on appeals? How much of the funding is related to the unwind of continuous eligibility? Is the funding working and reducing appeal times? How much of an increase over the base does the FY 2024-25 request represent?**

RESPONSE

HCPF processes various types of appeals (e.g., benefits, eligibility, pharmacy, etc.) and funding for those activities are paid through multiple line items, personal services and common policy. HCPF last received FTE for appeals work in 2013 in preparation for expected increases related to the implementation of the Affordable Care Act (ACA). As it relates to the request, HCPF has $204,376 in FY 2023-24 and $214,594 in FY 2024-25 appropriated in personal services for 2 FTE for appeals related work with the Office of Appeals. HCPF's R-8 "Eligibility Compliance" request is requesting 1.0 additional FTE, which is an increase of $126,290 total funds or 59% over the base appeals funding. HCPF also received temporary funding of $879,325 in FY 2023-24 and $73,277 in FY 2024-25 to assist with the increased appeals anticipated during the PHE unwind.

The second bucket is for Administrative Law Judge (ALJ) services paid through common policy. The Department of Personnel & Administration's (DPA) Office of Administrative Courts (OAC) bills HCPF for any work related to appeals cases that is attributable to Medicaid. HCPF also received temporary funding of $3,251,165 in FY 2023-24 and $270,930 in FY 2024-25 to

assist with the increased appeals anticipated during the PHE unwind. HCPF has $544,650 in FY 2023-24 and $876,047 in FY 2024-25 to fund 6 term limited ALJ positions.

Please note that this total does not include costs related to the vendors who assist HCPF with appeals, including Acentra (physical health utilization management vendor responsible for medical necessity reviews and prior authorization decisions), Magellan (pharmacy coverage determinations), Telligen (HCBS determinations), the Regional Accountable Entities (behavioral health coverage determinations), and the two full-risk Managed Care Organizations (Denver Health and Rocky Prime).

HCPF is seeing improvements in appeals timeliness with the additional PHE staff in place, for example there were 413 appeals that were outside the required 90-day processing time in August 2023, the number past due was 254 in November 2023. HCPF projects that the appeals timeline will increase after the PHE Unwind and staffing is reduced to normal levels.

VALUE BASED PAYMENTS

23. *[Sen. Kirkmeyer]* How much of the Department's current budget is tied to value-based payment, as measured in dollars?

RESPONSE

HCPF's goal, in line with CMS's targets, is to have 50% of payments tied to a value-based payment by 2025. The most up-to-date data that HCPF has for value-based payment (VBP) spend pertain to Calendar Year 2022 (service dates occurring from Jan. 1, 2022 – Dec. 31, 2022). In 2022, payments with a tie to value totaled $4.0 billion out of a total spend of $13.5 billion[3] on services and administrative costs for an overall VBP percentage of 29.5%. HCPF's current budget is based on prior years' actuals and historical trends. Applying the same percentage from CY 2022, HCPF estimates that approximately $4.6 billion of its current budget of $15.5 billion is tied to value-based payments. HCPF anticipates that the amount attributable to value-based payments will continue to increase through the implementation of new value-based payments, including the Hospital Transformation Project, prescriber tool alternative payment model, and increased uptake of Alternative Payment Model 2.

The table below shows the payment breakdown by category.

CY2022 Value-Based Payments		
VBP Categories	**Total Paid**	**Programs/Description**
Foundational Payments for Infrastructure & Operations	$197,682,417	Includes Administrative Care Coordination Payments to RAEs

[3] This is the average expenditure for FY 2021-22 and FY 2022-23 and includes administrative costs of about $350 million.

Pay-for-Performance	$2,238,153,875	Includes Alternative Payment Model 1 (APM1), Hospital Quality Incentive Payment Program (HQIP), Quarterly KPI Incentive Payments to RAEs, and Nursing Facility Pay for Performance
APMs with Shared Savings	$8,121,684	Includes Maternity Bundle Payment and Alternative Payment Model Track 2 - Shared Savings
Condition-Specific Population-Based Payment	$1,131,772,908	Includes Behavioral Health Capitation Payments to RAEs and Alternative Payment Model 2 (APM2) - Capitations
Comprehensive Population-Based Payment	$414,680,857	Includes Health Maintenance Organizations (HMO)
Total VBP:	**$3,990,411,741**	

24. ***[Sen. Kirkmeyer]*** **How do current payment rates vary across providers, such as hospitals, physicians, FQHCs and CMHCs?**

RESPONSE

Payment rates vary significantly across provider types, as each provider type performs different functions in the overall health care system. Generally, it is difficult to compare how rates compare across provider types. Most providers receive reimbursement on a fee-for-service basis. The following table shows, for each provider type reviewed by the Medicaid Provider Rate Review Advisory Committee, how each service type compares against the benchmark rate determined by HCPF in the most recent review:

Service Type	Benchmark	Percent of Benchmark	Most Recent Year Reviewed
Physician-Administered Drugs	Medicare (ASP Drug Pricing File)	109%	2016
Residential Child Care Facilities	Other States	Set all services between 80% - 100%	2019
Psychiatric Residential Treatment Facilities	Other States	114.36%	2019

Service Type	Benchmark	Percent of Benchmark	Most Recent Year Reviewed
Special Connections Program Services	Other States	114.54%	2019
Dialysis	Medicare/Other States	100%	2019
Durable Medical Equipment	Medicare/Other States	100.00%	2019
Pediatric Personal Care	Other States	134.35%	2020
Prosthetics, Orthotics, and Supplies	Medicare/Other States	Set all services between 80% - 100%	2020
Home Health Services	Other States	101.72%	2020
Private Duty Nursing	Other States	98.15%	2020
Speech Therapy	Other States	Set all services between 80% - 100%	2020
Physical and Occupational Therapy	Other States	Set all services between 80% - 100%	2020
Emergency Medical Transportation	Medicare/Other States	80%	2021
Non-emergent Medical Transportation	Medicare/Other States	70%	2021
Targeted Case Management	Other States	93.28%	2021
Waiver for Persons Who are Elderly, Blind and Disabled (EBD)	Other States	95.22%	2021
Community Mental Health Supports Wavier (CMHS)	Other States	80.42%	2021
Waiver for Persons with Brain Injury (BI)	Other States	116.80%**	2021
Waiver for Persons with Developmental Disabilities (DD)	Other States	103.81%	2021

Service Type	Benchmark	Percent of Benchmark	Most Recent Year Reviewed
Waiver for Persons with Spinal Cord Injury (SCI)	Other States	88.62%	2021
Children's Habilitation Residential Program Waiver (CHRP)	Other States	129.38%***	2021
Children's HCBS Waiver (CHCBS)	Other States	87.71%	2021
Supported Living Supports Waiver (SLS)	Other States	85.00%	2021
Waiver for Children with Life-Limiting Illness (CLLI)	Other States	106.17%	2021
Children's Extensive Support Waiver (CES)	Other States	131.11%	2021
Physician Services - Cardiology	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Cognitive Capabilities Assessment	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Ear, Nose, and Throat	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Gastroenterology	Medicare	Set all services between 80% - 100%	2022
Physician Services - Health Education	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Ophthalmology	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Primary	Medicare/Other States	Set all services between 80% - 100%	2022

Service Type	Benchmark	Percent of Benchmark	Most Recent Year Reviewed
Care/Evaluation & Management			
Physician Services - Radiology	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Respiratory	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Vaccines and Immunization	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Vascular	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Women's Health and Family Planning Services	Medicare/Other States	Set all services between 80% - 100%	2022
Physician Services - Other	Medicare/Other States	Set all services between 80% - 100%	2022
Dialysis & Nephrology Services	Medicare/Other States	Set all services between 80% - 100%	2022
Laboratory & Pathology Services	Medicare/Other States	Set all services between 80% - 100%	2022
Eyeglasses & Vision Services	Medicare/Other States	Set all services between 80% - 100%	2022
Injections & Miscellaneous J-Codes	Medicare/Other States	Set all services between 80% - 100%	2022
Outpatient Hospital Specialty Drugs	Children's Hospital CO invoice data	72%	2022
Anesthesia	Medicare	100%*	2023
Ambulatory Surgical Centers	Medicare	75%*	2023
Maternity	Medicare	Set all services between 80% - 100%*	2023

Service Type	Benchmark	Percent of Benchmark	Most Recent Year Reviewed
Fee-for-Service Behavioral Health	Medicare	97%****	2023
Pediatric Behavioral Therapies	Other States	100%*	2023
Surgeries – Digestive	Medicare	Set all services between 70% - 100%*	2023
Surgeries – Musculoskeletal	Medicare	Set all services between 70% - 100%*	2023
Surgeries – Cardiovascular	Medicare	Set all services between 70% - 125%*	2023
Surgeries – Respiratory	Medicare	Set all services between 70% - 100%*	2023
Surgeries – Integumentary	Medicare	Set all services between 70% - 100%*	2023
Surgeries – Eye and Auditory	Medicare	Set all services between 70% - 100%*	2023
Surgeries – Other	Medicare	Set all services between 70% - 100%*	2023
Dental	American Dental Association (ADA) 2022 Survey Data	Set select services to between 70-100%*	2023
*HCPF has submitted a budget request to adjust rates in these areas for 2023 MPRRAC rate review.			
**For Waiver for Persons with Brain Injury (BI) reviewed in 2021, the JBC approved to increase of 41.61% to Transitional Living Program only.			
***For Children's Habilitation Residential Program Waiver (CHRP) reviewed in 2022, the JBC approved a rate increase of between 5.47%-29.94% for Supported Living Program tiers only.			
****For Fee-for-Service Behavioral Health, HCPF has submitted a budget request to increase rates of 96110 and 96127 to $18.39 for 2023 MPRRAC rate review.			

Other provider types do not have similar benchmarks or are difficult to compare across other providers. For example:

- Federally Qualified Health Centers and Rural Health Centers have rates determined based on parameters defined in federal law based on their costs.
- Hospitals are paid through multiple methodologies based on each hospital's costs and the relative complexity of the services that are provided. Hospitals also receive supplemental payments to maximize federal funds as required by state statute, where the State share of the supplemental payment comes from a provider fee.
- Behavioral Health providers are not generally paid directly by HCPF, but instead bill and are reimbursed by the Regional Accountable Entities (RAEs). HCPF pays a prospective monthly capitation payment to each RAE that in turn is responsible for determining the reasonable payment rates paid to each provider. However, rates for Community Mental

Health Centers (and soon to be comprehensive and essential safety net providers) are specially regulated based on audited cost reports, similar to the FQHCs. HCPF recently released a Behavioral Health Provider Rate Comparison Report that further outlines these variations.

- Pharmacies are generally paid based on a statewide average of acquisition costs, representing the approximate cost of a pharmacy to purchase drugs from wholesalers. Pharmacies are also paid a dispensing fee each time they render service.
- Nursing facilities receive a cost-based per diem payment, pursuant to requirements in State statute. Nursing facilities also receive a supplemental payment to maximize federal funds, where the State share of the supplemental payment comes from a provider fee.

25. *[Sen. Kirkmeyer]* What reforms, if any, are necessary to the established cost and fee-based reimbursement models currently used by the Department?

RESPONSE

HCPF is committed to moving to a system of value-based payments and away from the current fee for service system. HCPF appreciates the Joint Budget Committee's support and approval of FY 2022-23 R-6, "Medicaid Value Based Payments" and FY 2023-24 R-6, "Supporting Primary Care Medical Providers with Value-Based Payments" decision items. HCPF is currently implementing the approved reforms for adult and pediatric primary care. The Prescriber Tool Alternative Payment Model went live on Oct. 1, 2023. HCPF continues to engage closely with stakeholders for all value-based payment models, including advancing the maternity model as well as the Providers of Distinction model, which leverages cost and quality indicators. Further, a number of initiatives have been authorized by the General Assembly and are currently in progress for providers that are paid based on cost-based reimbursement, such as the implementation of prospective cost-based rates for comprehensive and essential safety net providers delivering behavioral health services (HB 22-1278) and increases in the amount of nursing facility payments that are based upon performance measures in the domains of quality of life, quality of care, and facility management (HB 23-1228). The Joint Budget Committee can see a detailed explanation of Colorado's value-based payment reforms in the Performance Based Payments legislative report[4].

26. *[Sen. Kirkmeyer]* What steps is the Department taking to align enhanced payment with accountability for quality and access?

RESPONSE

HCPF is shifting away from a payment system solely based on fee-for-service reimbursement, which focuses on paying for care volume, to a system of value-based payments because value-based payments recognize provider performance metrics. Such metrics may indeed include

[4] https://hcpf.colorado.gov/sites/hcpf/files/Value%20Based%20Payments%20Report%202023.pdf

quality and access performance measures. HCPF is taking three steps to ensure that all selected quality metrics promote improvements in patient outcomes and access.

- The first step is reviewing nationally recognized quality metrics and assessing how Colorado Medicaid providers perform compared to national benchmarks. If HCPF identifies a quality metric where there is room for improvement, we will propose to tie this metric to payment.
- The second step is a HCPF-facilitated public stakeholder engagement process to review the proposed quality metrics with providers and other stakeholders to gather feedback on if the proposed metrics meet shared goals of improving access and outcomes. After a robust public stakeholder engagement process – including understanding how Medicaid proposed models can be adopted by providers in conjunction to emerging Medicare or commercial models as well as needed advances in provider tools and care delivery models - and stakeholder feedback is incorporated into metrics tied to payments in the value-based payment model.
- The third step is measurement against the value-based performance metric target, with the provider payment impacted accordingly.

27. ***[Sen. Kirkmeyer]*** **What additional resources does the Department need to fully execute its vision for value-based reforms, and ensure sustainability?**
1. Do these resources take the form of FTE, vendors, private or public sector partnerships?
2. Are other state agencies, such as the BHA, DHS, CDPHE, sufficiently organized and staffed to ensure accountability for provider status and payments?
3. How will the upfront cost of enhanced payment and state oversight be sustained in the long-term? Is the Department concerned that programs or provider capacity supported with ARPA funding are in jeopardy?
4. How would the Department recommend the JBC plan for contingencies associated with payment reforms, as well as impacts to access to care, patient safety, and quality?
5. What is the role and sustainability plan for providers, counties, community organizations, and private sector contractors in these contingencies?

RESPONSE

HCPF appreciates the Joint Budget Committee's commitment to supporting its transition to value-based payments and approval of the FY 2022-23 R-6, "Value Based Payments" and FY 2023-24 R-6, "Supporting Primary Care Medical Providers with Value Based Payments" decision items. HCPF has requested two additional FTE in the FY 2024-25 R-13, "Convert Contractor Resources to FTE," to ensure that these value-based payment initiatives are sustainable. These FTE are crucial for ensuring that HCPF can ensure efficient value-based payment reform to support improving member outcomes, closing health disparities, increasing affordability, and supporting the providers in their transition away from fee for service. Other

than the FTE requested in R-13, HCPF does not need additional resources at this time. That said, HCPF will be continually evolving its value-based programs. For example, as we have entered Year-3 of the 5-Year Hospital Transformation Program, hospitals are already inquiring about the next generation of this work to achieve shared goals and to secure federal payments that encourage advances in shared interests like cost control, quality, health equity, access and the like.

Further, value-based payments often require a change in provider practices to achieve better results. Examples might include the evolving team-based-care practices, like that which is encouraged in our Primary Care APM 2 capitation model, or the incorporation of the Affordability Module of the Prescriber Tool to earn "shared savings", or collaboration to connect members to programs that improve their health like diabetes management or pre-natal care – both required programs of the RAEs. The ACC Phase III concept paper addresses each of these areas, while also discussing appropriate evolution into member incentives and the importance of ensuring that the RAEs and providers are equipped with the tools and programs to change member outcomes and Medicaid affordability (i.e.: eConsults, Prescriber Tool, Cost and Quality Indicators, Social Health Information Exchange – all in various stages of evolution). We appreciate the JBCs collaboration in funding to date and thank the JBC in advance for collaborating to drive the future innovations and payments necessary to advance and modernize the Medicaid program and the value-based rewards that fuel provider and member collaboration. HCPF has partnered with other state agencies including the BHA, CDPHE, CDHS, DOI, and DPA to move Colorado towards a system of value-based payments and away from the fee-for-service health system. HCPF appreciates the partnership of these other state agencies in moving both Medicaid and commercial payers towards value-based reform.

Upfront costs associated with value-based payment programs are similar to costs associated with increasing providers rates generally. When appropriations are made for increases to provider rates, whether in the form of a direct rate increase or funding appropriated as incentive funding, that funding must remain available in future years or HCPF would be required to reduce rates and eliminate incentives in the future. Value-based payment programs create the ability for long-term sustainability by tying provider payment to quality metrics that are selected for their ability to reduce long-term costs by improving health outcomes. In some cases, these savings occur in the short term, such as when providers eliminate duplicative or low-value services; in other cases, these savings are more long term, such as when providers help an individual manage a chronic condition and thus, reduce the need for more expensive services, like emergency room visits and hospitalizations.

HCPF has no value-based payments that are paid with ARPA funding; therefore, there are no value-based payment programs that will be affected when ARPA funding expires.

HCPF does not anticipate any unfunded contingencies with value-based payment programs and is taking a thoughtful stakeholder-driven approach to designing these programs with the core goal of improving member outcomes, quality of care, access, and patient safety. If HCPF identified a contingency, it would notify the Joint Budget Committee via HCPF's Performance Based Payments legislative report and would submit an accompanying budget request to remedy the identified contingency. HCPF is required by statute (section 25.5-4-401.2, C.R.S.) to notify the Joint Budget Committee before implementing any new performance-based

payments; any proposal which requires funding must be submitted through the budget process.

HCPF is committed to the sustainability and full transparency of its value-based reform with the Joint Budget Committee and stakeholders including providers, counties, and community organizations. Stakeholders are an important part of HCPF's value-based reform process and HCPF prioritizes engagement with stakeholders on how to design and improve these programs. If a value-based payment program would negatively impact providers or members due to inadequate funding, HCPF would request additional funds from the Joint Budget Committee to mitigate those impacts. HCPF will engage with stakeholders on any Joint Budget Committee approved changes to ensure that the changes support HCPF's goal of improving member outcomes and access, while supporting providers.

The Joint Budget Committee can see a more detailed explanation of HCPF's stakeholder engagement activities in HCPF's legislative report on Performance Based Payments[5].

28. ***[Sen. Kirkmeyer]*** **How does the Department's strategy vary by type of service, such as primary care, hospital, behavioral health safety net, or otherwise?**

RESPONSE

HCPF's overall philosophy for value-based payments is consistent across provider types, intended to reward improvements in access, quality outcomes (including equity) and affordability – in accordance with our mission. Payment methodologies are at various stages of evolution, in achieving these goals. Payments to providers can vary based on their performance against predefined quality measures. Providers can receive additional payments when their efforts have been shown to achieve financial or quality metrics. HCPF's reimbursement methods are tailored to each provider type's unique reimbursement methodology. Examples include:

- Under the "Alternative Payment Methodology 1" program, primary care physicians can receive variable fee-for-service reimbursement based on quality scores.
- Under the "Alternative Payment Methodology 2" program primary care physicians and Federally Qualified Health Care Centers can earn upfront payments and receive shared savings payments related to members with specific health care conditions.
- Under the maternity bundled payment program, obstetrical providers can receive shared savings for improving maternal health outcomes and closing health disparities.
- Under the Hospital Transformation Program, hospital supplemental payments can vary based on hospital performance on predefined performance measures selected by the hospitals.
- Nursing facilities have a pay-for-performance program that allows for higher per diem reimbursement when quality measures are achieved.

[5] https://hcpf.colorado.gov/sites/hcpf/files/Value%20Based%20Payments%20Report%202023.pdf

- Managed care organizations (such as the Regional Accountable Entities) can receive additional payments when they hit quality targets known as "key performance indicators."
- Physicians who use the Prescriber Tool can receive shared savings payments when they have been shown to increase compliance with HCPF's Preferred Drug List.

Going forward, future value-based payments will continue to use these same mechanisms to reward providers for improving health care access, outcomes, and equity.

29. ***[Sen. Kirkmeyer]*** **What are the Department's goals for implementing a value-based prospective payment system for behavioral health? What does successful implementation look like?**

RESPONSE

The overall goal of the value-based prospective payment system (PPS) is to provide a flexible payment model that rewards improved outcomes for members and provides reliable and sustainable funds for approved providers. Increased financial flexibility provides opportunity for less restrictive and even innovative service delivery design, improved workforce flexibility, and long-term sustainability to improve strategic growth and improvements. These payments support team-based care and evidence based wraparound care models, such as street outreach, drop-in centers, crisis services, assertive community treatment, school-based and whole family services, housing and vocational supports, and complex care coordination.

Successful implementation includes the following:

- Expanding provider capacity and services offered.
- Increased timely access to behavioral health care, especially for priority populations.
- Improved patient health outcomes linked to an initial set of quality measures such as decreased hospitalizations, reduction in symptoms, reduced substance abuse, increased outreach following a serious crisis, and housing status. These measures are derived from the Centers for Medicare & Medicaid Services (CMS) Child and Adult Core Measure Sets, Substance Abuse and Mental Health Services Administration (SAMHSA), and Certified Community Behavioral Health Clinic (CCBHC) measures for behavioral health care services.

Overall, a value-based model should lead to more people thriving in the community of their choice and living in recovery with dignity.

30. ***[Sen. Kirkmeyer]*** **What is the role of the RAEs in value-based payment? What is the role of the BHA, and/or BHASOs, as HCPF considers its value-based payment strategy?**

RESPONSE

All capitation payments made by HCPF to the Regional Accountable Entities (RAEs) for behavioral health services are considered population-based value-based payments (VBP).

Within that structure, HCPF pays incentive funds for meeting quality goals for physical and behavioral health metrics; RAEs all hold value-based payment arrangements with at least some of their network providers. HCPF requires the RAEs to offer value-based payments to the Community Mental Health Centers, the state's existing safety net providers, a policy that will continue with the new comprehensive safety net providers.

HCPF and the BHA are jointly redesigning safety net payment structures in Colorado in partnership. The safety net rules passed by the BHA in 2023 are the foundation for setting up these payment mechanisms for comprehensive and essential safety net providers. HCPF and the BHA have collaborated with stakeholders to develop a prospective payment system (PPS) for Comprehensive Safety Net Providers. This alternative payment model (APM) is based on actual costs, serving priority populations, offering a comprehensive set of outpatient care, and has a value-based component, as outlined in HB22-1278, regardless of insurance or co-occurring diagnoses or disabilities. It was modeled after the national Comprehensive Community Behavioral Health Clinic (CCBHC) framework and standards. RAEs will be required to reimburse Comprehensive Providers in accordance with these APMs as of July 1, 2024.

HCPF and the BHA are in the process of developing enhanced payments for Essential Safety Net Providers. These providers must provide care coordination with at least one other identified safety net service, which could be either an outpatient or residential level of care and cannot deny services for individuals with co-occurring diagnoses or disabilities.

Both Comprehensive Safety Net Providers and Essential Safety Net Providers will also have enhanced reporting requirements. For more information on the work HCPF and the BHA are doing related to payment reform for Comprehensive Safety Net Providers, please see the Designing Alternative Payment Methodologies with Value Based Payment for Behavioral Health Comprehensive Safety Net Providers report prepared by Health Management Associates posted on HCPF's Behavioral Health Payment Reform webpage[6].

HCPF and the BHA are developing a joint behavioral health quality strategy that will inform quality-based VBPs that will be administered by the RAEs as soon as July 1, 2025.

For primary care, the RAEs are accountable for their contracted Primary Care Medical Providers (PCMPs) success in HCPF's value-based payment programs. This includes enrolling PCMPs into value-based payments and helping PCMPs to select quality metrics. RAEs are required to employ practice facilitators who are responsible for reviewing quality performance information with the PCMPs in their network to ensure that PCMPs have the opportunity to be successful in the value-based payment model. RAEs are held accountable for the PCMP success in their network through the ability to earn Key Performance Incentive dollars when quality goals are met by the PCMPs in their network.

[6] https://hcpf.colorado.gov/behavioral-health-rate-reform

PROVIDER RATES

31. ***[Rep. Bird]*** **Dr. Kretsch's closing comments included several suggestions for improving the rate review process. It would be helpful for the JBC to have these suggestions in writing.**

RESPONSE
The following is from Dr. Kretsch's closing comments summary and is verbatim her feedback on improving the rate review process:

One of our governing rules was "Tough on problems. Easy on people." But I see the problems are tough on people. We must look at the sustainability of providing these services. The overwhelming theme were providers and facilities expressing concerns that they may be unable to continue to provide services due to rising costs to do business in Colorado. It has been the same story for the 5 years I have been on this committee. Another governing rule is "Use the past only to describe a better future".

I bring these Rules to your attention because I think these spoke to the heart of the committee as we listened, reviewed, and discussed the recommendations we brought forward.

I think I speak for many stakeholders when I say that the most common comments around reimbursement were related to benchmarks used in the analysis and the relevance of these benchmarks to providers in Colorado. And there were concerns that some changes were made in the benchmarks mid-process. Two examples are taking out Nebraska for PBT and dental has the option for a full review next year, but the benchmarks will change and affect the proposed reimbursement increases if they opt for a full review.

The stakeholders are the key group in this process. They know the costs related to providing their services. They can do the math on any proposed rate increase and know if it will make a difference in their ability to continue in the state of Colorado.

MPRRAC heard the real-life financial pain points and barriers each service faces to continue to provide for the recipients of their specific service.

Honestly what we saw and heard in data did not always align with what is reported by stakeholders (mostly providers). It is data vs. boots on the ground. In some cases, it was questioned if HCPF had the most current data sets and/or challenged the data sets used as they to fit into a budget vs representing the actual costs the services incur.
This committee took the collaboration with HCPF very seriously. We had a couple of miscues that I want to highlight. The two I will mention are beyond MPRRAC scope. But some sort of modification would help facilitate the process going forward.

1. The information with benchmarks presented to us was what we based our recommendations upon. The final report from HCPF changed some of those benchmarks and MPRRAC was unaware. We never had a chance to weigh in on the changes or revise our recommendations. While HCPF has the prerogative and authority

to produce an entirely different set of recommendations. We should all be working from the same data analyses.

2. Transparency has been talked about for MPRRAC/HCPF for as long as I have been on this committee. *Purpose: "Public meetings are an opportunity for stakeholders and Medicaid Provider Rate Review Advisory Committee (MPRRAC) members to provide feedback on HCPF's data-driven and evidence-based analyses, conclusions, and recommendations."*
   In Sept we were informed that HCPF recommendations for the report were confidential as part of the budgetary process, again not much opportunity to collaborate. I understand this is a requirement currently. But I was left wondering if the confidentiality is supportive in the collaborative process.

HCPF has struggles as well within this process. They have a budget and they must make things fit. The numbers and benchmarks must be shifted but the overarching issue is the lack of funds to adequately support these services.

MPRRAC place a very high value on access to care which I think guided some of our recommendations. For many services the reimbursement rates are simply not sustainable. The adjustments approved in this cycle are meant to be the baseline for the next 3 years.

As we move forward into this process, one thing I want to stress is that even though our goal is to do a 3-year cycle for each service, we are still leaving people and families behind. The risk is real for some services that may not be able to continue. We heard about the need for emergency reviews because the rates were simply not adequate to cover overhead, especially in behavior health/PBT. While we quickly were aware the emergency rate review was out of our scope, it did seem to place an additional burden on staff. Review then re-review because the reimbursement is simply never adequate to solve the problems. It seems inefficient if the staff has to redo past analyses year over year as services hit a "crisis mode".

The goal for both HCPF and MPRRAC is to somehow balance each other out and support the state funded services in the most meaningful and impactful way. This is the great challenge with budgetary constraints.

In 2024 I just want to committee to be aware, which I am sure you are, that if the goal is to have better outcomes and improved equity and access, we need to have a reimbursement system that allows providers and facilities to function at a sustainable level in Colorado while also looking 3 years ahead.

We need to ensure the benchmarks are representative of Colorado cost to do business.

We will as a committee continue to dial into the access issues and engagement with stakeholders. I hope we can "Use the past only to describe a better future" for our state.
I think we all learned a ton this year and I look forward to continuing to improve and advance Colorado Medicaid services in 2024.

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32. *[Rep. Taggart]* Please provide a chart summarizing the changes the Department made to the MPRRAC recommendations and the rationale for each change

RESPONSE

The table below summarizes the MPRRAC's recommendations, HCPF's budget request and recommendations, and HCPF's rationale for any differences. The MPRRAC and HCPF's complete recommendations are provided in the 2023 Medicaid Provider Rate Review Analysis and Recommendation Report, published on Nov. 1, 2023.

Service Category	MPRRAC Recommendation	HCPF Recommendation	Reason
Anesthesia	• Reduction in anesthesia service rates to 100% of the benchmark • Add a travel rate	• Reduction in anesthesia service rates to 100% of the benchmark	There are regulatory and technical obstacles to implementing a specific travel rate for anesthesia at this time. See HCPF's response to question on anesthesia travel rates for further information.
Ambulatory Surgical Centers	• An increase of ASC rates to at least 80% of the benchmark	• Increasing ASC rates to 75% of the benchmark • Change the payment methodology for ASC	• Budgetary constraints limited HCPF's recommendation. • HCPF's targeted recommendation would encourage greater utilization of lower-cost options for surgeries while working towards an updated payment methodology that will address the majority of ASC rate concerns.
Fee-for-Service Behavioral Health Services	• Add a language translation modifier for native language speakers for testing codes • Increasing rates to 100% of the benchmark especially four psychological testing	Reverting the rates for 2 Autism Spectrum Disorder (ASD)/ Development screening assessment codes (96110 and 96127) to $18.39	• The codes selected by MPRRAC were at an average of 97% of the benchmark rates, per MPRRAC report, page 30. • HCPF plans to conduct additional analysis on the cost impact of implementing a

Service Category	MPRRAC Recommendation	HCPF Recommendation	Reason
	codes (96132, 96133, 96136, 96137)		language translation modifier. • Budget constraints prevented HCPF from recommending further increases.
Pediatric Behavioral Therapy	• Increase PBT rates to 100% of the benchmark including Nebraska • Open up a list of codes that are not currently covered by Colorado Medicaid	Increase four PBT rates to 100% of the benchmark excluding Nebraska leaving one procedure code (97158) with a benchmark ratio as 128.5% at its current rate	• Nebraska is a statistical outlier with rates that are between 41% - 508% above other states in the benchmark cohort. • HCPF does not have CMS approval to cover parent training and did not receive approval when HCPF originally opened this benefit. HCPF continues to explore coverage and payment options.
Maternity Services	An increase of maternity rates to 100% of the benchmark	• 14 general maternity service and care codes increase to 100% of the benchmark • 12 pregnancy or non-viable pregnancy codes increase to 80% of the benchmark	• Budgetary constraints limited HCPF's recommendation. • Recommended increases in rates for codes focused on supporting provider's provision of specific maternity-related services, with the purpose to promote improved pregnancy outcomes, reduce maternal morbidity and mortality, etc.
Dental Services	Increase 24 dental codes recommended by Colorado Dental Association to 100% of the benchmark to have the most immediate	• Increase 15 preventive, endodontic and periodontic codes to 100% of the benchmark	• Budgetary constraints limited HCPF's recommendation. • The benchmark used in the analysis was based on commercial charges.

Service Category	MPRRAC Recommendation	HCPF Recommendation	Reason
	impact on the dental community	• 13 diagnostic service dental codes to 70% of the benchmark	Commercial charges are frequently much higher than Medicaid rates and not always an appropriate comparison for what is paid in a public program.
Surgeries	• Keeping preventive surgery codes at 100% of the benchmark for digestive surgeries • Rebalance to 80% of the benchmark for all other codes for digestive and Musculoskeletal • Rebalance to 80% - 100% of the benchmark for the rest surgeries	• Keeping preventive surgery codes at 100% of the benchmark for digestive and Integumentary • Rebalance to 70% - 100% for all surgeries except for Cardiovascular surgeries • For Cardiovascular surgeries, rebalance to 70% - 125% of the benchmark using only non-facility Medicare rates as the benchmark repricing	• Budgetary constraints limited HCPF's recommendation. • Cardiovascular surgeries category has the lowest provider participation ratio among all surgery services (40%).
Co-Surgeries	No recommendation	Expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1'	• Increase access to high quality care for highly complex procedures. • Align more closely with Medicare's co-surgery policy and create clarity for providers.

33. ***[Sen. Kirkmeyer]*** **Why did the Department make so many changes from the recommendations of the Medicaid Provider Rate Review Advisory Committee (MPRRAC)? Why did the Department propose rate changes in areas reviewed by the MPRRAC without asking the MPRRAC for feedback? Why have the MPRRAC if the Department is not going to follow the recommendations?**

RESPONSE

HCPF was unable to fully fund the MPRRAC's recommendations with the funding available for the FY 2024-25 budget. HCPF was unable to share its budget request for provider rates with the MPRRAC prior to Nov. 1 because the budget is confidential to the Executive Branch until it is released publicly.

Since the inception of the MPRRAC in 2015, HCPF has never been able to fully fund the committee's recommendations due to budget constraints. As a result of this tension, the Joint Budget Committee sponsored SB 22-236 which created new requirements for the MPRRAC to present its recommendations directly to the Joint Budget Committee (section 25.5-4-401.5(3)(i), C.R.S.). This allows the Joint Budget Committee to directly consider the committee's recommendations when HCPF is unable to request full funding or otherwise disagrees with the committee. HCPF also includes the MPRRACs recommendations in the Nov. 1 report, even when HCPF's recommendation is different.

The MPRRAC is important to the rate review process, even if HCPF is unable to request full funding. The MPRRAC process allows for a formal process to review rates compared to other states, Medicare, and other available benchmarks, and allows for stakeholders to provide input that becomes available to the General Assembly for decision making. Although HCPF cannot always request funding for each MPPRAC recommendation, HCPF's recommendations frequently closely align with the MPRRAC's findings.

34. ***[Rep. Bird]*** **The Department made several rate recommendations related to rates reviewed by the MPRRAC that were not part of the MPRRAC recommendations. Please explain how the timing works. Did the Department bring these recommendations to the MPRRAC and the MPRRAC did not agree? Did the Department develop the recommendations independently and the MPRRAC never had a chance to discuss them, and if so, why wouldn't the Department solicit MPRRAC's expert feedback?**

RESPONSE

As specified in 25.5-4-401.5(1), C.R.S., HCPF must establish a schedule for annual review of provider rates. HCPF may exempt certain rates from review because they are adjusted periodically based on another state or federal law or regulation. The JBC reviews the schedule for the coming year in November and can vote to include any additional rates in the review. The MPRRAC only reviews the fee-for-service rates that are covered in the rate review list, as approved by the JBC, for that specific year; they do not consult on other potential adjustments that are identified separately for other services by HCPF.

Since the inception of the MPRRAC in 2015, HCPF has never been able to fully fund the committee's recommendations to due budget constraints. As a result of this tension, the Joint Budget Committee sponsored SB 22-236 which created new requirements for the MPRRAC to present its recommendations directly to the Joint Budget Committee (section 25.5-4-401.5(3)(i), C.R.S.). This allows the Joint Budget Committee to directly consider the committee's recommendations when HCPF is unable to request full funding or otherwise

disagrees with the committee. HCPF also includes the MPRRACs recommendations in the Nov. 1 report even when HCPF's recommendation is different.

Relative to its most recent recommendations, HCPF requested two off-cycle initiatives to increase rates for home- and community-based services (HCBS). The rates for HCBS services are reviewed by the MPRRAC but were not reviewed during this year's rate review process. The reasons behind HCPF's recommended changes for those two initiatives are described below. HCPF also requested adjustments for the single assessment tool rate and an increase to the primary care fund; these services are not reviewed by MPRRAC and therefore any change in rates or funding must be requested separately from that process. Lastly, HCPF requested a 1.0% across-the-board increase to account for overall cost-of-living increases, which is a broader scope than the specific list of rates that the MPRRAC must review each year.

HCPF requested funding to adjust the HCBS rates to account for increases in the minimum wage for Denver and statewide effective Jan. 1, 2024, in response to the direct care worker shortfall, in combination with the critical demand for such services to support people with disabilities and our growing older adult (over 65) population. HCBS services are provided by direct care workers who are often paid at or near the minimum wage. Increases to the minimum wage directly impact the costs of doing business for personal care agencies and many other HCBS providers. The HCBS rates must be adjusted to account for increases to the minimum wage to ensure the financial stability of providers and ensure members have an adequate provider network with enough workers to meet their needs. HCPF developed the proposed, off-cycle increase in rates independently from the MPRRAC based on an established authority as well as precedent over the last four years of adjusting HCBS rates based on minimum wage increases. HCPF is responding to a mandated, exogenous change in wages and had no option but to address the change in rates to maintain the stability of the industry and its workers.

35. ***[Sen. Zenzinger]*** **Does the proposed adjustment to the wage component of Home- and Community-Based Services (HCBS) take into account increases in related costs, such as unemployment insurance, professional and general liability insurance, workers' compensation, FICA, sick leave, and CDPHE licensure requirements?**

RESPONSE

The proposed increase accounts for the incremental increase in the minimum wage for Denver and statewide for CY 2024. It does not adjust for changes in related costs. However, the increase is applied to all rates, regardless of whether providers are currently paying direct care workers above minimum wage. In those cases, the increase in rates could be used to help cover increases in costs of other components. Provider costs related to service provision such as unemployment insurance, professional and general liability insurance, workers' compensation, FICA, sick leave, and CDPHE licensure requirements are considered separately as part of HCPF's HCBS rate methodology. Finally, the 1% common policy rate increase will also apply to these service providers and they will be able to use that increase without any wage obligation.

36. ***[Sen. Zenzinger]*** **The Denver minimum wage increase takes effect 1/1/2024. Does the Department plan to submit a supplemental request to increase Home- and Community-Based Services (HCBS) rates?**

RESPONSE

HCPF's request to implement the base wage increases in FY 2024-25 is based on the timing of receiving the authority through the supplemental bill and securing federal approval for the rate changes. HCPF would not receive funding from a supplemental request until March 2024. Depending on the magnitude of the increases, HCPF would then need to submit a request 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 may take as long as six months and must be completed before HCPF can implement increases to the rates. HCPF 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. HCPF will continue to work with local governments to increase understanding around the timing impact of increasing the minimum wage on direct care services.

The budget preparation and review processes are confidential until the Governor officially submits supplemental and budget amendment requests to the Legislature on Jan. 2, 2024.

37. ***[Sen. Zenzinger]*** **How do we address the discrepancy in provider rates if there are businesses and providers located outside of Denver but the individuals needing services are within the Denver county and city limits? Why is it that Denver county is identified as needing a higher provider rate but not the rest of the metro area? What would it cost to apply the Denver minimum wage adjustment to all metro counties?**

RESPONSE

HCBS reimbursement is based on the location that the service took place. If the provider is located outside of Denver County but delivers the service in a member's home within Denver County, the provider would be reimbursed the Denver-specific rate. Denver County is identified as needing a higher provider rate because the 2024 Denver minimum wage is $18.29 per hour while the 2024 Colorado minimum wage is $14.42 per hour.

Per Denver Revised Municipal Code § 58-16 through 58-18, the applicability of the Denver minimum wage is based on the location where work is performed. Employers with offices or principal places of business in Denver that employ workers performing work exclusively outside Denver are not required to comply with the minimum wage requirements for work performed outside Denver. Employers should comply with other wage and labor requirements for where such work is performed.

HB 19-1210 repealed the provision that prevented local governments from enacting minimum wage laws separate from those of the state. This bill also required the director of CDLE to

report to the director of HCPF if a local government enacts a minimum wage that exceeds the state minimum wage, and the director of HCPF would submit a report to the JBC as to whether provider rates need to be increased. Beginning in 2020, the Denver City Council increased the minimum wage in Denver above the Colorado minimum wage. Due to the requirements in HB 19-1210, HCPF then submitted a report to the JBC with recommendations to increase certain rates for the City and County of Denver. Each time the Denver minimum wage increased over the last several years, HCPF submitted requests to increase the HCBS rates to account for the new minimum wage, which were approved by the General Assembly.

HCPF is also requesting increases to the non-Denver HCBS rates to account for inflationary pressures across the state, including increases to the statewide minimum wage. HCPF is requesting to increase non-Denver rates to account for a base wage of $16.55 per hour for non-Denver providers, which is $2.13 per hour greater than the 2024 Colorado statewide minimum wage.

It would cost $44,886,277 in total funds, including $22,443,139 General Fund, to apply the Denver minimum wage adjustment to all Denver metro counties. This would increase the total request to $98,743,028 in total funds, including $36,049,088 General fund. The Denver Metropolitan Statistical Area, per the 2020 Census includes the following counties: Denver, Arapahoe, Jefferson, Adams, Douglas, Broomfield, Elbert, Park, Clear Creek, and Gilpin.

38. ***[Sen. Kirkmeyer]*** **How much would it cost to apply the Denver minimum wage adjustment to HCBS providers across the entire Front Range (Fort Collins to Colorado Springs)?**

RESPONSE

It would cost $76,119,457 in total funds, including $38,059,729 in General Fund, to apply the Denver minimum wage adjustment to the entire Front Range. This would increase the total request to $129,976,208 in total funds, including $51,665,578 in General fund. The Colorado Front Range, per the Department of Local Affairs, includes the following counties: Larimer, Weld, Boulder, Broomfield, Adams, Arapahoe, Denver, Jefferson, Douglas, El Paso, Pueblo, and Teller. Pueblo was excluded from the calculation, since it is south of Colorado Springs.

39. ***[Sen. Zenzinger]*** **What does the Department propose to do about provider rates between review cycles of the Medicaid Provider Rate Review Advisory Committee (MPRRAC)? Three years can be a long time to wait for a rate review for providers that operate on thin margins.**

RESPONSE

Originally, the time between provider type rate review cycles was every 5 years. Thank you for working with HCPF to reduce this timespan to every 3 years, beginning this year. Off-cycle rate adjustments are used to address emerging issues for a specific provider type, or to provide an opportunity for the JBC to consider a change in rates for services that need critical adjustments to ensure access to care outside of the scheduled review timeline. For example,

HCPF requested two off-cycle initiatives to increase rates for home- and community-based services (HCBS). The rates for HCBS services are reviewed by the MPRRAC, but were not scheduled for review during this year's rate review process. HCPF requested funding, recognizing the direct care workforce turnover and capacity challenges in combination with the increase in the state's over-65 population and needs of individuals with disabilities. The increase in funding was also put forward to adjust the HCBS rates to account for increases in the minimum wage for Denver and statewide effective Jan. 1, 2024. HCPF further requested funding to establish a higher rate for residential habilitation services for members who are transitioning out of a regional center, which would address an immediate concern that members are experiencing long delays to transition out of the regional centers. HCPF will continue to identify rates that need immediate adjustments and request the necessary changes through the regular budget process.

40. ***[Sen. Kirkmeyer]*** **When is Private Duty Nursing scheduled for review by the Medicaid Provider Rate Review Advisory Committee (MPRRAC)? How will the rate review take into account all the changes in the industry and the strains they put on providers, including reassessments, new rules, changes in the prior authorization process, and now a new assessment tool?**

RESPONSE

Private Duty Nursing is scheduled to be reviewed by the MPRRAC in 2024. During the MPRRAC process, the committee considers many factors when deciding on recommended rate changes. These factors include but are not limited to: comparing Colorado rates to Medicare, or other states if Medicare rates are not applicable, access to care metrics including geographical differences, and provider and community feedback.

There are recent changes that have taken place that impact Private Duty Nursing providers. The requirement for medical necessity reviews has resumed, a new Skilled Nursing Acuity Tool is being developed, and regulations are being revised through a robust stakeholder process. Though it is not expected that these policy or regulation adjustments will have an impact on the costs incurred by Private Duty Nursing providers, HCPF commits to collaboration with advocates, providers, and the MPRRAC to take these changes into consideration during the process of developing the recommendations.

41. ***[Sen. Kirkmeyer]*** **Certain durable medical equipment rates were updated in 2018 to match Medicare, described by the advocates as the UPL rates, but since that time they have not kept pace with Medicare rates. What would it cost to bring durable medical equipment rates up to Medicare?**

RESPONSE

Bringing DME rates that are subject to the federal Upper Payment Limit (UPL) in line with 100% of their Medicare benchmark would cost $296,350, including $148,175 General Fund, based on utilization from FY 2022-23. This would include bringing about 25% of the codes that are currently over 100% of the benchmark down to 100% of the benchmark and increasing

about 75% of the codes that are currently below 100% of the benchmark up to 100% of the benchmark. HCPF must keep the aggregate impact of the code set at or below 100% of the benchmark to comply with federal statute.

42. ***[Sen. Zenzinger]*** **Does the 1.0 percent common policy provider rate adjustment apply to all Health Care Policy and Financing providers, including the Office of Community Living and County Administration? Are there some exceptions?**

RESPONSE

Not all HCPF 's providers are eligible for the common-policy rate adjustment. A large portion of services have rates that are adjusted annually or periodically based on federal or state statute/regulation. These include but are not limited to: behavioral health capitations (including community mental health centers), CHP+ managed care, nursing facility per diem rates, pharmaceuticals, Medicare premiums, federally qualified health centers, rural health centers, hospice, and financing payments. HCPF also requested to exempt services that are receiving a separate targeted adjustment through the MPRRAC rate review process.

HCPF is requesting the 1.0% common policy provider rate adjustment for all providers that are not otherwise exempted, including for the Office of Community Living services and County Administration.

43. ***[Sen. Zenzinger, Sen. Kirkmeyer]*** **For providers that get money from more than one department – such as counties that get money for county administration or behavioral health providers that get money from Human Services and Health Care Policy and Financing – why does it make sense for them to receive a 2.0 percent increase for part of their business but only a 1.0 percent increase for the parts related to Medicaid?**

RESPONSE

Generally, providers are receiving reimbursement through different mechanisms or methodologies from state agencies. The different increase in rates between the two agencies would not result in a new discrepancy in rates, because they are not currently aligned.

HCPF 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. To balance these priorities, HCPF requested a lower common policy increase of 1.0% for Medicaid-eligible services as well as targeted adjustments for services that were identified as needing more significant increases to ensure access to care. Providers that receive reimbursement from other agencies will see an overall increase between 1.0 and 2.0%, depending on their mix of services and assuming they are not providing any services that are subject to a targeted adjustment.

44. *[Sen. Kirkmeyer]* Please provide a history of anesthesia rates compared to Medicare rates.

RESPONSE

In FY 2019-20, HCPF received approval from the General Assembly to lower anesthesia rates to 120% of the Medicare benchmark based on recommendations from the 2017 analysis report made by HCPF. However, in 2021 Medicare lowered their rates which left the state of Colorado's rates even higher than Medicare. The difference in rates was applied for the 2023 Rate Review Analysis Report and subsequent recommendations. The table below shows HCPF's recent comparisons of anesthesia rates to Medicaid rates.

Rate Review Year	Percent of Benchmark
2017	131.64%
2019	120.00%
2023	137.5%

45. *[Sen. Kirkmeyer]* Please provide a history of the Department's requests related to anesthesia rates and the General Assembly's responses.

RESPONSE

Below is a table showing HCPF's requests related to anesthesia and the General Assembly's response for each year since the MPRRAC was implemented.

Fiscal Year	HCPF's Request	General Assembly Response
FY 2016-17	No request	N/A
FY 2017-18	No request	N/A
FY 2018-19	Request to decrease anesthesia rates to 100% of the Medicare benchmark (R-9 Provider Rate Adjustments)	General Assembly denied the request
FY 2019-20	Request to decrease anesthesia rates to 100% of the Medicare benchmark (R-13 Provider Rate Adjustments)	General Assembly approved a lower reduction to 120% of the Medicare benchmark rates
FY 2020-21	Request to decrease anesthesia rates to 100% of the Medicare benchmark (R-10 Provider Rate Adjustments)	General Assembly denied the request
FY 2021-22	Request to decrease anesthesia rates to 100% of the Medicare benchmark (R-16 Provider Rate Adjustments)	General Assembly denied the request

FY 2022-23	No request	N/A
FY 2023-24	No request	N/A
FY 2024-25	Request to decrease anesthesia rates to 100% of the Medicare benchmark (R-6 Provider Rate Adjustments)	Pending

46. ***[Sen. Zenzinger]*** **Please elaborate on the travel reimbursement for anesthesia that was proposed by MPRRAC. Why does the Department believe that is not feasible?**

RESPONSE

The MPRRAC recommended introducing a travel rate for anesthesia providers due to additional travel costs and an expected improvement of access to care for rural communities. **Historically, billing provider costs associated with travel have not been deemed allowable by CMS.** CMS approved reimbursement is limited to medically necessary services for members and for transportation of members to and from medically necessary services. HCPF is not aware of CMS approving exceptions related to anesthesia.

As an example, rural hospitals partner with front range surgeons who provide services at local rural hospital sites. Medicaid does not pay for the travel for those surgeons to these rural sites as a covered Medicaid benefit. Adding this suggested travel reimbursement as a standalone benefit for anesthesia would be a clear outlier, misaligned from the covered reimbursements for other providers.

HCPF does not currently have any way to differentiate services by traveling anesthesiologists from other anesthesia services. Further, HCPF does not have an existing process associated with providing oversight of the usage of travel rates. Given these factors, HCPF would be unable to implement a travel rate specific to anesthesia without additional administrative and technology resources.

Last, MPRRAC is designed to provide rate recommendations in collaboration with HCPF to the JBC, not benefit addition recommendations. Adding travel as a covered Medicaid service would be a benefit increase, to be considered as part of the budget process, not as part of the MPRRAC process.

47. **[*Sen. Kirkmeyer]* What method did the Department use to determine the benchmark for pediatric behavioral therapy rates and what was the criteria for selecting comparison states? Please demonstrate whether the methodology and criteria were consistent with the way the Department has treated other rates. For example, please provide a list of cases where the Department threw out the high outliers but not the low outliers when determining the appropriate benchmarks for provider rates. Does the Department have written standards for how it determines benchmarks for rates, or is it just based on the subjective perspectives of program staff?**

RESPONSE

HCPF used a statistical methodology called interquartile range to establish whether any of the states used in the comparison were mathematical outliers. Here the interquartile range (IQR) measures the spread of the middle half of the data and it is a good measure for data dispersion and used to detect outliers (McClave et al., 2018, pp. 94-95)[7]. For pediatric behavioral therapy rates, Nebraska was the only mathematical outlier. HCPF also removed high statistical outliers in developing benchmark rates for integumentary surgeries and abortion services. HCPF used this methodology to examine other states' rates across all service categories in the development of the benchmark rates.

The comparison analysis and benchmark state list for pediatric behavioral therapy was based on research and feedback from HCPF's subject matter experts and Chief Medical Officer. HCPF also received input from the Colorado Association for Behavior Analysis (COABA).

HCPF's methodology associated with creating the benchmark rates is shown in Appendix A of the Analysis and Recommendation report published November 2023. In order to be transparent, HCPF provided information on what the benchmark rate would have been, the associated fiscal impacts associated with increasing rates to that benchmark, and if it had included statistical outliers for pediatric behavioral therapy benefit in the 2023 Analysis and Recommendation report (pages 34-38). The Medicaid Provider Rate Review Advisory Committee's recommendation is based on the average rate across all the states in the analysis, including statistical outliers.

48. **To improve the transparency and consistency of the MPRRAC state comparison process, we would like to know when HCPF last consulted with CMS to ensure their state selection and rate comparisons process aligns with the CMS guidelines? Which of these CMS guidelines did CO HCPF adopt in their process? 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

HCPF has not consulted with CMS regarding benchmark state selection and rate comparison process methods as it is not a CMS requirement. CMS has proposed, but has not finalized, regulations that would require states to report on their state Medicaid rates relative to comparable Medicare fee-for-service rates every two years; there is no proposed requirement to compare rates to other states.[8]

To ensure that HCPF has the most comparable states to Colorado, we partnered with Optumas, an external actuary contractor that has rich experience on rate review and rate comparison analysis across different states. When Optumas selects benchmark states, they

[7] McClave, J. T., Benson, P. G., & Sincich, T. (2018). Statistics for Business and Economics (13th ed.). Pearson Education.

[8] https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p

usually consider multiple factors: similar benefit packages, similar demographics or Medicaid population, FFS payment model, etc. In addition to utilizing Optumas, HCPF also asks internal subject matter experts for their input on what states would be best to compare to based on their experience and knowledge in their service category. Finally, HCPF asks the provider community to share the states they think are most comparable to Colorado for their service category.

DENVER HEALTH

49. *[Sen. Kirkmeyer]* How would Denver Health use the $5.0 million General Fund requested in R15?

RESPONSE

Denver Health leadership is proactively implementing strategies to stabilize the organization financially. Operational advances that improve quality outcomes, care delivery efficiencies, and overall cost control help us achieve shared goals while also assisting Denver Health in its sustainability turnaround. The proposed payment to Denver Health is contingent on the hospital agreeing to employ the funding to achieve these shared goals through the following categories:

- Improvements and modernizations in information technology systems. This might include:
    - accessing the Health Information Exchange, which drives care delivery efficiency and quality outcomes
    - advancing eConsult technology, which improve specialty care access while avoiding ineffective specialty visits and driving quality outcomes and affordability,
- increasing funding for Denver Health's nurse advice line, which avoids inappropriate ER utilization and triages individuals to the appropriate care, and
- timely eligibility application processing.

Denver Health is the largest safety-net provider in the State and serves Medicaid members each year through its hospital, clinic, and ambulance services. It is currently experiencing significant financial hardship with operating margins and uncompensated care that are not sustainable. The below reserves and profit data is from Audited Financial Statements and quarterly unaudited financials, both available publicly through EMMA.org.

System	Calendar Year	Days Cash on Hand	Reserves
Denver Health	2019	131	$364 M
	2020	159	$441 M
	2021	117	$381 M
	2022	87	$302 M
	2023 Q1, 2 & 3	82	$297 M

System	Calendar Year	Operating Profit Margin	Operating Profit[9]	Total Profit Margin	Total Profit (including investments)
Denver Health	2019	4.8%	$54 M	11.4%	$127M
	2020	-0.1%	($1 M)	9.1%	$99M
	2021	-0.8%	($9 M)	1.2%	$15M
	2022	-1.9%	($24 M)	-4.4%	($57 M)
	2023 Q1,2& 3	0.2%	$3 M	0.8%	$8 M

50. *[Sen. Kirkmeyer]* What level of transparency does the Department have into Denver Health's finances? Is it sufficient to assess the merits of Denver Health's request for additional state assistance?

RESPONSE

HCPF has a significant level of financial transparency for Denver Health. This includes annually reported detailed financial and operating information, as well as high level quarterly financial and operating information available through public websites. HCPF believes this is sufficient information to assess the merits of Denver Health's request for additional state assistance. While financial analysis and forecasting inherently have a level of uncertainty, HCPF has used standard practices and benchmarks from hospitals statewide to analyze Denver Health's financial situation.

51. *[Sen. Bridges, Sen. Kirkmeyer]* Please describe Denver Health's service expansions in other parts of the state. How do the service expansions factor into the request

[9] Parentheses indicate a negative value

for additional funds? Would any of the $5.0 million go toward financing the expansions?

RESPONSE

The $5 million investment is designed to advance Denver Health administrative operations associated with services to Medicaid members and the efficient operations of the Medicaid managed care organization operated by Denver Health. This includes investments that achieve our shared Medicaid affordability and quality improvement goals. Eligible investment categories are limited to improvements and modernizations in information technology systems such as Health Information Exchange or eConsults; increasing funding for Denver Health's nurse advice line; and eligibility application processing improvements. This investment is not intended to assist with or finance any potential Denver Health service expansions in other parts of the state.

Unrelated to the above, and as we understand it, in 2024, Denver Health is planning to have 14 apartments available for people experiencing homelessness.[10] Denver Health has expanded its access and affordability through in-network insurance access to include Humana Medicare Advantage.[11]

52. ***[Rep. Bird]*** **What are the Department's plans to help Denver Health figure out a sustainable long-term financial solution?**

RESPONSE

HCPF has provided insights to the Board and the CEO of Denver Health to propel its sustainability. HCPF leadership collaboratives with Denver Health leadership at least monthly on critical items, including sustainability strategies.

HCPF will continue its quarterly monitoring of Denver Health's financial stability. HCPF will explore areas for claiming federal funds, if any remaining avenues exist, such as Medicaid administrative functions performed by Denver Health where we are not currently drawing federal funds. HCPF will continue to consult with Denver Health and offer our expertise to review and provide commentary to proposed long-term strategy shifts to improve financial standing.

GENERAL FINANCING

53. ***[Sen. Kirkmeyer]*** **Please discuss why there is no increase proposed for rural critical access hospitals.**

RESPONSE

HCPF is maximizing reimbursement to critical access hospitals. Through increased Healthcare Affordability and Sustainability (HAS) supplemental payments, in addition to claims payments,

[10] https://www.9news.com/article/news/local/next/next-with-kyle-clark/denver-health-transitional-apartments-patients-who-have-nowhere-to-go/73-038f1900-1038-425b-9036-f09003679808
[11] https://press.humana.com/news/news-details/2023/Humana-and-Denver-Health-Sign-Agreement-to-Expand-Humanas-Medicare-Advantage-Provider-Network-in-the-Denver-Area/default.aspx#gsc.tab=0

critical access hospitals are reimbursed at or above cost of care for services provided to Medicaid members. Under the HAS fees supplemental payments, in addition to supplemental payments for inpatient and outpatient care, all critical access hospitals receive a total of $20 million per year ($588,235 per hospital per year) through an Essential Access supplemental payment, and the 23 critical access hospitals with the lowest revenue or reserves receive a Hospital Transformation Program Rural Support Payment totaling $12 million per year ($521,739 per hospital per year), limited currently to 5 years of payments, to support their operational needs.

In addition, through SB 22-200, HCPF is granting 23 hospitals a total of $10.6 million in one-time grant funding to invest in service expansion or infrastructure to improve access and affordability of health care in rural communities.

54. *[Sen. Bridges]* Is the Department maximizing the federal funds that could be matched for the University of Colorado School of Medicine (CUSOM)? For example, is the tobacco money that goes to Anschutz included in the interagency agreement?

RESPONSE

As described to the Joint Budget Committee as it considered the initial proposal for the physician supplemental payment made to the University of Colorado School of Medicine (CUSOM) in the FY 2017-18 budget, this payment is intended to expand CUSOM physicians' Medicaid patient volume, including expanding access to a medical home model and specialty providers, expanding rural patient access, expanding telemedicine, and investing in evidence-based outcomes access. HCPF and CUSOM have an Interagency Agreement that describes those priority areas and related funding amounts. A report is provided each year to the Joint Budget Committee through a Legislative Request for Information; this year's LRFI is available here: Multi-Department Legislative Request for Information #5.

The CUSOM physician supplemental payment is limited by a physician services Upper Payment Limit (UPL). In FY 2022-23, there was a remaining UPL gap of $65.3 million total funds, and in the current FY 2023-24, the UPL gap is expected to be about $50.6 million total funds. While the payments are not made up to the full UPL, as shown in the most recent LRFI under Table 5 on page 11, following all of the payments and expenses for the program in FY 2022-23 there was a remaining balance of $7.1 million. This carryforward was added to the previous carryforward balance for a current total of $65.5 million in unspent funds. This carryforward balance is earning interest, and HCPF and CUSOM are actively discussing how interest earned by CUSOM from the carryforward balance should be disclosed and included in the available funds to be expended to achieve the goals of the program, including benefiting Medicaid member care and access. Until the carryforward is spent down, and all interest is reported and accounted for in the priority spending areas in the Interagency Agreement, HCPF does not believe further increasing the CUSOM physician supplemental payment will further the program's objectives.

The Tobacco Litigation Settlement money is not included in the current or prior Interagency Agreements between HCPF and CUSOM. HCPF is not drawing down federal fund dollars on the

Tobacco Litigation Settlement money, and, in reviewing the Operating Agency Budget for the Department of Higher Education, the Tobacco Litigation Settlement is separate from the CUSOM funding and is part of the Cash Funds paid to the Regents of the University of Colorado.

55. ***[Sen. Kirkmeyer]*** **How are the additional federal funds earned through certified public expenditures by school districts distributed back to the school districts?**

RESPONSE

The School Health Services program allows participating public school districts, Boards of Cooperative Educational Services (BOCES), and the Colorado School for the Deaf and Blind to receive federal Medicaid reimbursement for health care services and transportation provided to Medicaid enrolled students with medical plans of care, including an Individual Education Program (IEP) and an Individualized Family Service Plan (IFSP).

In addition, School Health Services participants may claim Medicaid administrative costs for time spent in administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid.

The School Health Services participants incur the original expenditures using local tax dollars or appropriated General Fund, and HCPF draws federal matching Medicaid funds through the certification of public expenditures (CPE) mechanism. To draw federal Medicaid funds through CPEs, School Health Services participants must participate in a federally-approved quarterly time study and submit quarterly and annual cost reports.

Because the original expenditures of the medical service were incurred by a public entity using local tax dollars or General Fund appropriated to educational institutions, the Medicaid reimbursement is entirely federal funds. The federal funds are paid directly to the participants in monthly interim payments, followed by a final payment to reconcile to final, allowable costs.

As reported in Legislative Request for Information #7 submitted to the Joint Budget Committee on Nov. 1, 2023, for FY 2021-22, fifty-eight School Health Services participants received Medicaid reimbursement totaling $69,749,637.

56. ***[Sen. Bridges]*** **Why is the Healthcare Affordability and Sustainability (HAS) Fee set at 97 percent, rather than 100 percent? How does that compare to other states? Assess the risk if Colorado approached closer to 100 percent. How much additional federal funds could Colorado draw at 100 percent?**

RESPONSE

Under the recommendation of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board, supplemental payments funded by Healthcare Affordability and Sustainability (HAS) fees have been set such that total Medicaid hospital reimbursement equals approximately 97% of the available inpatient and outpatient Upper Payment Limits (UPL). [This is the same as the previous practice dating back to FY 2013-14 recommended by

the Hospital Provider Fee Oversight and Advisory Board under the former Colorado Health Care Affordability Act (CHCAA), 25.5-4-402.3, C.R.S. (repealed).]

Pursuant to the CHASE statute, subject to approval by the federal Centers for Medicare and Medicaid Services (CMS), the CHASE Board makes recommendations to HCPF and the Medical Services Board concerning the HAS fee. HCPF is the single state agency for administering Colorado's Medicaid program and authorized to draw federal Medicaid matching funds. The Medical Services Board promulgates rules for CHASE, including payment amounts. Ultimately approval of the HAS fee, supplemental payments, and the inpatient and outpatient hospital UPL demonstrations is the purview of CMS.

The CHASE Board, HCPF, and the Medical Services Board must consider many factors to achieve the purposes of CHASE; as the single state Medicaid agency, HCPF retains the discretion to administer the HAS fee consistent with standards of sound fiscal management and proper governmental practices.

The goals of sound fiscal management, proper governmental practices, maximizing the benefit to hospitals, and ensuring funding for health coverage expansions require HCPF to minimize the risk of disallowance of federal funds.

HCPF must submit its UPL demonstrations to CMS for review and approval each year. With the goal of maximizing reimbursement to hospitals under the HAS fee as directed by statute, Colorado's inpatient and outpatient hospital UPLs use a methodology that produces the highest total UPL amount possible, which CMS has explicitly stated subjects Colorado to particular scrutiny.

If we were to fund hospital supplemental payments to reach 100% of the current UPL methodology, provider rate increases passed in the Long Bill would necessitate recovery of supplemental payments and return of federal funds, and any data input error or minor calculation error would risk disallowance of federal funds. If our annual UPL demonstration submission to CMS with our aggressive methodology was at or near 100% of the UPL, HCPF could draw approximately $55 million additional federal funds annually. However, CMS is more likely to question the methodology, data inputs, and calculations, increasing the risk of non-approval of the UPL and disallowance of federal funds. This risk is not on the hospitals themselves as the HAS fee finances health care coverage for more than 600,000 Coloradans.[12]

HCPF could use other, approved UPL methodologies, subject to less scrutiny and risk, that would produce a lower overall UPL. HCPF is amenable to increasing the UPL percentage if it adopted a less aggressive UPL methodology. Note: doing so would result in lower supplemental payments compared to 97% of our current, more aggressive methodology.

[12] Since the inception of the CHCAA and through the implementation of the CHASE, the hospital provider fee and the HAS fee increased hospital reimbursement by an average of more than $415 million per year and substantially increased enrollment in Health First Colorado and CHP+, with more than 622,000 Coloradans with health coverage through coverage expansions financed by HAS fees as of September 2023.

57. *[Rep. Bird]* Is the nursing provider fee an enterprise, just like the Healthcare Affordability and Sustainability (HAS) Fee? If not, why not? Could we make it an enterprise, or include it in the HAS Fee enterprise?

RESPONSE

The nursing facility provider fee is not a state enterprise like the Colorado Health Care Affordability and Sustainability Enterprise (CHASE), which concerns the Healthcare Affordability and Sustainability (HAS) fee. Due to the adoption of Proposition 117 in the November 2020 general election, voter approval in a statewide general election would be required to create a nursing facility provider fee enterprise. Through proposition 117, codified at 24-77-109, C.R.S., the creation of a new state enterprise after Jan. 1, 2021, requires approval by the voters through a statewide general election if the expected revenue from fees is greater than $100 million within its first five years. Currently the nursing facility provider fee collects more than $50 million in fees per year so it would require voter approval to create an enterprise.

The nursing facility provider fee cannot be included with the CHASE. The CHASE, established at 25.5-4-402.4, C.R.S., specifically provides business services for hospitals that pay HAS fees. Expanding the CHASE statute to encompass nursing facilities would be a substantial change to the existing enterprise that would likely constitute establishing a new enterprise and be subject to voter approval.

58. *[Rep. Bird]* Are we maximizing the nursing provider fee and bumping up against federal upper payment limits, like with the HAS Fee, or is there room to increase our supplemental payments to nursing homes using the nursing provider fee?

RESPONSE

Total reimbursement to nursing facilities from claims and fee-financed supplemental payments is less than the allowable federal Upper Payment Limit (UPL), and there is room to increase supplemental payments, with approximately $100 million in total funds available under the UPL. However, state and federal limitations on the amount of nursing facility fees we can collect limit our ability to pay additional nursing facility supplemental payments. State statute at 25.5-6-203(1)(a)(II), C.R.S., restricts the amount of nursing facility fees we could collect, and the fee is currently at $17.17 per non-Medicare per day equaling approximately 4.8% of net patient revenues. The federal limit on provider fees is 6% of net patient revenues. With the federal limit on fee collection in FY 2023-24, we could only collect approximately $11 million more in fees if the state statutory limit on nursing facility fees was changed, equating to approximately $22 million more in supplemental payments.

R12-14 & GENERAL ELIGIBILITY

59. *[Rep. Bird]* What is the potential overutilization of dental services? How much is the risk and is it really that worrisome that we need to spend money for increased oversight?

RESPONSE

The administrative processes for the Dental Health Care Program for Low-Income Seniors (Senior Dental Program) are inefficient due to HCPF's limited resources for the program and the requirement for grantees to perform many of the program's administrative functions themselves.

Currently, eligibility is determined by the grantees who then invoice HCPF for services performed. HCPF has 1.0 FTE to administer this program. Within our existing resources, HCPF staff process the invoices manually and use an Access database to review for duplication and overutilization of services. This is a time intensive process, and HCPF lacks administrative resources to thoroughly review invoices for such overutilization or to perform a pre-service review or prior authorization. This means grantees may provide more services than allowed by program rules, or invoice for services HCPF will not pay or will require repayment of funds after the fact.

Services where HCPF may detect overutilization include service limits. For example, service limits such as: one routine examination to once every six months, x-rays of the whole mouth once every five years, and complete dentures once every five years, among others. If a client is seen at one grantee, receives dentures under the program, and then sees another grantee three years later, the program may pay for dentures more frequently than allowed under program rules. The Senior Dental Program is a state-only funded program limited to its appropriation with no overexpenditure authority.

HB 19-1326 directed HCPF to recommend the most effective options for administering the program. HCPF subsequently identified a gap in current resources and recommended a third-party vendor to improve efficiency and relieve administrative burden for grantees.

Each senior served receives on average about $1000 worth of care per year, and each year, grantees have waitlists, as there are more seniors in need than available funds. Each $1000 saved in reduced overutilization or duplication of benefits is one additional senior in need of dental care who could be served, rather than placed on a waitlist.

60. ***[Sen. Zenzinger]*** **Why is the Department only just now getting around to ensuring that the Department's documents are accessible to people with disabilities. Of all the departments struggling to implement this new statutory requirement, is seems like the Department of Health Care Policy and Financing should have been ahead of the curve.**

RESPONSE

HCPF has been working for many years to improve accessibility on our websites and other platforms. As technology advances, we have upgraded our website to improve accessibility. Staff from various offices within HCPF form a Web Team, led by HCPF's Webmaster. Web Team members are tasked with reviewing content for accessibility before it is posted to the public website, and membership on the Web Team is in addition to the assigned duties within their position descriptions. HCPF has worked collaboratively with other states agencies to institute a process for all new documents to be reviewed from an accessibility lens before

posting online. We have also instituted training for both new and existing staff and implemented templates to help improve document accessibility moving forward.

A significant challenge HCPF faces is with remediating historical PDF documents. HCPF has 11.5 million documents across 99 apps or platforms (this includes internal and external websites, portals or applications) that may need to be reviewed/tested and possibly need remediation. We have been working to prioritize and review these documents over the last two years.

In December 2022, HCPF onboarded our first Accessibility Technology Specialist, who has made great improvements towards compliance efforts. In October 2023, we hired a temporary funded full-time Project Manager, and we are currently in the hiring process for four additional term limited staff to support digital accessibility needs. We are hopeful that these term-limited staff will be able to address documents and content that predate our formalized accessibility processes and work with our vendors and outside content producers to ensure that they, too, are following these best practices.

61. *[Rep. Taggart]* Please elaborate on how the proposed conversions of existing contracts to state FTE will improve efficiency and effectiveness.

RESPONSE
HCPF requests to convert contractor resources to FTE for the following three administrative functions: rate and financial analysis for HCPF's payment reform efforts, administrative duties for HCPF's Substance Use Disorder (SUD) benefit, and staffing for the Program Eligibility and Application Kit (PEAK) call center. These are ongoing administrative functions that do not require specialized vendor expertise, reflect core competencies within HCPF, and can be performed more efficiently and effectively by FTE for several reasons.

- First, using FTE for these functions would reduce overhead workload and, except for the PEAK call center, reduce costs. Using outside contractors adds overhead workload to existing FTE who must oversee the contractor, process invoices and payments, manage budgets, draft contract documents, initiate corrective actions, perform contract solicitations, and more. Using FTE requires less overhead administrative workload and, except for the PEAK call center, reduces the cost of performing the function. HCPF often pays higher hourly rates to contractors compared to FTE for equivalent work, so HCPF would generate modest ongoing savings by converting these functions to FTE.
- Additionally, using FTE for these functions would allow HCPF to build institutional knowledge and achieve fewer interruptions to operations. HCPF often has a difficult time maintaining continuity of subject matter knowledge when work is transitioned between contractors due to circumstances such as federal re-procurement requirements or business closures and buyouts. Additionally, these transitions often result in delays in deliverables as one contractor closes out and another contractor ramps up. Using FTE for these functions enables HCPF to build and maintain institutional expertise that can be shared and passed along readily to new FTE, thus eliminating interruptions due to contractor transitions and enabling continuous operational improvement and knowledge growth.

- Finally, using FTE for these functions enables far more agility – agility that is necessary to respond to changing workloads, and competing priorities given the many goals, legislative mandates and federal requires impacting Medicaid, other safety net programs we administer, and HCPF as a whole. Compared to outside contractors, HCPF FTE are more ingrained, integrated and trained in HCPF operations; they can be more easily redirected and responsive to emergencies, changing priorities or pressing project work. Our HCPF structure – by Office - facilitates this training, expertise, collaborative approach and agility. Comparatively, contractors are generally less available and able to respond quickly or efficiently to HCPF emerging needs, especially in case of an urgent priority. Further, contractor changes require often lengthy contract negotiations and amendments to update their scope of work before work can begin on the emerging or urgent project. Additionally, since FTE are more ingrained in HCPF culture and operations, there are more opportunities for collaboration with other units in HCPF and finding synergies between different administrative functions, and greater continuity of expertise throughout HCPF.

As mentioned above, converting the PEAK call center to FTE would not reduce the cost of this function. The reason is that these call center positions would receive better pay as FTE than they currently do as contractors, which is critical to reducing turnover and maintaining better service to members. This is critical given PEAKs continually increasing utilization. While this would increase the cost of operating the call center, HCPF anticipates it would significantly benefit the program because it has had difficulty retaining the current contracted staff at the current starting pay that is offered. Currently, the contracted call center positions earn a starting pay as low as $18 per hour, equivalent to $37,440 per year.

HCPF requests to convert these positions to FTE at the Administrator I classification, which earns a minimum salary of $47,472 per year according to the FY 2024-25 Compensation Plan. A recent search of comparable Helpdesk Technician jobs in the Denver Metro area indicates an average starting pay of $57,653 per year. Thus, with better-paying helpdesk jobs available in the area, the current contracted staff in the PEAK call center often leave for significantly better paying positions that have similar job requirements. This frequent turnover is detrimental to maintaining knowledge and expertise in critical, member-facing roles that require knowledge of not only HCPF's programs, but also CDHS, CDPHE, and CDEC public assistance programs, as these state agencies also utilize the PEAK call center.

62. *[Sen. Kirkmeyer]* The net impact of converting the contacts to state FTE is a marginal increase in General Fund. Couldn't the Department absorb that cost within existing resources?

RESPONSE

HCPF is unable to absorb the cost of the FTE within existing resources for a several reasons. First, HCPF pays for FTE out of its Personal Services line item and the requested reductions to

contracts are in various contract-specific line items. To hire additional FTE, HCPF needs funding in the correct line item. Second, HCPF generally has very little, if any, General Fund flexibility in the Personal Services line item to hire additional FTE. HCPF did not revert any General Fund from Personal Services in FY 2022-23.

63. ***[Sen. Kirkmeyer]*** **For the contract true ups in R14, who are the contract providers, how long have they been the providers, and how much of an increase will they receive?**

RESPONSE

The first contract provider is Denver Health Hospital & Authority for the Colorado Medical Assistance Program (CMAP), which provides eligibility and enrollment services for Colorado's Medicaid and CHP+ medical assistance programs. Denver Health has been the provider since 2015. The R-14 requests an increase to the FY 2024-25 budget by approximately $1.8 million, an increase of 30%. The R-14 also includes a supplemental request for FY 2023-24 for approximately the same amount. The program lacks sufficient spending authority to support the expected increases in cost due to increased personnel costs, including inflationary increases.

The second contract is an interagency agreement with the Colorado Department of Local Affairs (DOLA), Division of Housing, which performs host home inspections and site visits of potential Medicaid host homes. DOLA has performed these inspections since FY 2019-20. The R-14 requests an increase of approximately $180,000, effectively doubling the budget. Additional funds are necessary because the number of host homes has increased significantly, the cost of initial and follow up inspections has increased in the last year, and the cost to maintain records of the completed inspections and active providers within Salesforce has also increased.

64. ***[Sen. Kirkmeyer]*** **Please describe the roles of the Regional Accountable Entities (RAEs) and Federally Qualified Health Centers in services for people with disabilities. Do they comply with federal and state laws and regulations regarding access to care for people with disabilities? What does compliance look like and what does the Department do to ensure compliance?**

RESPONSE

Federally Qualified Health Centers (FQHCs) must comply with standards set by the federal Health Resources and Service Administration (HRSA)[1] [2]. HCPF requires FQHCs to comply with HRSA standards as a condition of enrollment[3]. HRSA enforces compliance of their accessibility requirements[4] during on-site visits[5].

Health programs and services that serve the public and receive federal financial assistance (including FQHCs and RAEs, and HCPF) must comply with all applicable federal and state disability rights laws and regulations, which require equal access for individuals with disabilities. These laws include Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act of 1990, Section 1557 of the Patient Protection and Affordable Care Act of 2010 and the Colorado Anti-Discrimination Act (CADA). The U.S. Department of Justice's Civil Rights Division, and the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) are responsible for enforcement of federal civil rights

laws, which includes complaints against health care entities. The Colorado Department of Regulatory Agencies, Colorado Civil Rights Division (CCRD) has enforcement authority over CADA.

Regional Accountable Entities (RAEs) comply with all applicable federal and state laws and regulations regarding access to care for people with disabilities. The RAEs contracted role in compliance with these statutes and regulations is to ensure provider network adequacy requirements are met and that the network can serve all their members including those with disabilities. An independent external auditor monitors RAE compliance with federal network adequacy standards.

HCPF requires RAEs to develop and provide disability competency training programs to network providers and staff; develop and implement strategies to recruit and retain qualified, diverse and culturally responsive providers who serve the disability community; and collaborate with providers and organizations with specific competency in disability issues. HCPF ensures compliance by requiring RAEs to submit regular deliverables. These reports identify accessible practice sites and outline how their provider directories include information about disability access. Deliverables further detail contracting strategies to improve network access; describe relationships with community organizations that provide disability training; demonstrate RAE capacity to provide members with access to ASL, braille, large print text and speech to text services; and outline strategies to address disparities and improve access. While RAEs are compliant with statute and regulation, HCPF continues to prioritize improving the network's ability to provide disability competent care.

To this end, HCPF staff have been meeting regularly with members of the community including people with disabilities, disability advocates, and providers focused on serving people with disabilities to identify opportunities to change policy or practices to improve access to care for people with disabilities and improve the disability competency of the providers who serve them. HCPF conducted stakeholder meetings to gather feedback and ideas and is currently working to gather best practices from other states.

65. ***[Sen. Bridges]*** **A recent audit described Medicaid communications as indecipherable. How do the findings of that audit relate to the request? Will any of the requested funds address the audit concerns? Will there be additional requests for funding in response to the audit?**

RESPONSE

HCPF is not requesting funding in the FY 2024-25 budget to address the findings of the September 2023 Medicaid Correspondence Performance Audit because the timing of the audit did not coincide with the regular budget process. In addition to taking immediate steps to improve correspondence within existing resources, HCPF continues to identify future needs to fully implement the audit recommendations and is exploring leveraging the regular budget process in the future.

HCPF continues to make progress toward resolving the issues identified in Member Correspondence. HCPF has:

- Implemented a Standard Operating Procedure for Member Correspondence.

- Established Member Testing Toolkits and feedback process, which was expanded this year to include feedback on Spanish communications.
- Established Member Communication Standards & Common Terms Guide.
- Centralized the translation request process.
- Improved the following in CBMS Member Correspondence:
    - Consolidated 13 different letterheads into three.
    - Onboarded two projects to establish an ongoing monitoring dashboard and to make improvements.
    - Researched and reviewed 143 letters and discontinued 85 letters.
    - Rewrote 55 letters into plain language and member-tested 30 of those so far.
    - Corrected the following specific issues identified in the audit:
        - Missing information on denial reasons
        - Repeated instructions
        - Multiple letters sent

There is still much to do as HCPF simultaneously migrates from household-level eligibility determinations to individual members. Colorado is working closely with other states to identify and share best practices for improving member correspondence.

66. ***[Sen. Zenzinger]*** **Are all Supplemental Security Income recipients automatically receiving continued Medicaid benefits as required under the Social Security Act?**

RESPONSE

Yes, if an individual is receiving a Social Security Income (SSI) payment, or if they are eligible for the payment but not receiving or are in appeal, HCPF enrolls them automatically and provides continued Medicaid benefits. This automation is based on the receipt of a file from the Social Security Administration (SSA) for SSI eligible individuals and does not require any member or eligibility worker intervention.

67. **[*Sen. Zenzinger]* Please provide an update on the implementation of H.B. 23-1300 to provide continuous Medicaid coverage for select populations. Is there more the General Assembly should do to avoid challenges with disenrolling people from Medicaid only to reenroll them?**

RESPONSE

"Continuous Eligibility Medical Coverage" (HB23-1300) gave HCPF permission to apply for an 1115 demonstration waiver to: a) automate eligibility renewal for individuals with zero income when electronic verifications return no information; b) extend continuous coverage for children (0-3) enrolled in Child Health Plan *Plus* (CHP+) or Health First Colorado (Colorado's Medicaid program); c) extend 12 months of continuous coverage for people leaving incarceration from the Department of Corrections; and d) complete a feasibility study on health-related social needs and other continuous coverage options.

HCPF received Centers for Medicare & Medicaid Services (CMS) approval to implement automatic eligibility for individuals with zero income through flexibilities granted to states per the COVID Public Health Emergency continuous coverage enrollment requirements. This

flexibility continues through June 2024 and allows HCPF to perform more automated renewals so fewer members are disenrolled from Health First Colorado and CHP+. Because the current approval is temporary, HCPF is working with CMS to make this waiver permanent.

For extending continuous coverage for young children and individuals leaving incarceration, HCPF has drafted a concept paper to share with CMS, which is the first step to initiate negotiations with CMS. Simultaneously, HCPF has begun drafting the amendments to our current 1115 Waiver "Expanding the Substance Use Disorder Continuum of Care" (1115 SUD Waiver) with these two components from HB23-1300. HCPF is amending our existing 1115 SUD Waiver because it is more administratively efficient and waiver amendments are processed more timely by CMS. Two stakeholder meetings were held in late November, and a formal public comment period will open in January—including Tribal-specific notice. As required by the legislation, HCPF is on target to submit the 1115 SUD Waiver Amendment by April 1, 2024. Finally, the feasibility study is on track to be completed in January 2026. This includes an analysis on the potential to use Health First Colorado to cover health related social needs including housing and nutrition services for members, and continuous coverage for other priority populations.

Continuous eligibility prevents disenrollment of Health First Colorado and CHP+ members prior to their renewal period—even if their income changes. This reduces county workload, member paperwork, and administrative churn between health care coverages, or periods of uninsurance. The populations included under review for continuous coverage regardless of income are:

- Continuous eligibility for children to age six;
- Continuous eligibility regardless of income for all children for 24 months, rather than the 12 months HCPF already provides;
- Continuous eligibility regardless of income for all adults for 12 months, as HCPF does not provide continuous coverage for adults as it does for children; and
- Continuous eligibility regardless of income for adults for 12 and 24 months for specific populations including those who:
    - Have an income under 33% federal poverty level (FPL);
    - Are experiencing Houselessness; and
    - Are on parole, living in Community Corrections, or released from any carceral setting (e.g., county jails).

The current statute only requires a study, and neither authorizes HCPF to seek federal approval on the components of the feasibility study nor authorizes spending authority. If the General Assembly would like to authorize implementation of the components under HB23-1300 before HCPF submits the study in January 2026, the General Assembly will need to modify the current statute.

CHILD HEALTH PLAN *PLUS* BENEFIT

68. ***[Sen. Zenzinger]*** **Please provide a breakdown of requirements for services through CHP+. Is CHP+ only for income-restricted members? Will the Department be moving Medicaid members onto CHP+ to receive ASD services? How will this work and how will it impact patients?**

RESPONSE

The below table provides a summary of the differences between CHP+ and Health First Colorado.

	CHP+	Medicaid
Authority	Title XXI of the SSA	Title XIX of the SSA
Federal Matching	65%	50% children and parents 90% expansion adults
Finance Structure	State spending matched up to a capped allotment	State spending matched with no cap
Eligible Members	Children under 19 and Pregnant People	Children & Adults
Recent Enrollment Numbers[13]	57,406	1,506,863
Income Eligibility as percent of FPL	143%-260%	147% FPL for children 138% FPL for adults under 65 195% FPL for households
Delivery System	Fully capitated managed care 4 managed care organizations, county overlap in Metro Area	Regional Accountable Entities manage capitated behavioral health benefit and care coordination Fee-for-service physical health
Additional Similarities	12-month post-partum expansion 1289 Look-alike program 0$ enrollment fee	

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. CHP+ is only for children under 19, pregnant people and postpartum people up to 12 months after pregnancy whose income is too high to qualify for Medicaid but does not exceed 260% FPL. In Colorado, CHP+ is a fully capitated, managed care program that is administered by four managed care organizations. Unlike Medicaid, CHP+ members cannot have secondary, commercial insurance, and the benefits in CHP+ are benchmarked to commercial coverage.

HCPF will not move children off Medicaid and onto CHP+ to receive ASD services. Children only move to CHP+ if their family income is too high to qualify for Medicaid and remains below 260% FPL. This will happen through typical eligibility determination and redetermination processes.

As a reminder, Medicaid already covers ASD. The impact to members will be that if members churn from Medicaid or state-regulated commercial payers, where ASD services are covered,

[13] https://hcpf.colorado.gov/premiums-expenditures-and-caseload-reports

onto CHP+, they will no longer have access to these critical and time sensitive services based on current CHP+ benefits. Adding ASD coverage to CHP+ effective July 2024 will mitigate the gap in ASD care for children moving from Medicaid to CHP+ as a result of the end of the PHE and the associated end of the continuous coverage requirements. As CHP+ enrollment returns to pre-pandemic levels (more than doubling from its recent lows), children with ASD will be left without this critical developmental care without this CHP+ benefit addition. It is that gap in care that HCPF is asking the JBC to help us avoid, by adding ASD coverage to CHP+.

69. ***[Sen. Zenzinger]*** **If we expand the Children's Basic Health Plan (CHP+) benefit to include autism spectrum disorder (ASD) treatments, do we expect people to leave the private market and enter the CHP+ benefit? How many will that leave in the private market? What children will be excluded from ASD services once ASD services have been integrated into CHP+?**

RESPONSE

We do not expect people to leave the private market to receive ASD treatment through the CHP+ benefit because: 1) these treatments are accessible in the private market; and 2) historically, fears that individuals and employers would substitute CHP+ coverage for other group coverage have not been realized.

First, State regulated commercial insurance plans must cover treatment for ASD such as ABA therapy. This mandate was created under SB-09-244, C.R.S. 10-16-104 (1.4) (the section of title 10 that describes ASD providers and therapy), which is the same legislation that prohibited coverage under the CHP+ program due to recession-related budget constraints. Thus, if we consider the continuum of coverage options (Medicaid, CHP+, state regulated commercial insurance), CHP+ is a gap in that continuum.

Second, since CHIP's creation in 1997, and with each CHIP eligibility expansion, there have been concerns about the potential for crowding out commercial insurance. As a result, states are federally required to outline a plan for monitoring and preventing substitution of group coverage in their CHIP State Plan, and Colorado does this through an agreement with CMS to keep any substitution of group coverage with CHP+ coverage below 10%. This is measured through the bi-annual Colorado Health Access Survey, administered independently through the Colorado Health Institute. This federally-approved monitoring plan has shown no evidence of substitution or crowd out requiring mitigation. Thus, we do not anticipate that outcome given the history of the program.

Because many low-income families do not have access to employer-sponsored coverage, or cannot afford the family contribution to employer coverage, CHP+ serves as a critical component of our health care safety net for children at a key point in development when ASD treatment can be most impactful.

70. ***[Sen. Kirkmeyer]*** **Did the Department understand Sen. Zenzinger's pancakes and syrup analogy during the provider rate discussion? Why is the Department pursuing**

the syrup (expanding autism coverage to CHP+) before the pancakes (paying an adequate rate for autism services to retain providers)?

RESPONSE

Yes, HCPF understands the analogy and believes it is important to pursue both a rate increase in Health First Colorado and the addition of Autism Spectrum Disorder (ASD) services in CHP+. The addition of ASD services is not intended to be in lieu of a provider rate increase. Rather, it is designed to address a critical gap in access to benefits that exists in the CHP+ program and in the continuum of coverage options in the state. Under SB 09-244, ASD services became a mandated benefit in state-regulated insurance products. This same legislation prohibited coverage under the CHP+ program because of recession-era budget pressures. Thus, there is a gap in the continuum of coverage options. This change will ensure continuity of care for children who churn between Medicaid and CHP+ or between private coverage and CHP+. HCPF projects that this change will increase coverage to approximately 650 children and that at least half of them were previously receiving services on Medicaid. Furthermore, HCPF's R-6 request accounts for an increase in fee for service Medicaid rates for Pediatric Behavioral Therapies, which is a more expansive benefit than ABA therapy alone and applies to a wider range of diagnoses than ASD, as well as adding these important services to CHP+.

To clarify, the impact to children because of the difference in ASD coverage between CHP+ and Medicaid is far greater now because of the end of the PHE and the associated end of the continuous coverage requirement. As CHP+ enrollment returns to pre-pandemic levels (more than doubling from its recent lows), children with ASD will be moved to CHP+ coverage from Medicaid due to changes in their eligibility, and may have to accordingly discontinue their existing care, impeding critical, time-sensitive developmental (most effective from ages 0-8). It is that gap in care and development that HCPF is asking the JBC to help avoid, by adding ASD coverage to CHP+.

About half of the 650 children referenced above are already receiving ASD care from providers, meaning the industry needs to add capacity for about 325 additional children – those with ASD not yet receiving care (already on CHP+ and likely not receiving care). This increase due to the requested addition of ASD coverage under CHP+ in FY 2024-25 compares to an average of about 650 (647) over each of the last four years (FY 2019-20 through FY 2022-23) and an average 15% growth each year in Medicaid children receiving ASD care during the same four-year period. Given that individuals approach and enter care gradually (not all 325 children will seek new ASD care on July 1, 2024) we believe the industry can absorb this gradual 325 increase in covered children. Our priority is providing access to ASD care that is absolutely critical to the long-term development and capabilities for these children. And this latter point is our focus – ensuring a bright future for these children, while supporting their families, and finding a reasonable balance to increasing provider reimbursements concurrently. HCPF believes that such a balance is possible and offer our continued assistance to the JBC in finding that balance.

AUTISM PROVIDERS

71. ***[Rep. Bird]*** **Please discuss the impact of upfront investments in autism treatment services on out-year expenditures.**

RESPONSE

As noted in the National Institute of Health NIH) Library of Medicine, Autism is one of a group of neurodevelopmental disorders characterized by three core deficits: impaired communication, impaired reciprocal social interaction and restricted, repetitive and stereotyped patterns of behaviors or interests. Autism Spectrum Disorder (ASD) has a prevalence of one per every 36 children. Autism can be diagnosed by 18 to 24 months of age and given that evidence-based interventions are most effective when started before age four, it is important that early-intervention programs be available. A 2017 article in the Journal of the American Academy of Child and Adolescent Psychiatry[14] titled "Cost Offset Associated with Early Start Denver Model for Children With Autism" determined the effectiveness of the Early Start Denver Model, an early and intensive behavioral intervention (EIBI) treatment for children with ASD. The study noted that "in the postintervention period, compared with children who had earlier received treatment as usual in community settings, children in the ESDM group used less ABA/EIBI, occupational/physical therapy, and speech therapy services, resulting in significant cost savings in the amount of about $19,000 per year per child."

While this was a small study, the results showed that those who received the early intervention had those costs "fully offset within a few years after the intervention because of the reduction in other service use and associated costs."

Below, we have provided more detailed insights, from Penn Medicine, August 2017, indicating: "A recent study by Penn Medicine researchers published online ahead of print in the Journal of the American Academy of Child & Adolescent Psychiatry found that the costs associated with the Early Start Denver Model (ESDM), one evidence-based treatment for young children with autism, were fully offset after only two years following intervention due to reductions in children's use of other services.

ESDM is designed for children with autism ages 12 to 48 months. The program includes a developmental curriculum and a set of teaching procedures that are delivered by therapy teams and parents either in a clinic or the child's home. A randomized trial of 48 children between 18 and 30 months of age who were diagnosed with ASD found that children who received ESDM had better cognitive and behavioral outcomes than children who received community treatment. The present study of associated costs used data that was collected during that trial and for two years after the trial was completed.

During the intervention, children who received the ESDM had average annual health-related costs that were higher by about $14,000 than those of children who received community-based treatment, although this difference was not statistically significant. The higher cost of ESDM was partially offset during the intervention period because children in the ESDM group used fewer community services like early intervention and speech therapy. In the post-intervention period, compared with children who had not received ESDM, children in the ESDM group used fewer early intervention services, less occupational or physical therapy, and less speech therapy, resulting in cost savings of about $19,000 per year per child. While the exact reasons for this reduction in service use aren't known, it is likely that children who were in

[14] https://www.jaacap.org/article/S0890-8567%2817%2930313-1/fulltext Published July 4, 2017

the ESDM group used fewer services because they had made developmental gains to the point that their parents thought that they no longer needed those services.

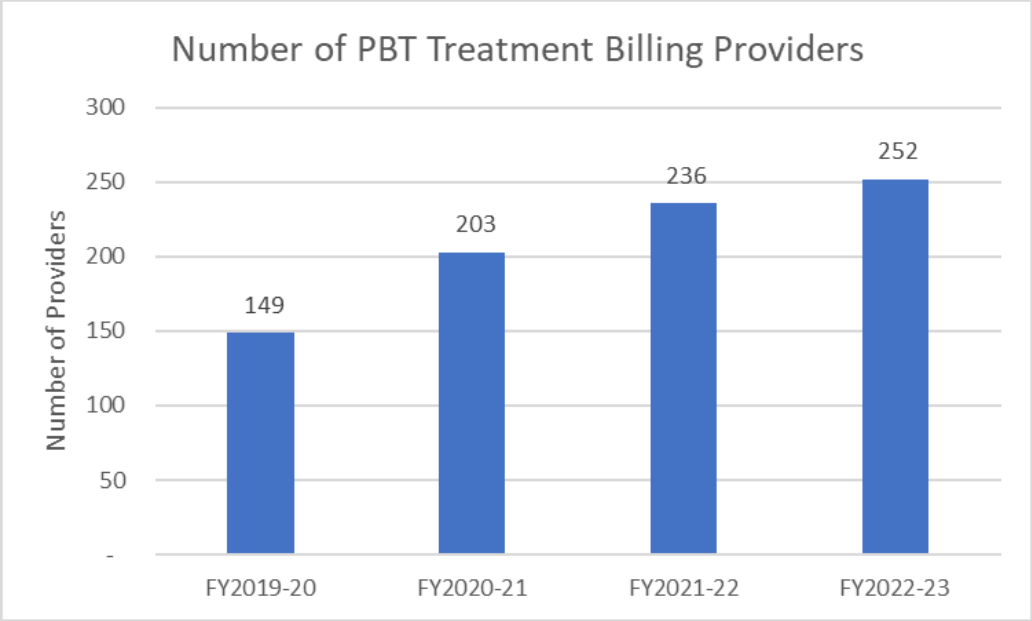
Zuleyha Cidav, PhD, the lead author of the study, and a research assistant professor at the Center for Mental Health Policy and Services Research says that the findings demonstrate the economic value of identifying young children with autism and providing early high-quality, intensive and comprehensive developmental behavioral treatment. “Prior studies have found that community-based early intervention costs between $40,000 and $80,000 per year,” Cidav said. “We found that the high-quality, evidence-based early intervention delivered in this study costs about $45,580. This suggests that the issue is not how much we spend on early intervention, but rather how we use that money most effectively to scale up such interventions so that they are effective in community settings.”

According to the study’s senior author, David Mandell, ScD, a professor of Psychiatry and director of the Center for Mental Health Policy and Services Research, prior studies that relied on simulated data to estimate the return on investment of early intervention generally found that it would take decades to see a financial return on investment. “We wanted to show what the short term payoff would be if payers invested in early intensive treatment for children with autism,” Mandell said. “Much to our surprise, we found that the entire additional cost associated with high-quality intervention as opposed to traditional community services, which often are not as intensive or as of high quality, was completely offset within two years.”

72. ***[Rep. Taggart]*** **The Department says that we are gaining autism providers, but the stakeholders say we are losing providers. Please explain. Do the Department's statistics account for inactive providers? A simple count of providers does not necessarily translate to a measure of capacity, because different providers see different numbers of patients. Can the Department shed any light on how capacity has changed?**

RESPONSE

As a point of clarification, ‘autism providers’ are a subset of all providers who may deliver services under the Pediatric Behavioral Therapy (PBT) benefit. PBT is a benefit that can be provided to children with autism, as well as other diagnoses. The majority of children who receive PBT have autism as a primary diagnosis. For HCPF, an ‘autism provider’ can include Applied Behavior Analysis (ABA) providers such as a Board-Certified Behavior Analyst (BCBA). However, the allowed providers for Pediatric Behavioral Therapies (PBT) can include other modalities such as those who provide Relationship Development Intervention (RDI). With that in mind, HCPF has pulled data on the number of providers who are billing for services rendered. Inactive PBT providers are excluded from the following data. Our data shows a continued increase in the number of Medicaid PBT providers billing for services year over year:



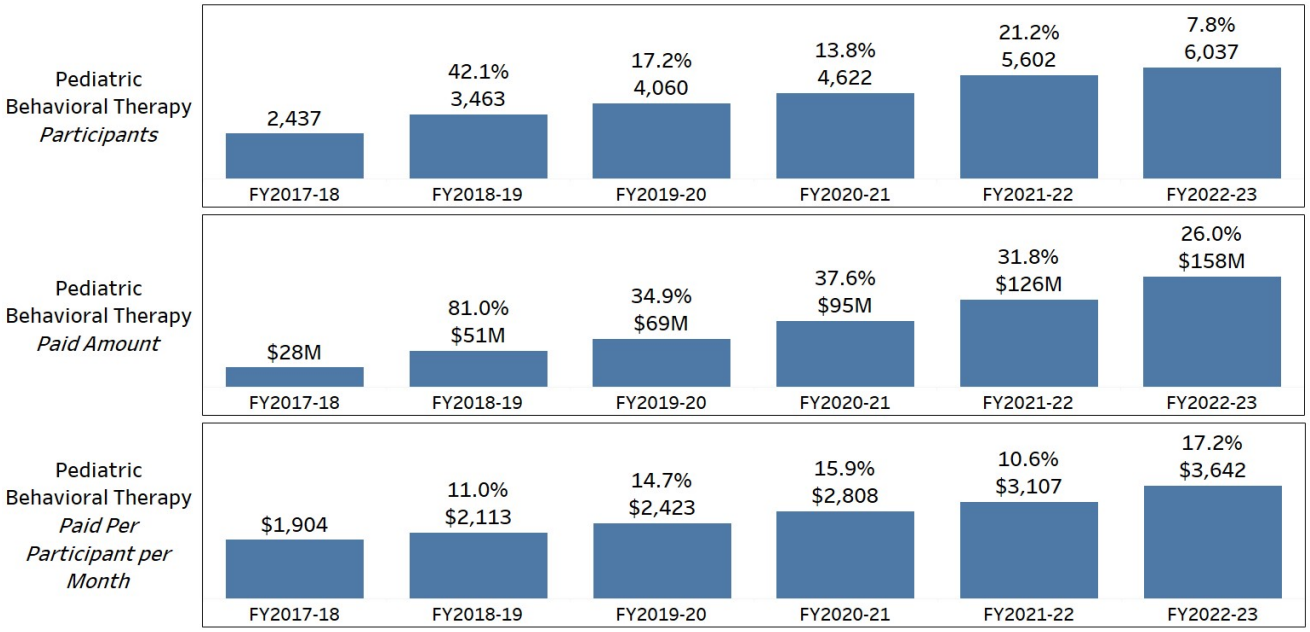
This increase in the number of providers follows the data reported by the National Library of Medicine in a 2022 study which shows that between July 1, 2018, and July 1, 2021, the number of Board Certified Behavior Analysts (BCBAs) in the U.S. increased by 65%, from 27,320 to 45,103. While the year over year numbers show an overall increase, there have been well-publicized provider departures from the market. HCPF is closely monitoring these closures to identify trend and subsequent mitigation strategies. As of now, these changes reflect similar fluctuations from prior years. Some of the recent departures, including one national company that filed for bankruptcy, have been practices that are owned by large, private equity firms. This unusual Private Equity impact on the ASD treatment industry and their impact on provider "owner" departure is a trend in autism treatment that HCPF is researching and tracking to understand the impact on the overall capacity to serve our members and Coloradans diagnosed with ASD as a whole. The research can also further our goal of creating and implementing strategies to expand access, mitigate the impact of Private Equity departures to care access and the ability of ASD providers to establish provider ownership when Private Equity divests, which we believe is a natural and therefore eventual course for PE.

Capacity
Unfortunately, provider capacity (the total number of children they are able to serve) and any corresponding wait lists are not reported to or captured by HCPF. It is difficult to capture caseload capacity information because caseload size is not a straightforward metric and may be provider specific. There are several factors for consideration: Not all BCBAs work with members who have autism spectrum disorder; not all BCBAs utilize comprehensive or focused treatment models; different patients require different dosages of treatment hours and caseload management time. For example, in some cases, a child could require 1:1 or 2:1 treatment, whereas other children may be able to receive therapy in small group settings.

However, we also hear from Health First Colorado members and providers about waitlists and are working to survey providers to understand the waitlists better. Nevertheless, the number of Health First Colorado members who are receiving PBT services and the amount paid for the

benefit continues to increase year over year. While FY 2022-2023 shows a slower increase (7.8%) in the number of members receiving PBT services compared to the prior fiscal year, the amount paid in FY 2022-23 increased by 26% compared to FY 2021-2022. HCPF is actively working with the community of PBT providers, parents and advocates to consider changes to the benefit that will help improve capacity. Some of these changes include recognizing a broader number of provider types, opening new codes, and creating a value-based payment methodology.

In FY 2022-23 the number of Medicaid members who received services increased from 5,602 children and youth to 6,037, a 7.8% increase. However, expenditures increased by 26% for those same children and youth, $126M per year to $158M per year. In summary, the below graphic indicates that the number of Medicaid children receiving PBT care increased over the six-year period by 248% while the total paid dollars to PBT providers increased fivefold and the amount per child per month increased by 91%.



73. ***Relatedly, how does HCPF measure providers reducing the percentage of their total caseload (or total number of clients served) on Medicaid? We are hearing from many providers that they used to serve entirely Medicaid clients and are now barely getting by with 35% of their caseload as Medicaid and the rest as private pay and commercial insurance.***

RESPONSE

Unfortunately, provider capacity (the total number of children they are able to serve) and any corresponding wait lists are not reported to or captured by HCPF. It is difficult to capture caseload capacity information because caseload size is not a straightforward metric and treatment is based on the individual's needs. There are several factors for consideration: Not all Board Certified Behavioral Analysts (BCBAs) work with members who have autism spectrum disorder; not all BCBAs utilize comprehensive or focused treatment models; different patients

require different dosages of treatment hours and caseload management time. For example, in some cases, a child could require 1:1 or 2:1 treatment, whereas other children may be able to receive therapy in small group settings.

Private companies are able to choose the mix of payers that works best for them. With the 2009/2010 Colorado law that required all health plans to cover treatment for autism, payer mixes have been determined by PBT companies. There is no one size fits all payer mix for providers and it also depends on the size of the provider practices.

74. **Multiple ABA providers have recently exited CO citing inadequate Medicaid reimbursement rates. What is HCPF doing to ensure that no further provider companies will be exiting CO due to the unsustainable rates? How will they monitor for improvement in provider loss?**

RESPONSE

As noted in the response on provider capacity for pediatric behavioral therapies, the year over year PBT provider totals show an overall increase. However, there have been well-publicized provider departures from the market, which have included both large and small providers. HCPF is closely monitoring these closures to identify trend and subsequent mitigation strategies. As of now, these changes reflect similar fluctuations in total provider numbers from prior years.

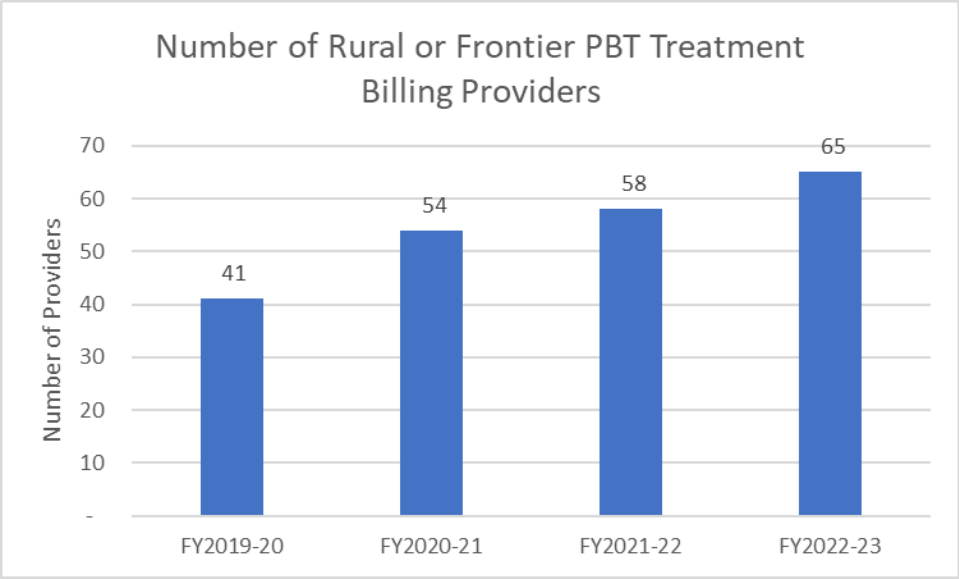
Some of the recent departures, including one national company that filed for bankruptcy, have been practices that are owned by large, private equity firms. Private equity impact on the ASD treatment industry is a trend that HCPF is tracking to understand the impact on the state's overall capacity to serve children with ASD. The research on the market trend will complement our ongoing comprehensive review of the PBT benefit. This review incorporates stakeholder involvement and feedback, evaluates additional procedure codes, and assesses inclusion and exclusion criteria. The comprehensive review extends our ongoing efforts to ensure that members have access to the necessary care with an adequate number of providers to meet those needs.

75. ***[Rep. Bird]*** **Please discuss changes in the availability of autism services by region. Are there regions where autism services are particularly scarce and do they share characteristics (e.g. rural)?**

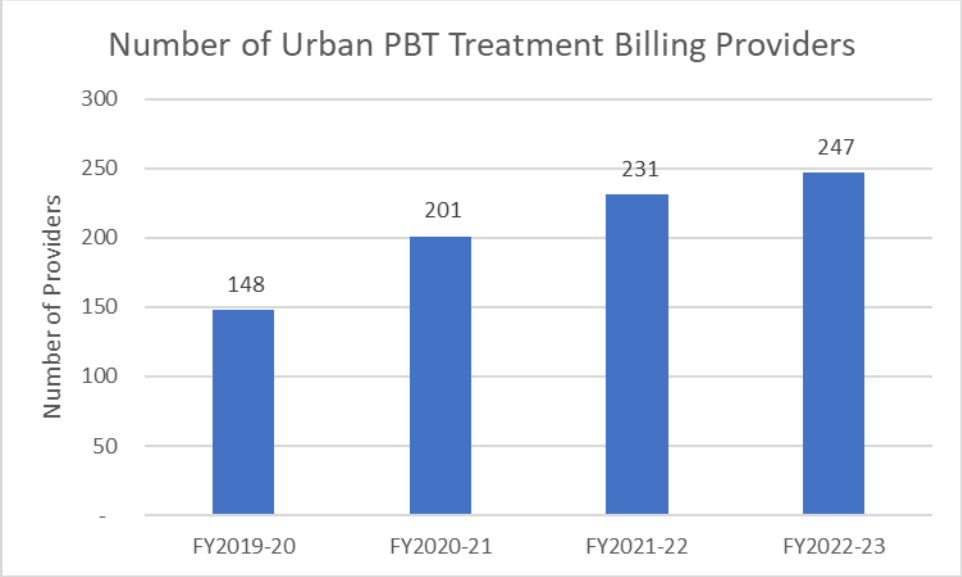
RESPONSE

There has been an increase in Health First Colorado-enrolled PBT providers in the rural and frontier regions as well as the metro areas.

Rural/Frontier counties show a 58% increase in the number of overall Health First Colorado-enrolled PBT providers between FY 2019-20 and FY 2022-23.

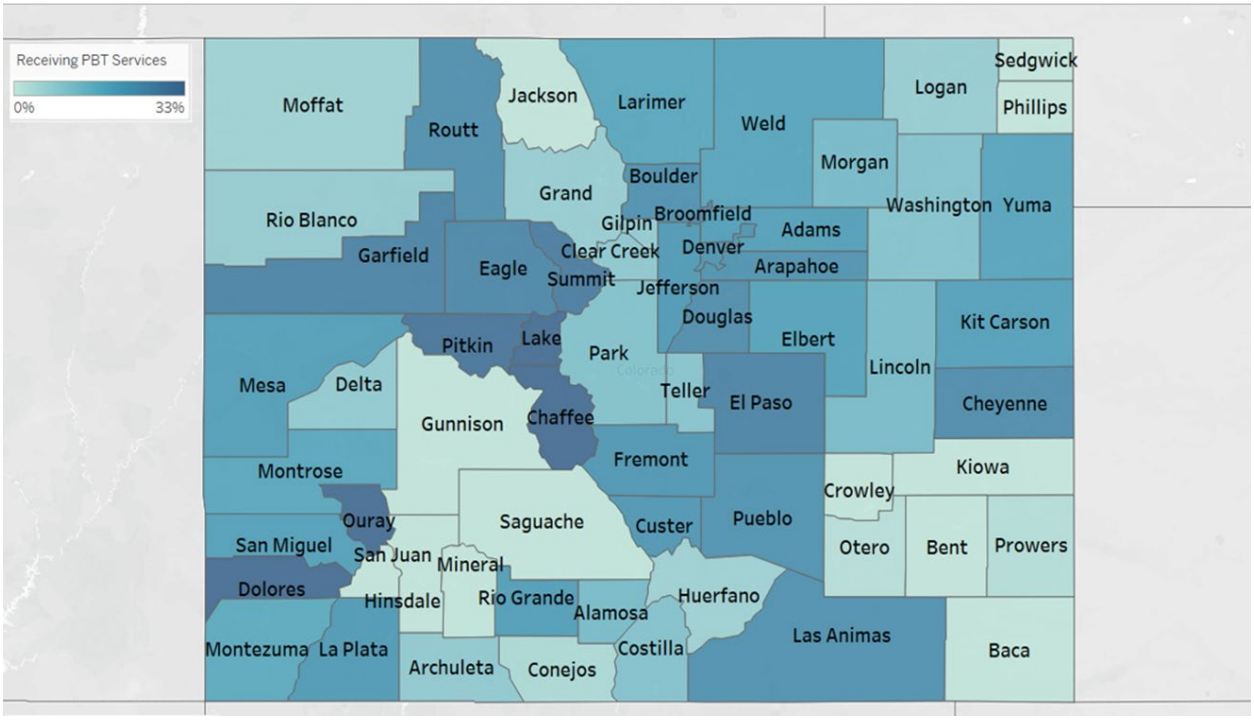


Urban areas show a 66% increase in the number of Health First Colorado-enrolled PBT providers over the same time period.



The Trends in Geographic Access to Board Certified Behavior Analysts Among Children with Autism Spectrum Disorder (2018-2021 study) appears to show several rural and frontier counties without an ABA provider. However, the study does not take into account the use of telehealth services as well as those companies who state they are able to provide services statewide. A HCPF-generated map based on claims data shows where Health First Colorado members are currently accessing Pediatric Behavioral Therapy services:

For Medicaid Members Under 21 with an Autism Diagnosis, Percentages of Members Receiving Pediatric Behavioral Therapies (PBT) Services. The State Average is 22%.



The map above reflects that 22% of Health First Colorado-eligible members under the age of 21 with an autism diagnosis are receiving PBT services. It is important to note that not all children and youth with a diagnosis of Autism Spectrum Disorder need PBT services. Though participants' IQ levels and linguistic functioning vary widely across studies, research suggests that early ABA treatment (before age 7) could be effective for 27% to 48% of children with ASD[1]. Other common services utilized by youth with ASD and their families are: Case management, Occupational therapy, Speech and Language therapy, Physical therapy, Play therapy and Cognitive Behavior Therapy. Because there can be overlap in symptoms between ASD and other disorders, it is important that any treatment focus on a child's specific needs, rather than the diagnostic label.

76. Why does HCPF require treatment goals for caregiver involvement and treatment implementation but does not have a mechanism for providers to be reimbursed for these services?

RESPONSE

HCPF does not require treatment goals for caregiver involvement. However, treatment goals for caregiver involvement and treatment implementation are recognized as best practices within the ABA treatment model and therefore can be found on ABA provider treatment templates. Recognizing this, HCPF has previously sought CMS approval to reimburse for caregiver involvement codes.

Historically, CMS (Centers for Medicare and Medicaid Services) has not approved reimbursement for the caregiver education services. In recent months, CMS has demonstrated a willingness to

reimburse for these caregiver codes in other states. As part of the comprehensive PBT benefit review, HCPF has requested that CMS reconsider their past denial. Absent CMS approval, reimbursement of these codes would need to be funded using state-only dollars. The Department projects that it would cost $56.6 million to cover the costs of opening these codes.

OFFICE OF COMMUNITY LIVING

COMMUNITY-BASED PROGRAM GROWTH

77. ***[Sen. Bridges]*** **What is the reason for the spike in the cost per full program equivalent (FPE) for Children's residential in FY 2017-18, FY 2018-19, and FY 2019-20?**

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 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 HCPF to make significant changes to CHRP to better support children, youth, and their families. Under the authority of this legislation, HCPF 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.

In FY 2018-2019, the enrollment on the CHRP waiver was limited to children in the custody of Child Welfare, and the enrollees were only utilizing high-cost residential services. Many of the enrollees had significant needs necessitating a higher reimbursement level. Beginning in 2019 with the eligibility changes, enrollments in CHRP increased. Many of the new enrollments did not utilize residential services, rather using other lower cost services available on the CHRP waiver, which decreased the average cost per FPE.

HCPF 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, providing services to more children and youth across the state.

Since 2019, HCPF 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:

- Increasing rates for residential services, including negotiated rates for those with extremely high needs;
- Allowing family members who are not the legally responsible party for the child or youth to provide residential and respite services;
- Increasing Respite unit limits;
- Adding Specialized and Therapeutic Respite; and
- Allowing parents to provide Community Connector services.

78. ***[Rep. Bird]*** **Why does the Department expect the Adult Comprehensive (DD) waiver to continue trending upward? Please explain the drivers there. Why is there a significant rise in expenditures/costs for the waiver itself?**

RESPONSE

Over the past several years, the costs for the Home and Community-Based Services (HCBS-DD) waiver increased primarily due to enrollment growth. The FY 2021-22 Long Bill included funding to enroll 667 members from the waitlist. In addition, HCPF's request each year includes authority for reserved capacity enrollments, which include individuals needing emergency placements, individuals transitioning out of foster care or from a youth waiver, and individuals transitioning from an institutional setting. Costs have also increased due to provider rate increases, including base wage increases for direct care providers, across the board rate increases, and other targeted rate increases.

HCPF is projecting increases in the DD waiver due to reserved capacity enrollments, which are projected to result in 411 new enrollments per year. HCPF also anticipates an increase in total cost for the waiver due to rate increases that were approved in the FY 2023-24 Long Bill for base wage adjustments, group residential support services, and non-medical transportation. HCPF anticipates that per capita costs will remain relatively steady outside of these approved adjustments.

LTSS COST GROWTH

79. ***[Sen. Zenzinger]*** **What are the most significant drivers of increasing General Fund costs for the elderly and people with disabilities? The needs appear so much larger than the available funding that it feels overwhelming. When and how is the state ever going to catch up? What is the Department's plan to get these costs on a sustainable path?**

RESPONSE

There are three primary drivers of increasing costs for older adults and people with disabilities - population growth, rate increases, and service utilization. For these populations,

service expenditures receive approximately a 50% federal match rate so increasing costs overall also drive General Fund increases.

According to the Colorado State Demography Office, Colorado is second only to Alaska in the U.S. for the fastest growing 65+ population. Over the past decade, the 65+ group has grown by more than 317,000 in Colorado to more than 800,000 people. Between 2010 and 2020, the 65-74 age range was the quickest growing demographic in the state. In the next decade, it will be the 75-84 age range. From 2020 to 2050, adults aged 65 and older will nearly double in population, from roughly 876,000 to more than 1.6 million. Overall, though, Colorado still has the sixth lowest number of 65+ people compared to other states. A big part of the reason for the increase is because Colorado saw baby boomers move to the state in the 1960s and 1970s who have chosen to stay.

The growing older adult population and people with disabilities account for a faster growing portion of Colorado's Medicaid enrollment, increasing the utilization and cost of long-term care and supports. It is estimated that 70% of people over age 65 will need long-term care at some point, and 20% will need it for longer than 5 years.

Medicare does not cover long-term care beyond an acute episode, leaving much of long-term care to be paid out-of-pocket until savings are spent and a person is eligible for Medicaid. From FY 2019-20 to FY 2022-23 enrollment growth for Medicaid long-term services and supports (LTSS) increased 5.9% to 64,425 full time equivalent individuals.

During this same period, HCPF saw an 18.9% increase in total cost of care per LTSS member per month, from $4,760 to $5,659. Much of this growth stems from provider rate increases. From FY 2019-20 to FY 2022-23, the state has invested an estimated $488M in rate increases related to LTSS, including adjustments such as the establishment of a long-term services and supports base wage, rate increases for the Program for All Inclusive Care for the Elderly (PACE), rate increases for Nursing Facilities, local minimum wage adjustments, across-the-board provider rate increases, and targeted rate increases.

In addition to rate increases, utilization of services is also a driving factor in cost growth for this population. While growth is expected as members' needs change, HCPF has seen a significant increase in utilization of In Home Support Services (IHSS). From FY 2019-20 to FY 2022-23, annual expenditures for IHSS have risen 115%. While some of the increase includes rate increases, the primary driver was members previously utilizing different modalities of care shifting into IHSS to better meet their needs, thus increasing overall service utilization. Members who have experienced staffing shortages or missed visits in other skilled service delivery options, like Private Duty Nursing, have successfully transitioned to IHSS. Because attendants are not required to be licensed nurses or certified nurse aides, there is a larger potential pool of attendants who can assist the member. Many members rely on their friends or family members to provide the services needed to stay independent in their homes and communities. Home care agencies across the state have reported challenges in hiring and retaining staff; IHSS agencies have been less impacted thanks to the built-in workforce for IHSS members and the inherent flexibility of the services. This is a driving factor for the increase in IHSS costs and a clear solution for better serving members.

Though these increases put pressure on the overall budget, they are investments that help Medicaid members receive necessary services in the community and avoid costly institutional

placement. In fact, it is also a federal requirement that all home and community-based services waivers must demonstrate cost neutrality - meaning that the cost of home and community-based services, on average, is lower than facility placement.

Overall, HCPF is also continuously working to ensure that members access care in the most cost-effective manner to meet their needs. Utilization management helps us accomplish this, as do strategies and solutions intended to enable individuals to receive care in their community versus in more costly nursing home or congregant settings. The ACC Phase III model also incorporates a more thoughtful alignment with Medicare Advantage plans and Case Management Agencies (CMAs) to achieve shared cost management and health improvement goals, while improving the service experience for members.

In addition to existing measures like electronic visit verification and utilization management review of services, another way HCPF has done this is by working with the General Assembly to seek federal financing opportunities like Community First Choice (CFC). CFC generates state savings by utilizing an enhanced 56% Federal Financial Participation (FFP) rate on existing and new consumer directed services in the State Plan. This is anticipated to save the state $38M annually after its second year of implementation. HCPF also looks for federal grant opportunities to bolster home and community-based services without additional cost to the state. One such grant is the Money Follows the Person (MFP) grant, which also provides an enhanced FFP rate that results in 25% savings for the services offered by participating states that can be reinvested in additional community-based supports.

Finally, as HCPF identifies significant cost drivers within its programs, it works to dampen the impact through policy adjustments and requests, as appropriate. For example, the third-party assessor for Private Duty Nursing (PDN), Long-Term Home Health (LTHH), and Health Maintenance Activities (HMA) requested in HCPF's FY 2024-25 R-10, is aimed at mitigating the risk of duplicative authorization across all three skilled care modalities, while also streamlining and improving the process for members and controlling cost growth.

80. ***[Sen. Kirkmeyer]*** **What are other states doing to contain the costs of services for the elderly and people with disabilities? Are there promising strategies Colorado can/should implement from other states?**

RESPONSE

To contain costs of services for older adults and people with disabilities many states, including Colorado, have looked to federal financing options to ensure robust services are in place to support individuals in the community, while also minimizing the General Fund impact on the state budget.

Through SB 23-289, Colorado was approved to join nine other states in implementing Community First Choice (CFC). This federal financing option gives states the opportunity to increase access to community-based services while also generating state savings by utilizing an enhanced 56% Federal Financial Participation (FFP) rate. This program will generate significant annual ($38 million) General Fund savings from existing services that will move from Home and Community Based Services (HCBS) waivers to the State Plan.

Another financing strategy other states, and Colorado, are utilizing to contain costs is the Money Follows the Person (MFP) grant. MFP is a federal Medicaid demonstration grant that helps institutionalized members access home and community-based services. Savings are generated for the state through the lower cost of care in the community. The program also provides an enhanced FFP rate that results in 25% savings for the services offered by participating states that can be reinvested in additional community-based supports. Colorado is among the majority of states that have participated in Money Follows the Person since 2013 and received an additional demonstration award this fiscal year.

In addition to federal financing strategies, states, including Colorado, aim to provide comprehensive care for individuals in the community, which costs significantly less, on average, than providing care in institutional settings. As of FY 2022-23, Colorado serves approximately 83% of Medicaid members receiving Long-Term Services and Supports in the community, a number that continues to grow year over year. Through services approved in HCPF's FY 2023-24 BA-07 and Money Follows the Person grant, HCPF anticipates additional transitions to the community will be possible, leading to better and more cost effective services for older adults and people with disabilities. Continued investments by the Joint Budget Committee to address workforce shortages and build community-based services to meet individuals' needs will ensure members have access to what they need to remain in the community at a lower cost of care. Investing in home and community-based services as an alternative to institutional care is a strategy used by most states adapted to fit their specific program design and population needs.

Finally, HCPF is leveraging $550M from Section 9817 of the American Rescue Plan Act to not only investigate innovative payment and service delivery models aimed to control costs but invest in projects to bolster the overall home and community-based services landscape, address workforce shortages, drive innovations, and further care in the community. In particular, HCPF is examining a potential tiered rate structure for residential providers that would pay more for individuals with more significant support needs. Additionally, HCPF is examining geographical rate modifiers that would acknowledge both rural and frontier areas of our state and pay additional monies to ensure critical services can get to those areas. Finally, HCPF has already implemented an entirely new service that empowers members to receive care in their home via remote supports as well as a series of changes that allow for both adjustments in when, where, and who can render many critical services to allow them to remain in the community.

THIRD PARTY ASSESSOR

New Skilled Care Acuity Tool Development and Engagement

81. ***[Sen. Zenzinger, Rep. Bird]*** **Did patients, providers, and advocates request a new nursing assessment tool? How does the nursing assessment tool respond to the stakeholder concerns that led to suspending Prior Authorization Requests (PARs) for Private Duty Nursing and Long-term Home Health? Providing a new assessment tool might be missing the point of why people were upset.**

RESPONSE

The R-10 budget request is not for a new assessment tool, but rather funds to use a third party assessor to implement the existing skilled care acuity tool, which will improve the current Utilization Management (UM) process by mitigating procedural inefficiencies and addressing PAR concerns raised by stakeholders.

Stakeholders have expressed frustration and concerns with the Utilization Review/Utilization Management (UR/UM) processes. Stakeholders have verbalized a desire to be more actively involved in the assessment tool completion and document submission process. Members often communicate that they are unaware of what services they qualify for, especially when there are multiple steps, vendors, tools and agencies in the prior authorization process. Providers have requested that HCPF streamline the processes to ease member confusion and administrative burden.

HCPF believes the implementation of the nurse assessor will streamline the current bifurcated processes, making it easier for members, case managers, and providers. It will allow members to work with a professional with a clinical background to identify the most appropriate benefits and facilitate improved UM/UR PAR processes.

Stakeholder desire for new tool

While the R-10 budget request is not for a new tool, there is one that is in development. The skilled care acuity tool (new assessment to determine medical necessity) is currently being developed using section 9817 funding from the American Rescue Plan Act (ARPA). Development of a skilled care acuity tool has been a desire of HCPF and stakeholders for several years. Agencies have been contributing feedback to the tool developers and have verbalized a desire for consistent and validated tools.

The goal of the new skilled care acuity tool is to provide consistent application of benefits through the use of a validated tool

PAR concerns

After a two year pause on the Prior Authorization Request (PAR) process, in part due to the Public Health Emergency (PHE), HCPF reinstituted the requirement for PARs and medical necessity review for Private Duty Nursing (PDN) services in November 2021. After the PDN PAR process had been in place for several months, HCPF began to hear from families and advocates with concerns about denial notices and denial rates. This led to HCPF administratively approving PARs while stakeholder concerns were addressed. Additionally, stakeholders requested more transparency and engagement from HCPF on these issues.

To address stakeholder concerns, HCPF has revised the denial notices to improve readability, conducted stakeholder engagement, held meetings with key advocacy organizations, met individually with impacted members/families, held meetings with every provider agency, added clinical reviews to ensure consistent Utilization Review/Utilization Management processes, and recently completed nurse liaison hiring. To further facilitate consistency, HCPF conducted extensive training and technical assistance with all PDN agencies.

R10 furthers our work to mitigate the PAR concerns

By utilizing a third-party assessor to complete the skilled care acuity tool directly with the member, HCPF believes needs can be consistently and reliably determined and UR/UM can be expedited due to the standardized application of the tool. This initiative aims to simplify, what can be a complicated and bifurcated process, and provide a more person-centered approach to the authorization of all skilled services.

82. ***[Sen. Kirkmeyer]*** **Who is developing the validated acuity tool for nursing services? What is it based on and what is the validation process? What is the evidence that the nursing assessment will place people with the right services?**

RESPONSE

The University of Massachusetts (UMass), acting by and through the UMass T.H. Chan Medical School, is developing the skilled care acuity tool (medical necessity) funded through section 9817 of the American Rescue Plan Act- Project 6.01. The Private Duty Nursing (PDN) portion of the tool will draw on the Continuous Skilled Nursing (CSN) tool from the Commonwealth of Massachusetts and Colorado statutes and board of nursing requirements. The Long-Term Home Health (LTHH) component of the tool is based on the Pediatric Assessment Tool (PAT) currently being used in Colorado.

Both reliability and validity are assessed throughout the tool development process, including through testing and review of inter-rater reliability. Inter-rater reliability is assessed by having multiple Registered Nurses independently complete the tool for the same individual. The validity of nursing hours assigned to each nursing task assessed by the tool will be evaluated through review by a clinical expert external to the project team. Concurrent validity will be assessed by comparing the nursing hours calculated by the new tool to the hours calculated by tools used in other states, where available.

UMass is working to incorporate both adult and pediatric needs into the tool so that the assessor can complete the assessment regardless of the person's age. It should be noted that the skilled care acuity tool is not intended to place members into a specific service, but instead objectively evaluate their individual needs and allow them to choose how they receive a service including offering alternative services to better fit the individual's need.

83. ***[Sen. Kirkmeyer]*** **Is the Department looking at nursing assessment protocols in other states? How are practices and lessons learned from other states informing the Department's assessment approach?**

RESPONSE

HCPF's contract with the University of Massachusetts (UMass) includes research around nursing assessments, acuity tools, and regulations across the U.S. Over 80 separate tools were evaluated from all 50 states. Of all of the tools researched, 13 states' tools utilized points-based systems and algorithms to determine the number of services/hours individuals need. Very few states used tools with reliability or validity information available or used algorithms to convert points to hours. From this research, UMass determined that the optimal approach

for Colorado is to utilize a tool with a points-based system and service algorithms that demonstrate assessment reliability and validity.

UMass is conducting interviews with each of the 13 states to gather additional information about their programs and nursing tools. Several key findings have emerged from these interviews thus far, specifically, that no model tool currently exists as there is no standardized or validated point to service hours system being used in the field. With this information, UMass is working to leverage best practices and other state experiences to create Colorado's new skilled care acuity tool.

84. ***[Sen. Kirkmeyer]*** **Describe the Department's stakeholder engagement process related to the nursing assessment. What input is the Department receiving from case managers and clients?**

RESPONSE

Stakeholder meetings were conducted in April and May 2023 to discuss the skilled care acuity tool and its implications for member service delivery. Several home health agencies that utilize the current Private Duty Nursing (PDN) and Long-Term Home Health (LTHH) tools provided feedback. Additional external stakeholder meetings will begin in March 2024, with a pilot test of the tool set to begin in early Summer 2024. Throughout the pilot process, members, providers, case managers, and advocates will test the tool and provide input that will shape the final product. The final prototype of the tool will be complete in September 2024, with implementation planned in early 2025.

85. ***[Sen. Kirkmeyer]*** **How does the assessment adjust for pediatric versus adult populations and the different needs associated with each?**

RESPONSE

The skilled care acuity tool is still being researched and developed. UMass is working to incorporate both adult and pediatric needs in the tool so that the assessor will be able to complete the assessment regardless of the person's age.

The current plan for this new, objective tool is that it will account for both adult and pediatric members utilizing Private Duty Nursing (PDN) and Health Maintenance Activities (HMA) and adults utilizing Long-Term Home Health (LTHH). As HCPF already has an accurate and reliable tool for Pediatric LTHH called the Pediatric Assessment Tool (PAT), the new tool will be built to utilize the PAT. The tool will incorporate age-appropriate standards to correlate with the needs of the pediatric member.

86. ***[Rep. BIrd]*** **How will the nursing assessment take into account when a parent is the one providing care?**

RESPONSE

The skilled care acuity tool will be used to evaluate and determine care, whether the parent is the caregiver or not. The member or family member is able to then decide which medically necessary service best fits their care needs. Members and their legally responsible persons participate in the assessment process by providing all relevant information to support medical necessity determinations. HCPF recognizes the value of family caregivers and has a long-standing policy of allowing those who are trained and have the necessary credentials to provide services irrespective of their relationship to the individual receiving care. For example, a parent who is a registered nurse may provide medically necessary Private Duty Nursing (PDN) services or Health Maintenance Activities (HMA) in Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS).

87. ***[Rep. Bird]*** **The assessment for nursing services sounds like it is about restricting access to services. How will this improve circumstances for patients and providers?**

RESPONSE

HCPF is required to follow federal guidelines when reviewing requests for medical services. This includes confirming that requested services are medically necessary. The proposals to implement a skilled care acuity tool and have a nurse complete the evaluation are intended to improve this process for members and other stakeholders and are not intended nor expected to restrict access to services.

As detailed below, by using a nurse assessor as proposed in R-10, and applying valid tools for multiple benefits, members may be afforded additional resources. Members are often not aware of alternative service delivery options that may best meet their needs, because skilled services have been historically reviewed and authorized in bifurcated systems and processes. The completion of the skilled care acuity tool will facilitate timely and accurate approvals by the UM vendor. The nurse assessor and the member can select the service modalities that best meet the member's skilled care needs. Additionally, self-directed service delivery will be available in the state plan beginning in July 2025 through Community First Choice, including Consumer Directed Attendant Support Services (CDASS) for children. This will provide members greater choice and flexibility in meeting their support needs than what can often be found within a traditional agency-based model.

Current state

Several assessments by multiple entities: The current system of skilled care authorizations requires a series of assessments, performed by different agencies and specific to the benefit provided by an agency. Each agency may have different policies and access to supporting documentation. Depending on how many service modalities (Health Maintenance Activities, Long-Term Home Health, Private Duty Nursing) a member utilizes, assessments may be needed up to three times for any one individual (once for each service modality).

Additionally, the assessments conducted by the provider agencies present a conflict of interest. The entities providing the services are also the entities assessing and requesting authorization of services. There may be unintentional bias towards the use of particular services.

Limited insight into other resources: In the current system, agencies may not be looking at a member's total needs, nor are they required to know other available services. For example, a Long-Term Home Health agency is not expected to know whether a member has access to waiver benefits and/or they are aware of self-directed services.

Future state

Nurse assessors using the skilled care acuity tool: By streamlining the assessment process, members will only require one assessment for skilled services, regardless of how many modalities they choose to utilize. The post-assessment review for In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) will no longer be necessary, and this will significantly reduce the amount of time required to authorize and initiate services.

More member options: The nurse assessor will evaluate individual needs and apply the validated tool for multiple service modalities, including self-directed benefit options. With the application of the skilled care acuity tool, the member then becomes fully aware of the criteria and options available across the benefits and is not limited by a specific provider agency's offerings. The nurse assessor can collaborate with HCPF nurse liaisons as well as the Regional Accountable Entity (RAE) to ensure benefit options are fully explored and considered.

88. ***[Rep. Bird]*** **What is the role of the Regional Accountable Entities (RAEs) in assessments for nursing services? Should the RAEs have a larger role?**

RESPONSE

Regional Accountable Entities (RAEs) are organizations that support networks of primary care providers and behavioral health providers. RAEs do not conduct case management activities for HCBS waiver or state plan long-term care services. For members who have more complex needs, RAEs are available to work with the member and their different providers to support improved coordination of services. The activities outlined in R-10 are outside the scope of the RAE contracts; this work should be completed by a Quality Improvement Organization (QIO) vendor with specialized clinical staff focused on assessment of individual needs and identification of the appropriate benefit to fit the skilled need identified in the assessment.

89. ***[Rep. Taggart]*** **How long will the proposed nursing assessments take? When people need these services, they need them now. Why is the Department proposing that this should be a statewide service, rather than a local service? Would it be better and quicker to have local assessments?**

RESPONSE

Currently, skilled care assessments are done across multiple agencies, some with different instructions and guidelines. Skilled service modalities include Health Maintenance Activities (HMA), Long-Term Home Health (LTHH), and Private Duty Nursing (PDN). Depending on how many skilled services a member is utilizing, assessments may be needed up to three times for any one individual (once for each service modality).

To decrease duplication of effort and streamline this process, HCPF is developing the skilled care acuity tool. The length of time that will be needed to complete the skilled care acuity tool (medical necessity) will be dependent on the complexity and acuity of the member's needs. If this request is approved, HCPF intends to secure a Quality Improvement Organization (QIO) vendor with sufficient capacity to have a nurse complete the skilled care acuity tool (medical necessity) quickly and holistically. The use of QIO will also provide HCPF with a 75% federal match on the cost of a nurse assessor. Utilizing a statewide centralized process will allow for consistent assessment of member's needs with the goal of improving appropriate authorization of skilled services through the Utilization Management (UM) vendor. Additionally, it will mitigate the risk of duplication of effort and conflict of interest.

By using a QIO nurse assessor with the skilled care acuity tool, members will be assessed on their skilled care needs, regardless of how many modalities they choose to utilize. The post-assessment review will no longer be necessary for Health Maintenance Activities in self-directed services. This holistic, person-centered approach will consistently include the documentation to support the medical necessity of the requests, ensure wrap-around services are consistently applied, and minimize turn-around time for the UM vendors when reviewing PDN and LTHH.

90. ***[Sen. Kirkmeyer]*** **How would the new assessment for Private Duty Nursing (PDN), Long-term Home Health (LTHH), and Health Maintenance Activities (HMA) change current procedures for Prior Authorization Requests (PARs) related to these services? Will the Department be using a different vendor?**

RESPONSE

Colorado intends to use the skilled care acuity tool to assess a member's skilled service needs. The Tool will be utilized by a Quality Improvement Organization (QIO) through a new contract, determined through a Request for Proposals (RPF) process. The use of a QIO will allow for HCPF to receive a 75% match related to the nurse assessor. Prior Authorization Request (PAR) procedures will not be impacted by this request, though HCPF anticipates that streamlining assessments and reviews will shorten the time between referrals and the start of services.

HCPF is requesting to have the skilled care acuity tool completed by a third-party nursing assessor who is part of a contracted Quality Improvement Organization (QIO) vendor via R10. Using a nurse assessor through a QIO eliminates the conflict of interest and burden of having providers determine service authorizations. By establishing a consistent assessment with the application of the validated tool to each member seeking services, the UM process can be improved and potentially expedited. In addition, the QIO clinical assessment provides increased awareness of special member circumstances through an "eyes on" clinical

perspective. Overall, the request to use a third-party nurse assessor will streamline skilled care authorizations, eliminate the practice of duplicative reviews, and provide a simpler pathway for members to access skilled services.

91. ***[Sen. Zenzinger]*** **Reinstatement of the Long-Term Home Health Prior Authorization Requests (PARs) has been delayed due to federal maintenance of effort requirements. Please elaborate on these requirements. Does the proposed assessment resolve the issues?**

RESPONSE

Maintenance of Effort (MOE) requirements outlined in the original State Medicaid Directors Letter sent on May 13, 2021, prohibited all States from imposing stricter eligibility standards, methodologies, or procedures for Home and Community-Based Services (HCBS) programs and services than were in place on April 1, 2021. When applied to pediatric Long-Term Home Health (LTHH) prior authorization requests (PARs), the use of the Pediatric Assessment Tool (PAT) and required medical necessity Utilization Management (UM) review process was impacted because members could experience a lengthier review when compared to the adult LTHH PAR process when compared to the adult LTHH PAR process. While adult LTHH PARs are not currently paused, the approval process does not have an assessment or medical necessity UM review requirement. The adult approval process relies on a cost-containment and service duplication review completed by the Case Management Agencies. By developing an assessment tool for adult LTHH, there will be the same assessment process for both adults and children and therefore no risk of an MOE violation. HCPF's proposal would make the assessment process for adults and pediatrics more streamlined and person-centered when determining services and ensure the same path for review of needs is followed for both age groups.

92. ***[Sen. Bridges]*** **Will implementation of the proposed assessment reduce expenditures and access to care? Will it just move expenditures from one place to another place that could be costlier, like a hospital setting?**

RESPONSE

This initiative is expected to mitigate the risk of duplicative authorization across all three skilled care modalities. Presently there is no consistent tool or practice to determine the necessity of skilled services; each skilled service option has its own process with varying levels of agency/provider input. HCPF has identified a risk of duplication specifically between the In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) Health Maintenance Activities (HMA) and Long-Term Home Health (LTHH) and Private Duty Nursing (PDN). Within the current system, HMA is reviewed by a different Utilization Management (UM) vendor than LTHH/PDN. This bifurcation results in HCPF having a limited ability to ensure that either UM vendor has a complete, holistic view of all supports a member may have in place or need.

Utilizing a nurse assessor to complete the skilled care acuity tool (medical necessity) will not only reduce the risk of duplication across all skilled care modalities, but it will also streamline the authorization process. These procedural changes will result in members receiving access

to necessary skilled care more efficiently and more quickly. The current system often requires multiple assessments, home visits, and post-assessment reviews that can slow down access to care. In addition, members have limited understanding or choice in how their services are provided. HCPF believes the nurse assessor will bring valuable education to the member through a person-centered assessment and the application and discussion of the validated tools. With the nurse assessor, members can expect discussion and comparison of the benefits to meet their individual needs. By eliminating the need for multiple assessments and reviews, HCPF anticipates that members will be able to access necessary services and avoid entry into more costly settings such as hospitals and skilled nursing facilities.

R-11

93. *[Rep. Bird]* In R11 the Department requests funding for a direct care workforce unit and preventative care analyst. How do these fit with efforts of the Department of Public Health and Environment (CDPHE)? Why do these belong in the Department instead of CDPHE?

RESPONSE

Direct Care Workforce Unit

While CDPHE does offer some workforce development programs (Rural Essential Access Provider, Colorado Health Service Corps), these do not directly relate to, or include, direct care work within Home and Community-Based Services (HCBS). The focus of CDPHE's programs tends to be clinical providers, such as doctors, specialists, nurses, and mental health providers. CDPHE's workforce development, while essential in its own right, does not focus on the critical direct care workers that serve aging and older adult and disabled members like the HCPF Direct Care Workforce Unit (DCWU). The DCWU has partnered with CDPHE in a number of capacities, particularly related to career advancement opportunities, such as with the Community Health Worker/Health Navigator roles. The DCWU is a better fit within HCPF as it seeks to build a robust HCBS workforce to support members with all of the services provided in the ten HCBS waivers.

HCPF has launched a resource and job hub to connect job seekers and HCBS and Long-Term Home Health providers to support recruitment efforts. Additionally, this site offers direct care workers a variety of resources and training opportunities that can build their knowledge base for both work and personal support. This site will soon house free and portable training modules that workers can use to expand the populations they can work with. Over the past two years, the DCWU has engaged direct care workers directly to determine their satisfaction with compensation, benefits, career advancement, training, and their overall satisfaction with their employment. From this engagement, we've identified a strong desire for access to benefits and have leveraged other state resources, like Connect For Health, to expand workers' awareness of available resources. Also, over the last two years, HCPF has been actively engaging providers to collect data on starting and ending wages, wages for each primary service offered through each of the waivers, and vacancy rates to both identify compliance with the minimum base wage and to better understand the state of the workforce at a macro and micro level. This allows HCPF to bring true accountability in ensuring a stable

and lasting workforce. Last, but not least, HCPF actively engages stakeholders on a routine basis to provide information, seek input, and collaborate on how to move forward with initiatives that have a positive impact on members.

Preventive Care Analyst

This position is intended to work specifically with the Health First Colorado and CHP+ populations. The analyst will work in partnership with CDPHE to improve vaccination rates and other preventive measures for Health First Colorado and CHP+ members by working with RAEs and providers to improve their outreach to members, and to ensure adoption of best practices and adherence to outcome measures. This position will be a liaison between the RAEs, providers, CDPHE, and subject matter experts and benefits managers in HCPF to improve uptake of vaccines and other preventive care services.

This position belongs at HCPF because it is specific to the Health First Colorado and CHP+ populations and needs an understanding of these programs, their payment structure, and delivery systems. A focus on vaccines and preventive care among Health First Colorado members is important to achieving higher quality, higher value care.

94. ***[Sen. Kirkmeyer]*** **Please describe the Department's stakeholder engagement process for the planning, implementation, and monitoring of the four initiatives where the Department is requesting on-going General Fund in R11. How is the Department improving communication and interaction with advocates, including involving them with testing?**

RESPONSE

Since receiving approval of our American Rescue Plan Act (ARPA) Home & Community Based Services (HCBS) spending plan, HCPF has employed a robust stakeholder engagement process. Through October 2023, we conducted over 200 meetings with stakeholders and engaged more than 9,350 individuals. The ARPA HCBS website has served as an important platform for transparency and information for external stakeholders, providing up-to-date engagement opportunities and initiative implementation activities. As the 63 initiatives have progressed, we have continuously analyzed the effectiveness and sustainability of the work post-ARPA. The following four areas were identified as essential for continued funding. Each program area will continue to be monitored through implementation, with stakeholders engaged throughout.

HCBS Systems Support

The additional FTE requested in R-11 for Home and Community Based Services (HCBS) System Support is to support the ongoing implementation, management, and maintenance of system(s) enhancements and functionality implemented as a result of ARPA and the Go Live of the Care and Case Management (CCM) system. As stated above, HCPF has conducted extensive stakeholder engagement outreach, and continues to do so regarding ARPA-related projects including system enhancements, changes and additions. The feedback and information collected as a result of those stakeholder engagement activities are incorporated directly into

the ongoing HCBS Systems Support, including development of modifications and enhancements to existing and proposed systems and enhancements to existing system functionality. HCPF staff will continue to use input from stakeholders throughout the system planning and implementation process, and into ongoing operations. A major driver for the need for additional FTE is to allow HCPF to efficiently and effectively review, research, and address end user and stakeholder feedback and user experiences and test proposed system solutions to identified issues prior to system deployment. Following implementation of any system modification or enhancement, HCPF closely monitors feedback on identified issues from end users through the CCM support center, help desk tickets, emails and other methods to ensure successful implementation and to identify potential issues in a timely and efficient manner and whenever necessary, develop an appropriate resolution to the identified issues. HCPF has leveraged external stakeholders to assist with system testing and continues to look for opportunities to expand their involvement. Additionally, when developing testing plans and testing scenarios following any system change, the feedback and concerns received through various methods, as well as input directly from those participating in stakeholder engagement activities are incorporated in coordination with our system vendors.

Person-Centered Budget Algorithm (PCBA)

HCPF conducted extensive stakeholder engagement throughout the development and piloting of the Colorado Single Assessment, which will feed into the Person-Centered Budget Algorithm (monthly meetings from 2017-2021). During this engagement with stakeholders, HCPF determined that more data from the implementation of the Colorado Single Assessment was necessary before proceeding with the development of e Person-Centered Budget Algorithm. Therefore, direct stakeholder work on the Person-Centered Budget Algorithm was paused.

In 2022-2023, the same group of stakeholders advised HCPF on lessons learned from the Supports Intensity Scale and Support Level Algorithm to inform work on the Person-Centered Budget Algorithm. This stakeholder group continues to meet monthly to provide input on the training associated with the Colorado Single Assessment implementation and has engaged with HCPF in “mock” Level of Care assessments to test the functionality in the Care and Case Management system and to provide feedback to HCPF. The stakeholder group has also provided input on the draft rules for implementation of the Colorado Single Assessment and will provide input on the Person-Centered Budget Algorithm rules in the future. HCPF brings communications and materials related to the Colorado Single Assessment and Person-Centered Budget Algorithm to this stakeholder group, ongoing, for input prior to disseminating to broader stakeholder audiences.

Direct Care Workforce Unit

As part of the initial planning for ARPA initiatives, stakeholders were very clear that the direct care workforce crisis was one of their top, if not the top, priority. As a result, HCPF created the Direct Care Workforce unit to focus efforts on nine initiatives intended to strengthen the workforce and enhance rural sustainability. Stakeholder recommendations closely directed the work of the Direct Care Workforce Unit (DCWU) and the development of each initiative. This stakeholder group included consumer advocacy organizations, personal care workers, worker organizations, home care agencies, disability advocacy organizations, senior advocacy organizations, children’s advocacy organizations, members/representatives

of members who receive personal care, homemaker (or in-home support services), and representatives of state departments. The DCWU has continued to engage stakeholders statewide in 16 formal meetings since its formation in March 2022. Most recently, engagement has been directly with employers and direct care workers to soft launch the Direct Care Careers site. Ongoing engagement with advocacy organizations, workers, employers, and other state departments continues to develop and evaluate the standardized core direct care worker curriculum that will be available on the Direct Care Careers site in Spring 2024.

HCPF has launched a resource and job hub to connect job seekers and HCBS and Long-Term Home Health providers to support recruitment efforts. Additionally, this site offers direct care workers a variety of resources and training opportunities that can build their knowledge base for both work and personal support. This site will soon house free and portable training modules that workers can use to expand the populations they can work with. Over the past two years, the DCWU has engaged direct care workers directly to determine their satisfaction with compensation, benefits, career advancement, training, and their overall satisfaction with their employment. From this engagement, we've identified a strong desire for access to benefits and have leveraged other state resources, like Connect For Health, to expand workers' awareness of available resources. Also, over the last two years, HCPF has been actively engaged providers to collect data on starting and ending wages, wages for each primary service offered through each of the waivers, and vacancy rates to both identify compliance with the minimum base wage but to also better understand the state of the workforce at a macro and micro level. This allows HCPF to bring true accountability in ensuring a stable and lasting workforce. Last, but not least, HCPF actively engages stakeholders on a routine basis to provide information, seek input, and collaborate on how to move forward

Preventive Care Analyst

The ARPA-funded Vaccine Outreach Analyst launched the Statewide COVID19 Collaborative to connect the RAEs with each other and local and state public health officials, and to identify best practices for increasing COVID immunization rates. This work has evolved to include routine immunizations and will continue to include additional partners and stakeholders in the implementation of improved practices. This position has also supported the formation of a collaborative group that focuses on increasing rates for all routine immunizations and includes stakeholders from Medicaid, CDPHE, community immunization leaders, pharmacies, and providers. Efforts will continue to evolve and elevate the collaboration between Medicaid and external stakeholders to ensure that future preventive care promotion efforts are collaborative and center the voices of members and communities.

The Preventive Care Outreach Analyst expands HCPF's ability to engage and respond to stakeholder needs and concerns around preventive care that are unique to our member population. With this FTE, HCPF will be able to continue vital partnerships with community organizations, underserved communities, advocates, providers, other state agencies, and our managed care entities. They will extend our ability to communicate and to offer stakeholder engagement via forums, listening sessions, and targeted collaboration.

DEVELOPMENTAL DISABILITIES WAITLIST

95. ***[Sen. Kirkmeyer] What is the process for getting people off of the Adult Comprehensive (DD) waitlist? What is the order in which people are chosen to be offered a DD waiver? How are people selected for removal from the list? What is the Department providing in terms of services for the people that are sitting on the waitlist?***

RESPONSE

Individuals waiting for Home and Community Based Services - Developmental Disabilities (HCBS-DD) waiver have a status of "Yes-Waiting" with one of the following timelines:

- As Soon As Available (ASAA) – The individual has requested enrollment as soon as available.
- Date Specific – The individual does not need services at this time but has requested enrollment at a specific future date. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday.
- Individuals on Waiting Lists Needing Services Immediately - individuals waiting for services with an ASAA timeline and individuals with Date Specific timelines who have requested enrollment within the current fiscal year.
- Safety Net – The individual does not currently need or want services, but requests to be on the waiting list in case a need arises. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday. There are many reasons an individual may choose to be on the Safety Net waiting list. For example, they are currently receiving services through another HCBS waiver, they are currently with their families and do not feel they need outside assistance, they do not meet age requirements of the HCBS-DD waiver, or they are currently residing out of the state but are likely to move back.

Enrollments for the Home and Community Based Services - Developmental Disabilities (HCBS-DD) waiver are determined to be available through:

1. Monthly churn (as individuals pass away, withdraw, or move out of the state);
2. Identification of Reserve Capacity for Emergencies, Youth Transitions, or Deinstitutionalization;
3. Determination that individuals have declined an authorization (declinations); and
4. One-time appropriations when approved by legislation.

An individual's position on the waiting list is determined by their Order of Selection date. This is the date on which the person was initially determined to be eligible for the HCBS-DD waiver waiting list, or the fourteenth birthday if a child is determined to have a developmental disability by the case management agency prior to the age of fourteen. An individual will always maintain their Order of Selection date no matter how many times they change status or leave/get back on the HCBS-DD waiting list.

People with the oldest Order of Selection dates are at the top of the list and are first in line to be offered an enrollment via churn, declinations, or one-time appropriations.

Reserve Capacity are prioritized enrollments that do not take into consideration an individual's Order of Selection date and are requested by case management agencies on an individual's behalf. After HCPF review of the information provided, these requests are approved or denied once it has been determined whether the individual meets criteria for a Reserve Capacity under the following circumstances:

1. Emergencies-including aging caregiver;
2. Youth transitions - Individuals enrolled in the HCBS-Children's Extensive Support (HCBS-CES) waiver or HCBS-Children's Habilitation Residential Program (HCBS-CHRP) waiver; and
3. Deinstitutionalization.

The HCBS-DD waiver waiting list is ever changing as individuals can come on/off and change their status whenever they would like, but maintain their Order of Selection Date. This can make it look as though an individual has been waiting much longer than they actually have if they switch from "Safety Net" status to "As Soon As Available," once they are ready to enroll into services. For instance, in a scenario where someone places their name on the "Safety Net" waiting list in 2010, moves to the "As Soon As Available" waiting list in 2021, and receives an authorization in 2023, the individual's total time on the waiting list would be 13 years, but only two years on the "As Soon As Available" list.

The HCBS-DD waiver is the only HCBS waiver in Colorado that has a waiting list. Individuals can receive services through other HCBS waivers and services while on the HCBS-DD waiting list. Of the 3,357 individuals on the HCBS-DD "As Soon As Available" waiting list, 97% are currently receiving other services (services in another HCBS waiver, Medicaid professional services, or state general fund programs) while they wait for authorization to enroll (63% are enrolled in the HCBS-SLS waiver). HCPF has seen about a 25% declination rate for HCBS-DD waiver. The primary reason for refusal was individuals reporting they are happy with their current services. As of July 1, 2023, the average number of years from a person's Order of Selection Date and enrollment is six years, a three-year decrease from June 30, 2018, when the average was nine years.

96. *[Sen. Zenzinger]* Please provide an update on the "plan for a plan" to eliminate the waitlist as spoken about in previous briefings over the past few fiscal years.

RESPONSE

House Bill (HB) 14-1051 required HCPF to develop a comprehensive plan "to ensure that Coloradans with intellectual and developmental disabilities and their families will be able to access the services and supports they need and want at the time that they need and want those services and supports." This strategic plan, first submitted on Nov. 1, 2014, outlined several initiatives aimed at achieving the goal to have all eligible individuals enrolled in services by the year 2020. The initiatives, made possible by HCPF working in tandem with stakeholders and the General Assembly, and within budgetary limitations, led to impactful changes. Between FY 2013-14 and FY 2022-23:

- Total enrollment in waivers that support individuals with intellectual and developmental disabilities saw a growth of 83%.
- HCBS-Supported Living Services waiting list was eliminated.
- Total waiting lists were reduced by 66%.

In addition to dramatically growing enrollment rates in waivers that serve individuals with intellectual and developmental disabilities and reducing or eliminating waiting lists, HCPF has improved our process for managing churn in the HCBS-Developmental Disabilities (HCBS-DD) waiver, resulting in an average of 635 enrollments per year over the last 6 years.

Importantly, HCPF has secured ongoing funds for Reserve Capacity enrollments to ensure that no member is in crisis because they need HCBS-DD waiver services and to ensure that members in the following circumstances do not have to be on the HCBS-DD waiting list before accessing services in their homes and communities:

- Emergencies - including aging caregivers;
- Youth transitions - Individuals enrolled in the HCBS-Children's Extensive Support (HCBS-CES) waiver or HCBS-Children's Habilitation Residential Program (HCBS-CHRP) waiver; and
- Deinstitutionalization.

Through these efforts and through one time authorization HCPF has authorized 3,478 individuals to enroll in the HCBS-DD waiver since July 2019.

This year's Intellectual and Developmental Disabilities Strategic Plan Annual Report was submitted to the Colorado General Assembly on Nov. 1, 2023. The Nov. 1 report, as well as previous submissions of the annual strategic plan, is on HCPF's Legislator Resource Center.

97. [Sen. Bridges, Sen. Zenzinger] Before COVID there was a real effort to try to eliminate the Adult Comprehensive (DD) waitlist. How much would it cost to eliminate the DD waitlist? If we cannot immediately eliminate the waitlist, what can we do to reduce it? What would it take to completely eliminate the waitlist? In addition, please speak to the scalability of any proposal to eliminate the waitlist and functionally eliminate the waitlist (with enough providers).

RESPONSE

HCPF estimated what it would cost to eliminate the Home and Community-Based Services - Developmental Disabilities (HCBS-DD) waiver waiting list over six years, including: the impact of shifting costs from other waivers to the HCBS-DD waiver; funding for one FTE staff to oversee case management, waiting list and reporting; and $727,200 annually for capacity building costs to assist case managers with their increasing caseloads. The total cost by fund source and fiscal year is shown below.

Year	General Fund	Total Funds (includes 50% federal match)
FY 24-25	$12,652,113	$25,304,224
FY 25-26	$35,242,220	$70,484,438
FY 26-27	$57,897,722	$115,795,443
FY 27-28	$80,554,509	$161,109,015
FY 28-29	$103,211,296	$206,422,588
FY 29-30	$126,120,089	$252,240,178
FY 30-31	$136,118,173	$272,236,342

HCPF made the following assumptions in the calculations:

- HCPF assumes all enrollments authorized on July 1 of a fiscal year will enroll within 12 months in a linear fashion.
- HCPF's analysis does not include any provider rate increases over time.
- HCPF assumes that the waiting list would continue to grow while the enrollments occur. Using the past 6 months of waiting list data, HCPF estimates that 3 people will join the waiting list each month.
- HCPF assumes that all members currently on the waiting list will accept enrollment on DD when offered the opportunity to join the waiver.
- HCPF's estimate does not incorporate the effect of people deciding not to enroll in the waiver when they are offered a spot. In these situations, HCPF would offer the enrollment to the next person on the waiting list. This may result in the waiting list being exhausted sooner than expected.
- HCPF incorporates the impact of cost shifting by only including the incremental cost for each member compared to the services they are currently receiving. For example, most people currently on the waiting list are receiving services through the HCBS Supported Living Services (HCBS-SLS) waiver. The average cost per person for the HCBS-SLS waiver is forecasted to be $23,615.50 in FY 2024-25, compared to the average cost per person for the HCBS-DD waiver of $96,324.71. HCPF added only the incremental cost of joining the HCBS-DD waiver of $72,709.21 for people currently on the HCBS-SLS waiver in its estimate. HCPF has calculated separate impacts for the following populations: people

receiving no Medicaid services, people receiving state plan services only, people on the HCBS-SLS waiver, and people on the HCBS-EBD waiver.

If the JBC does not choose to eliminate the HCBS-DD waiting list, the JBC could take action to reduce the HCBS-DD waiting list by authorizing additional enrollments. HCPF assumes that this request is scalable as the JBC could authorize enrolling any number of people off the HCBS-DD waiting list, up to eliminating the waiting list completely.

Since the main barrier to completely eliminating the HCBS-DD waiting list is funding, HCPF's annual strategic plan to reduce and eliminate the HCBS-DD waiting list, as required by House Bill (HB) 14-1051, takes into consideration other ways in which we can serve individuals with other waivers or services that do not have waiting lists.

98. *[Sen. Zenzinger, Sen. Kirkmeyer]* Is there capacity to reduce the DD waitlist? How is the Department monitoring capacity? What is the Department doing to build capacity?

RESPONSE

Individuals seeking enrollment into the Home and Community-Based Services - Developmental Disabilities (HCBS-DD) waiver are placed on the HCBS-DD waiting list because the state has reached the state-appropriated number of enrollments and thus, enrollments must be managed monthly based on the criteria below. Budgetary limitations restrict the capacity to serve all individuals who are eligible for the HCBS-DD waiver.

There has been steady progress to add more capacity to the HCBS-DD waiver and allow more people to enroll from the waiting list. This capacity has been added in two main ways - with the addition of funding from the General Assembly and better management of churn in the waiver. Through the additional funding and HCPF's HCBS-DD waiver and waiting list management processes, HCPF has been able to offer 3,478 individuals an authorization to enroll into that waiver since July 2019.

Historically, individuals have requested to be placed on the HCBS-DD waiting list due to limitations with established Service Plan Authorization Limits (SPALs) in the HCBS-Supported Living Services (SLS) waiver. Additionally, members with intellectual and developmental disabilities have reported challenges related to finding adequate and affordable housing.

The three examples below outline HCPF's most recent efforts to broaden services within the HCBS-Supported Living Services (SLS) waiver to better support the needs of members waiting for the HCBS-DD waiver and potentially eliminate their need to be on the HCBS-DD waiver. Each of these initiatives can continue to be available as an alternative approach to build capacity and address the needs of individuals on the HCBS-DD waiver waiting list:

- **Supported Living Services (SLS) Exceptions**
  The SLS Exception process allows access to services beyond the established limits and Service Plan Authorization Limit (SPAL) funding to eligible HCBS-SLS waiver members. The increased amount of services available for eligible HCBS-SLS members can help

members maintain independence in the community, eliminating the need for a higher level of care through the HCBS-DD waiver.

- **Housing Voucher Program**
  Along with our partners at the Department of Local Affairs (DOLA), HCPF leveraged resources already available from other state programs to provide vouchers for individuals on the HCBS-SLS waiver who are on the HCBS-DD waiver waiting list but who could be appropriately supported through the HCBS-SLS waiver if they had stable, accessible housing.
- **Supported Employment Services Changes**
  The Colorado Legislature passed Senate Bill 21-039 to end subminimum wage practices in Colorado and address some of the systematic barriers to employment faced by adults with intellectual and developmental disabilities. This legislation directed HCPF to remove individual Supported Employment services from the Service Plan Authorization Limit (SPAL) in the Supported Living Services HCBS-SLS waiver, allowing individuals to receive more support to attain or remain in employment and better support themselves in their community.

In addition to HCPF efforts to directly address capacity for the HCBS-DD waiver and get more services to people waiting for the waiver, there are simultaneous efforts by HCPF to address the direct care workforce capacity. The Direct Care Workforce Unit (DCWU) was created to address current and future direct care workforce needs, including data infrastructure, training support, and resource and job connections to support and bolster the direct care workforce. Over the past 20 months, the DCWU has been steadfastly focused on supporting initiatives that build and retain Colorado's direct care workforce. Building capacity requires a varied approach including compensation, connection, training, and data collection and analysis.

In 2.5 years, the average direct care worker wage went from $12.41 to $17.67 per hour. Targeted rate increases that support wage improvement also allow providers flexibility to enact compensation strategies beyond base wages. The DCWU has supported over 2,030 grant-funded trainings delivered in the past year. These trainings build provider capacity and direct care worker skills.

Poor recruitment and high turnover are systemic problems for the direct care industry. To address these issues, standardized and transferable training to onboard and upskill direct care workers is currently being developed and will be available statewide. Access to free and portable training will ease the training and onboarding costs for providers. Additionally, the DCWU is collaborating on the building of a resource and job hub to connect new and current direct care workers to employers. This site can save providers valuable time and money that they can then reinvest in retention strategies. Finally, the DCWU is focused on building a data infrastructure, as it is essential to be able to identify which strategies are effective in building capacity within HCBS providers. All of these strategies will ensure there is capacity from the workforce to continue to serve members enrolling on the HCBS DD waiver.

99. ***[Rep. Taggart]*** **Please provide the percentage for the projected 4,600 individuals in the Supported Living Services (SLS) waiver that are on the DD waitlist. Is there overlap there? Please explain.**

RESPONSE

As of July 2023, 43.9% of all members receiving services on the Home and Community-Based Services - Supported Living Services (HCBS-SLS) waiver were on the As Soon As Available (ASAA) waiting list for the Home and Community-Based Services - Developmental Disability (HCBS-DD) waiver. Not all members on the HCBS-SLS waiver need residential services that are offered on the HCBS-DD waiver, so they are not on the HCBS-DD waiting list.

Colorado continues its strong support of community-based living for individuals with intellectual and developmental disabilities, which has enabled the vast majority of these individuals to reside in communities of their choosing and in the least restrictive setting possible.

There are currently 3,357 on the As Soon As Available waiting list for the HCBS-DD waiver.

- 2,238 (66.7%) members on the HCBS-DD As Soon As Available waiting list who are receiving services through other waiver programs.
    - 2,115 (94.5%) through the HCBS-SLS waiver,
    - 123 (3.7%) through the HCBS-Elderly Blind and Disabled (EBD), HCBS-Community Mental Health Services (CMHS), and HCBS-Brain Injury (BI) Waivers

Members who are on the HCBS-DD waiting list can also access non-duplicative services through State General Fund programs for people with Intellectual and/or Developmental Disabilities (IDD) while they are on the HCBS-DD waiting list. On the As Soon As Available waiting list for the HCBS-DD waiver:

- 551 (16.4%) of members are receiving services through the Family Support Services Program (FSSP)
    - 283 (51.3%) of these members are also enrolled into an HCBS waiver program
- 146 (4.4%) members are receiving services through the State Supported Living Services Program
- 72 (49.3%) of these members are also enrolled into an HCBS waiver program
    - 882 (26.27%) of people on the HCBS-DD waiver waiting list are not currently receiving long-term care services through a waiver or another state program, but the vast majority are receiving other Medicaid services such as professional services (Occupational Therapy, Physical Therapy, or treatment, etc.)

CARE AND CASE MANAGEMENT SYSTEM

100. ***[Sen. Zenzinger]*** **When will the Department have the Care and Case Management system working properly? How is the Department addressing communication with consumers and their families who need to go through disability reviews?**

RESPONSE

The goal of the new Care and Case Management system is to create a more efficient, streamlined user experience for case managers and members. Despite this goal, HCPF acknowledges that the implementation of the system has not been without challenges. HCPF wants to recognize the dedication of case management agencies throughout this initial implementation phase. HCPF is committed to working in partnership with these agencies to solve the issues still present within the system.

The Care and Case Management system includes several phases of system implementation. To resolve the issues identified with the Phase 1 of the system launch, the first two of approximately five updates were completed on Nov. 21 and 30, 2023. It is anticipated that the remaining updates needed to resolve the most pressing issues, will be completed by the end of December 2023. HCPF staff meet routinely with case management agency leadership to provide updates on progress towards resolutions. The system is designed to be operational during each phase and HCPF is taking lessons learned during this first phase to better mitigate issues as well as ensure more timely resolution of unanticipated issues that may occur.

Communication with members and their families who need to complete an annual Level of Care Eligibility Determination Assessment is facilitated by their case management agency, which also schedules and performs the assessment. This assessment is required on an annual basis, or sooner if the member has a significant change in condition. Due to the compounding issues related to the Care and Case Management system, Case Management Redesign agency transitions, and the financial renewals required by the end of the COVID-19 Public Health Emergency, HCPF is dedicating extra resources to ensure members are receiving their annual assessments.

- HCPF is providing case management agencies with member financial renewal timelines to ensure case management agencies are encouraging members to complete their financial renewal with the County Departments of Human/Social Services or other eligibility sites.
- Beginning Dec. 18, 2023, HCPF will provide case management agencies with reports with the due dates for member's Level of Care Eligibility Determination Assessment and Prior Authorization for services outside of the normal reporting processes.
- Finally, HCPF has developed an escalation process for cases that are experiencing issues to ensure timely renewal.

ASSESSMENT

101. *[Rep. Bird]* Please provide an update on implementation of the Single Assessment Tool and describe the issues that have caused the delays in implementation. How is the Single Assessment Tool similar to the proposed nursing assessment and how is it different? Considering how long it has taken to implement the Single Assessment Tool and the amount of stakeholder feedback the Department has received, why does the Department think it can implement a nursing assessment tool so quickly?

RESPONSE

Single Assessment Delays and Update

The Colorado Single Assessment tool has been developed, piloted, and built into the new Care and Case Management system; it is currently being tested. Due to a convergence of difficult changes, including challenges related to the launch of the Care and Case Management system, the Public Health Emergency and subsequent unwind and financial eligibility renewals, and Case Management Redesign agency transitions, HCPF has decided to further delay the implementation of the Colorado Single Assessment Tool. A new implementation date has not been determined, but will likely be set for Summer/Fall 2024 to allow time for the pressures on the case management system to stabilize and resolve.

The previous issues that have caused delays include:

- HCPF and stakeholders determined that there was not a current assessment available that would meet Colorado's needs and decided to develop a unique assessment process and assessments for Colorado. (2 years)
- Because Colorado built an entirely new assessment tool, robust testing and piloting of the Single Assessment was necessary to establish reliability. (1.5 years)
- The original IT system built to house the Single Assessment was inadequate, and HCPF had to terminate the contract with the vendor and procure a new vendor. (1 year)
- The new vendor experienced delays in building and testing the new assessment tool within the new IT system, the Care and Case Management system. Because HCPF wanted to provide adequate training and an opportunity for member advocates to experience the assessment in the system, HCPF decided to launch the Care and Case Management system with the current legacy assessments in July 2023 and further delay the launch of the Single Assessment as noted above. (1 year)

While we have yet to implement the Colorado Single Assessment, we have made great strides toward achieving the vision originally set out by SB 16-192 to have a single assessment process for all people seeking or receiving Medicaid Long-Term Services and Supports (LTSS). We now have an Information Technology (IT) system capable of streamlining the experience of case managers and members. We have finalized a robust Single Assessment process that will better capture the needs and preferences of members. We have been able to steadily engage stakeholders on the design, rules, and impact of the Single Assessment. And, when we move into implementation of the Colorado Single Assessment, we will have many lessons learned as we are actively learning how to better manage large systems change through the experiences of the last few years.

Differences and Similarities between the Colorado Single Assessment and the skilled care acuity tool

The skilled care acuity tool (nursing assessment) has a much narrower scope than the Single Assessment Tool. The skilled care acuity tool assesses only for nursing, skilled care, and certified nursing assistant care and is less complex than the Single Assessment Tool, which assesses for long-term services and supports (LTSS) and home and community-based services (HCBS) eligibility. The Single Assessment Tool spans over 50 services across 15 LTSS programs.

The skilled care acuity tool will be limited to skilled care services while also sharing what alternative benefits may exist in meeting their needs.

HCPF believes that we are in a better position to implement the skilled care acuity tool due to the less complex nature of the tool and the lessons learned from the Single Assessment development process.

102. *[Sen. Kirkmeyer]* How will the Person-Centered Budget Algorithm address budget calculations for people with intellectual and developmental disabilities given challenges with the Supports Intensity Scale?

RESPONSE

The Person-Centered Budget Algorithm will use data collected from the Colorado Single Assessment to determine a Budget Tier for people with intellectual and developmental disabilities, as well as other waiver participants. The Colorado Single Assessment is a robust needs assessment tool that includes vastly more information about members' long-term services and support needs than the existing Supports Intensity Scale.

The purpose of the Person-Centered Budget Algorithm is to support resource allocation decisions that are objective, transparent, equitable, and consistent across Colorado. To help accomplish these goals, HCPF will assign each service recipient to a range (Budget Tier) in accordance with their individual need(s). This range will be used to help members make decisions about their services as part of HCPF's person-centered planning process. The range is not intended to be the sole determinant of need, and there will be situations not captured, which will be addressed through an exceptions process.

To address historical challenges with the Supports Intensity Scale, HCPF convened a Supports Intensity Scale/Support Level stakeholder workgroup in June 2022. This stakeholder group evaluated lessons learned with the Supports Intensity Scale. Stakeholder input is being used to address the budget calculations for people with intellectual and developmental disabilities as we move toward full implementation of these new assessment and resource allocation methodologies.

COMMON QUESTIONS - FOR WRITTEN RESPONSES ONLY

1. **Please describe any budgetary or administrative impacts from the implementation of H.B. 21-1110 (Laws for Persons with Disabilities) as it pertains to IT accessibility. Please describe any budget requests that include components related to the implementation of IT accessibility requirements.**

RESPONSE

HCPF was appropriated $2,933,182 through FY 2023-24 BA-01 (OIT) "IT Accessibility" in FY 2023-24 for remediation and term-limited FTE. This funding has roll forward authority through June 30, 2025. HCPF has an estimated 11.5 million historical PDFs across 99 applications which need to be reviewed/tested and possibly remediated. HCPF developed a process to ensure new documents added the website are accessible before posting online. HCPF has submitted a budget request, FY 2024-25 R-12 "Administrative Support," for 1.0 FTE and

$250,000 in contractor funding ongoing to achieve and maintain compliance with nondiscrimination laws, including the requirements of HB 21-1110.

HCPF is still collecting data on the budgetary risk that HB 21-1110 will place on the agency. Most of the digital assets HCPF manages are not currently accessible per the bill, which opens the agency up to possible civil suits resulting in compliance fines that may impact future budgetary needs. The legal division is working with the procurement team to identify and mitigate potential issues of vendor non-compliance. The full extent of the budgetary and administrative impacts on the agency are unknown until at least July 1, 2024, when the punitive aspect of the bill goes into effect.

HCPF is undertaking an agency-wide effort to identify and prioritize existing digital assets for remediation and utilizing the funding established in FY 2023-24 BA-01 of $2,933,182 for the remediation of its assets. This HCPF-wide effort requires every staff member to assist with identification and prioritization scoring. Additionally, HCPF established and conducted staff training on how to identify and build digitally accessible assets correctly. This training will be part of new staff onboarding.

2. **Please identify rules the Department promulgated in FY 2022-23. With respect to these rules, has the Department 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? Has the Department conducted a cost-benefit analysis of Department rules as a whole? If so, please provide an overview of each analysis.**

RESPONSE

From October 2022 to October 2023, HCPF promulgated 92 rules. HCPF performs a cost-benefit and regulatory analysis for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analysis is included in the rule-making document packet that accompanies each rule proposed by HCPF and is on HCPF's website at **https://hcpf.colorado.gov/medical-services-board**. 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 HCPF 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.

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

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 rulemaking in the Colorado Register. With respect to the rules promulgated in FY 2022-23, no external request for a cost-benefit analysis was made for any of the rules.

3. **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 2008-2023: 452

Not Fully Implemented Bills with a HCPF Fiscal Impact 2008-2023: 5

HCPF has records of the status of implementation for legislation dating back to 2008. Over the last 15 years, HCPF has successfully implemented over 328 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, HCPF was unable to implement these bills.

All legislation passed in the last two years—in the 2022 and 2023 legislation session—has either been successfully implemented or is on track for a timely implementation.

Bills Not Implemented

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 HCPF 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.	HCPF 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. HCPF 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 HCPF 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. HCPF 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. HCPF worked through this with the vendor and executed a contract July 1, 2023. HB 22-1189 extended the timelines for implementation of HB 21-1166 and we will meet those implementation deadlines.
SB 19-005 Import Prescription Drugs from Canada (Rodriquez, Ginal/Jaquez Lewis)	This bill creates a new program in HCPF called the Canadian Prescription Drug Importation Program. Under the bill, HCPF must submit a federal waiver application to legally import prescription drugs from Canada. Once approved, HCPF will work to design a safe and affordable system to import quality medications at a lower cost for all Coloradans.	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 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 HCPF submitted a formal application to the federal government in December 2022. As of March 2023, HCPF is responding to an FDA-issued Request for Importation (RFI) and updating the application as appropriate, to be resubmitted in the first quarter of 2024.
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	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

	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.	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. HCPF 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.	HCPF has not yet implemented HB 15-1318, a fully consolidated Intellectual and Developmental Disabilities (IDD) waiver. HCPF'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, HCPF 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	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive	HCPF 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

(Tochtrop, Williams/Soper, Riesberg)	hospice care; reimburse inpatient hospice facilities for room and board.	payment to the nursing facility. CMS has indicated to HCPF 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.

4. **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 Excel Template A, please:**
   - **List each source of non-tax revenue (e.g., fees, fines, parking revenue, etc.) collected by the 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.**
   - **For each source, list actual revenues collected in FY 2021-22, and projected revenue collections for FY 2022-23 and FY 2023-24.**
   - **List each decision item that the Department has submitted that, if approved, would increase revenues subject to TABOR collected in FY 2024-25.**

RESPONSE

The following table lists each of HCPF's sources of non-tax revenue that is subject to TABOR that exceeds $100,000 annually. The table also shows the revenues collected in FY 2022-23 and the projected revenue collections in FY 2023-24 and FY 2024-25. HCPF did not submit any FY 2024-25 decision items that would increase revenues subject to TABOR.

5. **Please use the attached Excel Template B to summarize the Department's funded and actual FTE for the last three fiscal years and identify the origin of changes in funded FTE. If positions have not been filled, please describe challenges in preventing positions from being filled and how vacancy savings are being utilized.**

RESPONSE

Over the last several years, HCPF has converted contractor funding to FTE through several budget requests that were approved by the JBC. 18% of this "Funded FTE" growth between FY 2020-21 and FY 2023-24 is due to this strategy. This approach has proven very successful in

controlling HCPF administrative expenses (lowest in the state by far of all payers), while also enabling agility to respond to the changing health care dynamics especially challenging during COVID and completing the unprecedented workload related to market transformations (payments, behavioral health, HCBS, ARPA dollar projects, transparency and more).

Part A: Please summarize HCPF'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**
2020-21	557.3	607.8	50.5	9.1%
2021-22	654.9	629.6	(25.3)	-3.9%
2022-23	745.0	745.3	0.3	0.0%
2023-24	787.9	N/A	N/A	
FTE Change over 3 years	230.6			
% Change over 3 years	41.4%			

* "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.

Part B: Please identify the origin of changes in funded FTE for FY 2022-23, including the number of new positions HCPF has been able to fill.

FY 2022-23: Status of New Funded FTE				
Fiscal Year	**Funded FTE**	**Actual FTE**	**Actual Above/(Below) Funded FTE**	**% Difference**
TOTAL BASE: 2021-22	**654.9**	**629.6**	**(25.3)**	**4%**
Annualizations of Prior Budget Actions	0.1	0.1	0.0	0%
Decision Items:				
FY 2022-23 R-6 Value Based Payments	3.8	3.8	0.0	0%
FY 2022-23 R-8 County Admin Oversight	5.9	5.0	(0.9)	18%
FY 2022-23 R-11 ACC CHP+ Accountability	2.0	2.0	0.0	0%
FY 2022-23 R-12 Convert Contractor to FTE	23.2	22.2	(1.0)	5%
FY 2022-23 R-13 Compliance FTE	10.0	9.1	(0.9)	10%
FY 2022-23 R-14 MMIS Funding Adjustment	11.8	11.8	0.0	0%
Bills:				

HB 22-1278 Behavioral Health Admin	4.5	4.5	0.0	0%
HB 22-1289 Cover All Coloradans	5.1	4.0	(1.1)	28%
HB 22-1290 Repair Complex Rehab Tech	1.0	1.0	0.0	0%
HB 22-1302 Health-Care Practice Transformation	14.3	14.3	0.0	0%
HB 22-1303 Residential Behavioral Health Beds	1.8	1.8	0.0	0%
HB 22-1397 Statewide Equity Office	1.8	1.8	0.0	0%
SB 22-106 Conflict of Interest in Public BH	0.9	0.9	0.0	0%
SB 22-196 Health Needs of Persons in Criminal Justice	0.7	0.7	0.0	0%
Long Bill Add-On:				
FY 2023-24 JBC Action CBMS Funding Transfer	3.2	3.2	0.0	0%
FTE changes unrelated to decision items or bills		29.5	29.5	0%
TOTAL: 2022-23	**745.0**	**745.3**	**0.3**	**0%**

HCPF has filled 86.2 positions of the 90.1 appropriated through the budget process. The unfilled positions are identified below.

- R-8 County Administration Oversight – 0.9 FTE - HCPF continues to work on filling this FTE.
- R-12 Convert Contractor Resources to FTE – 1.0 FTE – HCPF has had difficulties in prioritizing this position due to other vacant positions within the program area. This position is now in the hiring process.
- R-13 Compliance FTE – 0.9 FTE – an employee was selected and offered the position but declined it. A follow up hiring process is now underway.
- HB 22-1289 – 1.1 FTE – an employee was selected and offered the position but never started. This position is now in the recruitment process.

HCPF has provided the FTE count as part of the Nov. 1 request from the Schedule 14A and 14B, which provide actual expenditures. For the upcoming years, HCPF manages the dollar appropriation which has been affirmed by two Supreme Court cases (Colorado GA v. Owens and Anderson v. Lamm).

HCPF made significant improvements in hiring and recruitment intake processes. HCPF 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, HCPF successfully implemented a project management tool to manage recruitment efforts for all positions. HCPF continues to recognize that IT and Finance roles are particularly difficult to fill, given competition with market wages for similar roles in

the private sector and the increased demand for certain roles, especially in the area of IT. HCPF has initiated special pay plans for those roles and other targeted classifications.

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 record.

6. **For each line item in the Department with FTE please provide the following information for the last five fiscal years.**
   - **a. FTE allocated in the Long Bill and other legislation;**
   - **b. Actual FTE;**
   - **c. Vacancy rate;**
   - **d. Actual expenditures associated with FTE;**
   - **e. Reversions by fund source;**
   - **f. Vacancy savings; and,**
   - **g. Amount transferred to the State Employee Reserve Fund (SERF).**

RESPONSE

See tables below. In some cases, data is unavailable since the Personal Services budget is included in the overall program appropriation. 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 record.

Table 1 - (1) Executive Director's Office; (A) General Administration, Personal Services						
Row	**Category**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**
A	FTE Allocated in Long Bill	465.8	500.0	517.1	610.4	696.2
B	Actual FTE	487.2	525.2	572.8	600.5	704.7
C	Vacancy Rate	-4.59%	-5.04%	-10.77%	1.62%	-1.22%
D	Total Spending Authority	$48,060,196	$49,365,243	$59,315,235	$67,775,860	$83,453,739
E	Actual Expenditures	$47,320,210	$48,397,781	$57,630,608	$65,653,747	$78,901,553
F	Reversions	$739,986	$967,462	$1,684,627	$2,122,113	$4,552,186
G	General Fund	($444,346)	$0	($1,075,325)	$0	($2,411)
H	Cash Funds	($10,601)	$2,682	$0	$0	$200,511
I	Reappropriated Funds	$572,245	$633,584	$761,732	$120,039	$884,776
J	Federal Funds	$622,688	$331,196	$1,998,220	$2,002,074	$3,469,310
K	Vacancy Savings	$0	$0	$0	$0	$0

L	SERF Transfer	$0	$866,760	$0	$1,104,600	$0

Table 2 - (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Office of eHealth Innovations Operations

Row	Category	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
A	FTE Allocated in Long Bill	0.0	2.7	2.7	3.0	3.0
B	Actual FTE	0.0	0.1	0.1	0.0	0.6
C	Vacancy Rate	0.00%	96.30%	96.30%	100.00%	80.00%
D	Total Spending Authority	$0	$1,958,154	$9,610,170	$9,219,607	$10,224,177
E	Actual Expenditures	$0	$1,937,375	$6,556,066	$4,385,240	$5,096,812
F	Reversions	$0	$20,779	$3,054,104	$4,834,367	$5,127,365
G	General Fund	$0	$804	$300,342	$1,076,035	$750,922
H	Cash Funds	$0	$0	$0	$0	$0
I	Reappropriated Funds	$0	$0	$0	$0	$0
J	Federal Funds	$0	$19,975	$2,753,762	$3,758,332	$4,376,443
K	Vacancy Savings	$0	$0	$0	$0	$0
L	SERF Transfer	$0	$0	$0	$0	$0

*Spending authority and reversion show the full amount which includes the subset of Personal Services and are not broken down on the Schedule 3 to calculate the Personal Services portion.
*Actual FTE paid for with this line item are housed within the Governor's Office and are paid through an IA, so although FTE looks low, there are 3.0 associated with OeHI.

Table 3 - (4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (1) Administrative Costs, Personal Services

Row	Category	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
A	FTE Allocated in Long Bill	40.5	40.4	37.5	37.5	39.5
B	Actual FTE	40.6	39.7	34.7	29.1	33.7
C	Vacancy Rate	-0.25%	1.73%	7.47%	22.40%	14.68%
D	Total Spending Authority	$3,530,508	$3,600,329	$3,471,358	$3,469,613	$3,469,613
E	Actual Expenditures	$3,530,508	$3,598,584	$3,471,358	$3,425,143	$3,469,613
F	Reversions	$0	$1,745	$0	$44,470	$0
G	General Fund	$0	$0	$0	$0	$0
H	Cash Funds	$0	$0	$0	$44,470	$0

I	Reappropriated Funds	$0	$0	$0	$0	$0
J	Federal Funds	$0	$1,745	$0	$0	$0
K	Vacancy Savings	$0	$0	$0	$0	$0
L	SERF Transfer	$0	$1,749	$0	$295,874	$214,777

Table 4 - (6) Other Medical Services; ARPA HCBS State-only Funds						
Row	**Category**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**
A	FTE Allocated in Long Bill	0.0	0.0	0.0	4.0	4.0
B	Actual FTE	0.0	0.0	0.0	0.0	5.6
C	Vacancy Rate	0.00%	0.00%	0.00%	100.00%	-40.00%
D	Total Spending Authority	$0	$0	$0	$14,182,695	$57,116,818
E	Actual Expenditures	$0	$0	$0	$0	$479,942
F	Reversions	$0	$0	$0	$0	$0
G	General Fund	$0	$0	$0	$0	$0
H	Cash Funds	$0	$0	$0	$0	$0
I	Reappropriated Funds	$0	$0	$0	$0	$0
J	Federal Funds	$0	$0	$0	$0	$0
K	Vacancy Savings	$0	$0	$0	$0	$0
L	SERF Transfer	$0	$0	$0	$0	$0
*Appropriation shows the full amount which includes the subset of Personal Services and is not broken down on the Schedule 3 to calculate the Personal Services portion.						

7. Describe General Fund appropriation reductions made in the Department for budget balancing purposes in 2020, and whether the appropriation has been restored with General Fund or another fund source through budget actions or legislation.

RESPONSE

- Increase in Member Co-pays: Increased co-pays for many services to the federal maximum, which would result in lower overall payments to providers and save $4.4 million total funds, including $1.0 million General Fund, in FY 2020-21 and $8.8 million total funds, including $2.1 million General Fund, in FY 2024-25 and ongoing. HCPF was not able to implement this initiative in FY 2020-21 due to a prohibition on decreasing benefits during the public health emergency. The FY 2021-22 long bill included funding to undo the increase in co-pays. In FY 2022-23, HCPF requested to eliminate all member

co-pays except for those on non-emergent utilization of the emergency room, which was approved as requested.

- Reduction in Senior Dental Program: A decrease of $1.0 million General Fund for services provided through the senior dental program. The funding was fully restored in the FY 2021-22 long bill.
- Reduction in PACE Rates: A 2.37% reduction to rates for the Program for All Inclusive Care for the Elderly in FY 2020-21, which was expected to save $5.9 million total funds, including $2.8 million General Fund. This reduction was one time in nature. The rates reverted to normal growth in FY 2021-22.
- Reduction in Teaching Hospital Supplemental Payment: A decrease of $4.4 million total funds, including $1.9 million General Fund, to eliminate supplemental payments to Denver Health and the University of Colorado for graduate medical education. The funding attributable to the Family Medicine program of $1.2 million was restored in FY 2020-21 and subsequently combined into the Family Medicine line item in FY 2021-22. The remaining funding was not restored.
- Reduction in Pediatric Hospital Supplemental Payment: A decrease of $2.7 million total funds, including $1.3 million General Fund, to reduce this supplemental payment to Children's Hospital by 20%. This funding was not restored.
- Reduction to APCD Scholarship Program and State Support: A decrease of $1.2 million General Fund for eliminating a $500,000 grant program that offset access costs for qualifying applicants and reducing state-only support. This funding was restored in the FY 2022-23 long bill.
- HB 20-1361 Adult Dental Cap Reduction: Reduced the adult dental benefit cap from $1,500 to $1,000 per recipient per year, which reduced appropriations by $5.2 million total funds, including $1.1 million General Fund, in FY 2020-21 and $11.1 million total funds, including $2.3 million General Fund, in FY 2021-22. HCPF was not able to implement this initiative in FY 2020-21 due to a prohibition on decreasing benefits during the public health emergency. SB 21-211 reversed the reduction and restored the funding. The cap was eliminated completely in the FY 2023-24 long bill.
- HB 20-1362 Nursing Facility Reduction: Limited the annual increase for nursing facility rates from 3.0% to 2.0% for FY 2020-21 and FY 2021-22, which reduced appropriations by $7.0 million total funds, including $3.3 million General Fund, in FY 2020-21 and $16.5 million total funds, including $8.3 million General Fund, in FY 2021-22 and ongoing. This reduction was not restored, however the nursing facility rates increased by 10.0% in FY 2023-24 per HB 23-1228.
- HB 20-1384 Delaying SB 19-195 Wraparound Services: Delayed a program created under SB 19-195 that provides wraparound services for children and youth in or at risk of out-of-home placement. It reduced state expenditures by $1.8 million total funds, including $1.0 million General Fund in FY 2020-21 and $10.8 million total funds, including $5.6 million General Fund, in FY 2021-22 and ongoing. The funding for this program was restored in the FY 2021-22 long bill to allow HCPF to restart the implementation of SB 19-195.

- HB 20-1385 Use of Increased Medicaid Match: Allowed the state to use a temporary increase in federal funds related to Medicaid from the Families First Coronavirus Response Act to reduce General Fund obligations rather than having the benefit accrue to cash funds. It reduced appropriations by $24.7 million General Fund in FY 2019-20 and $26.8 million General Fund in FY 2020-21. The provisions in the bill were extended past FY 2020-21 through SB 21-213 as the public health emergency and enhanced federal match continued to be extended. HCPF's FY 2023-24 appropriations and FY 2024-25 base budget account for the phase down of the enhanced federal match and corresponding increase in General Fund to make up the difference.
- HB 20-1386 HAS Fee Offset: Authorized the use of hospital fee revenue to offset General Fund expenditures for Colorado's Medicaid program in the amount of $161 million for FY 2020-21 only. This reduction was one-time in nature.

8. Provide a list and brief description of all interagency agreements that the Department is party to, including any statutory authority or requirements for specific interagency agreements. Please further describe any appropriations and transfers of funding between departments associated with interagency agreements.

RESPONSE

Table begins on the next page.

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
ARPA - Provider Training	CDHS	Expand immersive training opportunities for direct care workers at the Pueblo and Grand Junction Regional Centers' HCBS Waiver programs. Performing agency requests payment for unpaid, obligated balance of agreement funds.	(6) Other Medical Services, ARPA HCBS State-Only Funds	$98,000
ARPA - Section 9817 Compliance	DPA	Provide assistance with the oversight, compliance, and monitoring of Section 9817 ARPA funds (SB 21-286). Fixed price paid upon acceptance of deliverables.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$852,115
ARPA - Training Fund 1	CDLE	New Program Management I to outreach position to educate future direct care workers, HCBS employers, and other entities. Monthly fixed price invoicing. Funded through ARPA Section 9817	(6) Other Medical Services, ARPA HCBS State-Only Funds	$92,997
ARPA 1.06 Career Pathways Coordinator	CDLE/CO Community College System	Hire Healthcare Credentials Pathway coordinator to support the mapping of nonlinear career pathways. Funded through ARPA Section 9817 with invoicing for monthly reports delivered.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$109,020

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
ARPA 1.06 DCW Training Modules	Arapahoe Community College	Development of video soft skill and virtual job shadow training modules for Direct Care Workforce. Funded through ARPA Section 9817. Payments to contractor based on fixed deliverables.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$449,500
ARPA 6.06 Digital Casefile Scanning Services	CDHS	CDHS to improve cybersecurity by scanning active case files at the county level. Funded through ARPA Section 9817. HCPF transferred full contract amount upon execution of IA.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$2,428,254
ARPA Career Pathway Program Manager	CDLE/Dept of Higher Education	CDLE to hire one program manager to oversee and develop non-linear career pathways resources for the health care workforce. Funded through ARPA Section 9817. CDLE to invoice monthly and paid fixed price amount for deliverables.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$109,032
CDPHE Facility Survey and Certification	CDPHE	HCPF as the state Medicaid administration agency, and CDPHE as the state Public Health Programs and Survey and Certification agency, agree to work collaboratively on the Medicaid funded health programs, services, health information systems, health facilities survey and certification, and any	(1) Executive Director's Office; (B) Transfers to/from Other Departments, Transfer to CDPHE for Facility Survey and Certification	$8,507,461

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
		other provider certifications, licensing, or agency operations required		
DOLA DOH Emergenetics Training	DOLA, Division of Housing	HCPF will provide Emergenetics training for all new DOH staff. HCPF will be reimbursed based on number of attendees at a fixed rate upon training.	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$4,000
DOLA Host Home Regulation and Modification	DOLA	This IA allows HCPF and DOLA to ensure authorized funding is effectively utilized to support oversight of the HCBS Home Modification and Home Accessibility Adaptation benefits as well as the IRSS Inspection program. In addition, this agreement will provide for oversight of ARPA funding available to enhance the Home-Modification benefit by up to $10,000 per eligible member until Sept. 30, 2024.	(1) Executive Director's Office; (B) Transfers to/from Other Departments, Transfer to DOLA for Home Modification Benefit Administration and Transfer to DOLA for Host Home Regulation	$576,395

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
DORA IA Nursing Aide Billing	DORA/CDPHE	The purpose of this IA is to provide training, certification and performance monitoring of nurse aids under Section 12.255.101 et seq. C.R.S., the Nurse and Nurse Aide Practice Act.	(1) Executive Director's Office; (B) Transfers to/from Other Departments, Transfer to DORA for Nurse Aide Certification	$324,040
Early Childhood Leadership Commission-FY 24	Department Early Childhood	The Colorado Department of Health Care Policy and Financing (HCPF) is contracting with the Colorado Department of Early Childhood (CDEC) to provide and receive subject matter expertise to and from the Early Childhood Leadership Commission (ECLC).	(1) Executive Director's Office; (A) General Administration, General Professional Services	$22,590
Governor's Office IA Analysis Services	Governor's Office	HCPF shall pay the Governor's Office for dues to the National Governors Association, Disability Policy Advisor, Fiscal Health Advisory Services, and Budget Analyst Services outlined in SOW. HCPF shall pay GO upon either at execution or quarterly/monthly based on deliverables.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$193,308

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
HB1302 BHA Stakeholder Engagement	CDHS, Behavioral Health Administration	HCPF contracts this funding to BHA to support planning and stakeholder engagement for Universal Contract provisions and behavioral health safety net rule revisions. Funds appropriated with HB 22-1302 Healthcare Practice Transformation and payments to CDHS are limited to unpaid, obligated balance of agreement funds.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$100,039
LTSS Case Manager Training Approach	CDHS	HCPF is working with the CDHS Staff Development Center Manager and team to develop a case manager training approach and continuous quality improvement plan for the implementation of a new eligibility determination assessment/Level of Care needs assessment, and person-centered support plan for all individuals receiving long-term services and supports. This IA allows HCPF to reimburse CDHS for SDC training.	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$60,000
Money Follows the Person - DOLA IA	DOLA	Funding to help transition individuals with disabilities from an institutional setting to a community setting for the MFP Demonstration Grant,	N/A - Federal grant not included in the Long Bill	$92,909

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
		Colorado Choice Transition program. Includes implementation of multi-year housing plan for Colorado Choice Transition created by Division of Housing.		
OAC Staffing for Medicaid Appeals	DPA	DPA to obtain temporary OAC staff for Medicaid Appeals processing arising from the Coronavirus pandemic and pursuant to the Families First Coronavirus Response Act and the Consolidation Appropriations Act 2023. DPA will invoice HCPF monthly based on fixed rates for stated services.	(1) Executive Director's Office; (A) General Administration, Personal Services	$3,251,165
OeHI Governor's Office Staff	Governor's Office	HCPF has the appropriation for OeHI's operations staff but the staff is paid monthly by the Governor's Office. This IA allows HCPF to reimburse the Governor's Office for work performed by a Deputy Director of OeHI, Operations and Special Project Coordinator, and a Director of the Office of eHealth Innovation.	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Office of eHealth Innovations Operations	$413,130

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
Olmstead Special Advisor	Lieutenant Governor's Office	LGO will collaborate to lead a statewide effort to coordinate and implement initiatives related to Olmstead analysis and policy Development. Funded through HB 22-1302 and HCPF will transfer funds quarterly upon invoice.	(1) Executive Director's Office; (A) General Administration, General Professional Services	$118,447
Supported Employment Pilot Program	CDLE	To reimburse Providers of Supported Employment Services for their costs to obtain nationally recognized training/certification as per SB 16-077 and 18-145.	(4) Office of Community Living; (3) State only Programs, Supported Employment Provider and Certification Reimbursement	$303,158
Work Number Verification	CDHS	This Agreement is to reimburse CDHS for HCPF's portion of the employment and income verification services with Equifax.	(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Work Number Verification	$3,305,114

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
DORA Review	DORA	The Office of Policy, Research, & Regulatory Reform in DORA conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when HCPF had a law requiring a sunset review, a specific line item was established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review	(1) Executive Director's Office; (B) Transfers to/from Other Departments, Transfer to DORA for Reviews	$3,750
CDPHE Prenatal Statistical Information	CDPHE	IA requires statistical data from CDPHE to evaluate the effectiveness of the Prenatal Plus program	(1) Executive Director's Office; (B) Transfers to/from Other Departments, Transfer to CDPHE for Prenatal Statistical Information	$5,887
DHS Electronic Health Record	CDHS/GO-OIT	Funding for the ongoing operational needs of the Electronic Health Record (EHR) System, used at the three State-owned Regional Centers.	(7) Department of Human Services Medicaid Funded Programs; (F) Office of Adults, Aging, and Disability Services, Regional Center	$680,382

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
			Electronic Health Record	
Dept of Education - Public School Health	DOE	Provides supervisory and administrative support for the School Health Services Program pursuant to C.R.S. 25.5-5-318 and provides technical assistance to school districts that choose to participate in the program. Technical assistance includes determining levels of funding for Medicaid certification of public funds expended, developing cost survey information, obtaining the indirect cost rate, developing Local Services Plans that meet State guidelines, and accurate reporting of expenditure of reimbursement funds and delivery of services.	(6) Other Medical Services, Public School Health Services	$202,194
Quitline	CDPHE	Reimburses for allowable costs incurred by DPHE for the provision of services and performance of administrative activities for Colorado Quitline services including outreach, cessation counseling and evaluation of services to eligible Medicaid clients.	(2) Medical Services Premiums	$1,285,726

Interagency Agreement Name	Department(s) Associated with IA	Description of IA (*Include a brief description of the IA, including any statutory authority or requirements. Please further describe any appropriations and transfers of funding between departments associated with the IA*)	Line Item	IA Amount
PDMP Data	DORA	Data Sharing Agreement to coordinate data transfers with DORA's PDMP Contractor as it relates to Medicaid member fee-for-service and managed care organization (MCO) pharmacy data. The reporting provided is to comply with new CMS annual reporting requirements pursuant to Section 5042 of the SUPPORT Act for Patients and Communities Act, beginning with submission of the FFY 2023 annual reporting to CMS.	(1) Executive Director's Office; (E) Professional Services Contracts	$125,000

Joint Budget Committee Hearing
Health Care Policy & Financing

Dec. 19, 2023

Kim Bimestefer, Executive Director
Cristen Bates, Behavioral Health Initiatives and Coverage Office Director
Rachel Reiter, Policy, Communications and Administration Office Director
Bettina Schneider, Finance Office Director
Adela Flores-Brennan, Medicaid Director
Bonnie Silva, Office of Community Living Director

Thank you for your partnership

- 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

Average 1.6M covered lives over FY

- Covering **1 in 4** Coloradans
- **40%+** of Colorado's children
- **40%+** of births
- **4%** of members use long-term services & supports (LTSS)

Change in Medicaid population

ACA Expansion (2014-2016)

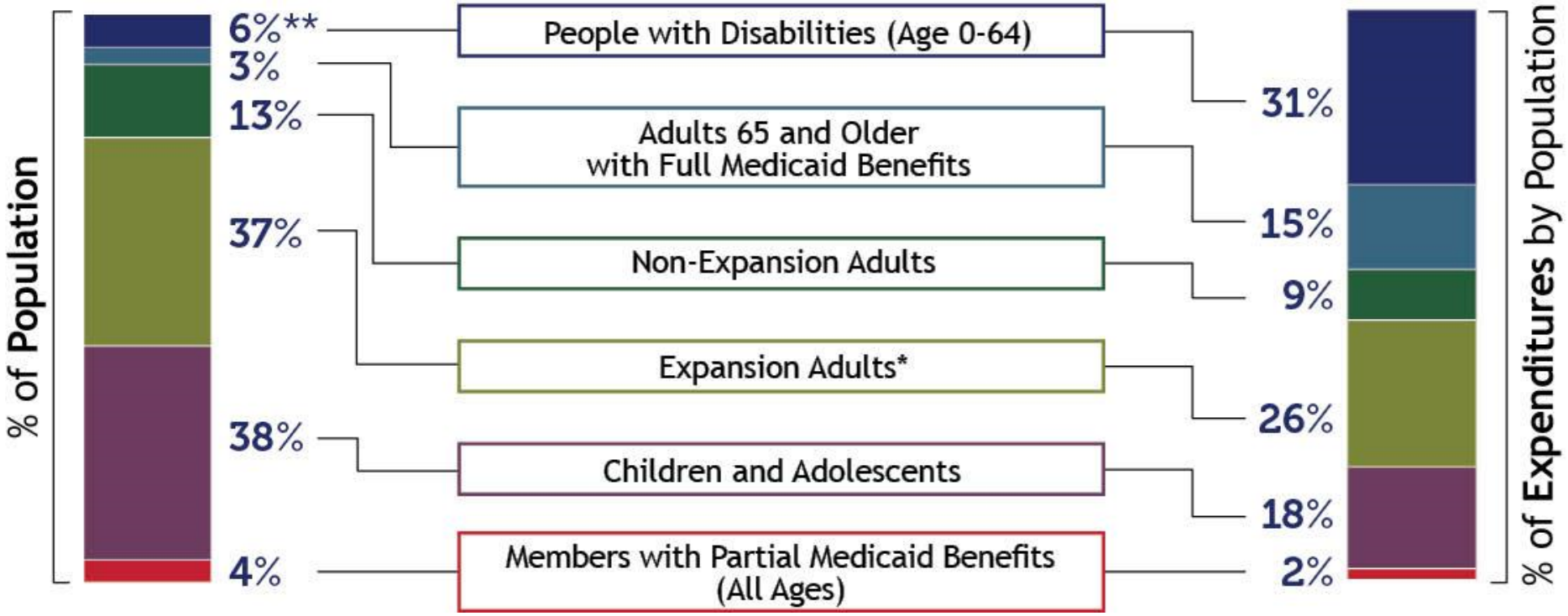
Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2012-13	682,994	5,194,662	13%
2015-16	1,296,986	5,446,593	24%

COVID-19 Pandemic (March 2020-April 2023)

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2018-19	1,261,365	5,676,913	22%
2022-23	1,719,393	5,838,736	29%

- Significant surges in Medicaid enrollment. Now PHE disenrollments.
- Changing demographics impact costs, trends, needs
- Fed funding impacts revenue: 90/10% expansion; 6.2% added FMAP thru PHE
- Returned $1.7B to JBC of add'l 6.2% FMAP through June 2023
- Enhanced federal match fully expires fiscal year 2023-24, accounting for $89M of the General Fund requested in FY 2024-25

HCPF $$ by major enrollment category



*ACA Medicaid Expansion 90/10 federal funding for Expansion Adults, state fund source: the Healthcare Affordability and Sustainability Fee (CHASE)

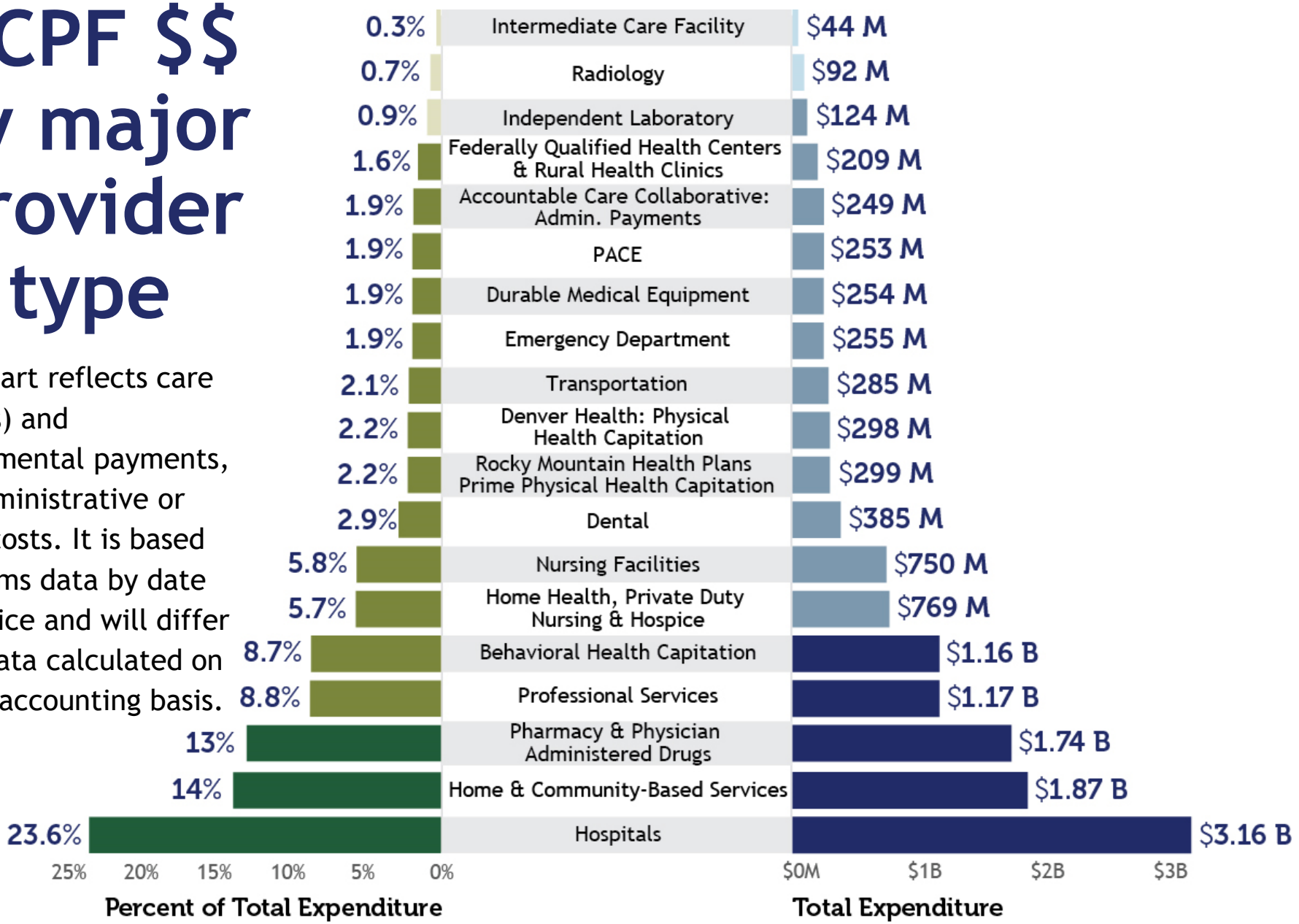
**Not all members with disabilities use long-term services & supports (LTSS)

Responding to dynamic environment

- **Expanded access to care, with enrollment surges:** number of providers enrolled March 2020 to Nov. 2023 up >50%
  - Continued challenges in access: behavioral health, home and community based services, front line workers (CNAs, RNs) for hospitals, nursing homes, PBT/ABA, and the like
- **Massive system changes necessary to navigate the PHE and other priorities:** 242 claim system projects since Sept. 2019
- **High member and provider call center standards:** calls answered in <60 seconds, medical claims paid in <5 days
- **Controlling claim trend and admin**
  - 2.1% claim trend per person per month (FY 2022-23)

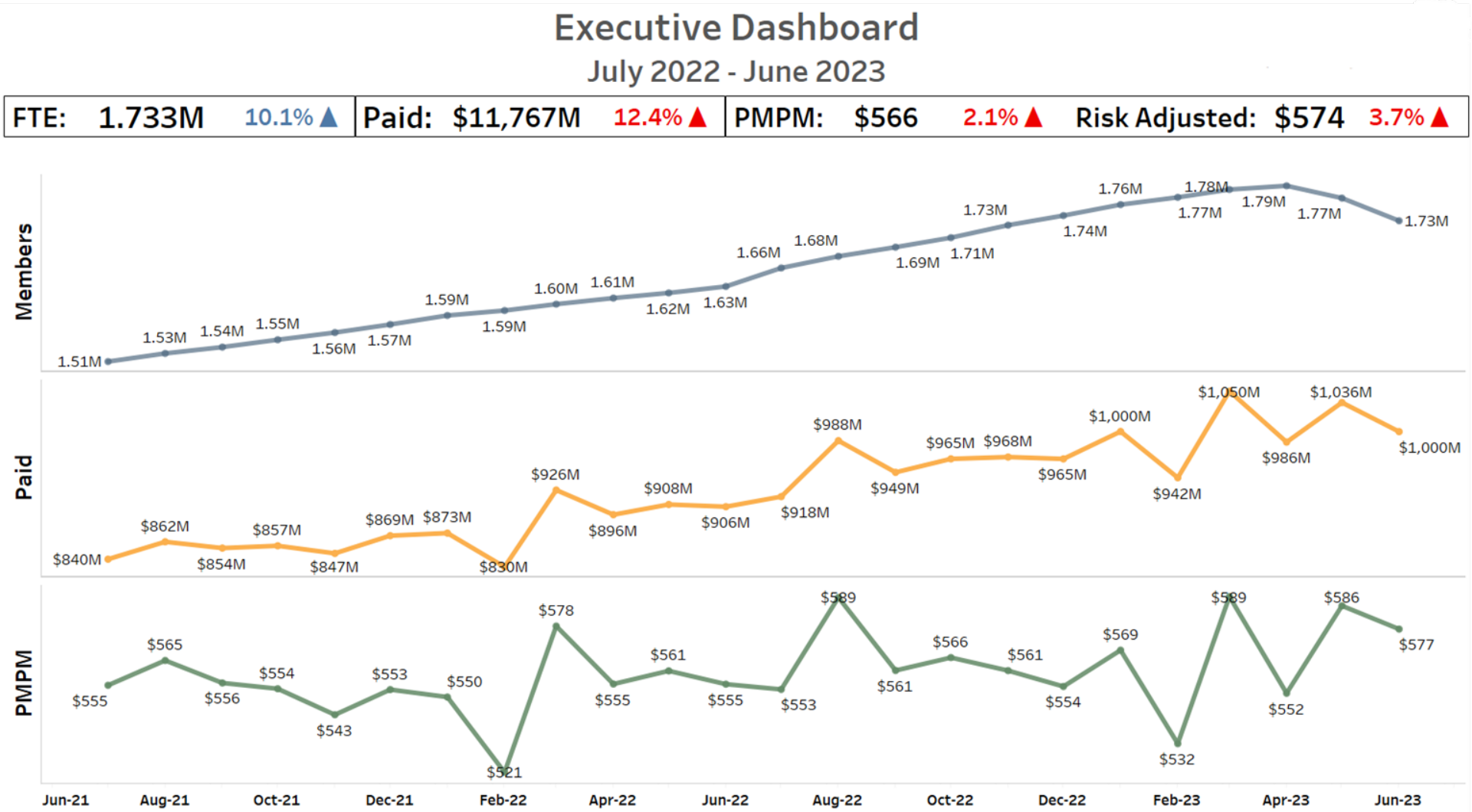
HCPF $$ by major provider type

This chart reflects care (claims) and supplemental payments, not administrative or other costs. It is based on claims data by date of service and will differ from data calculated on a cash accounting basis.



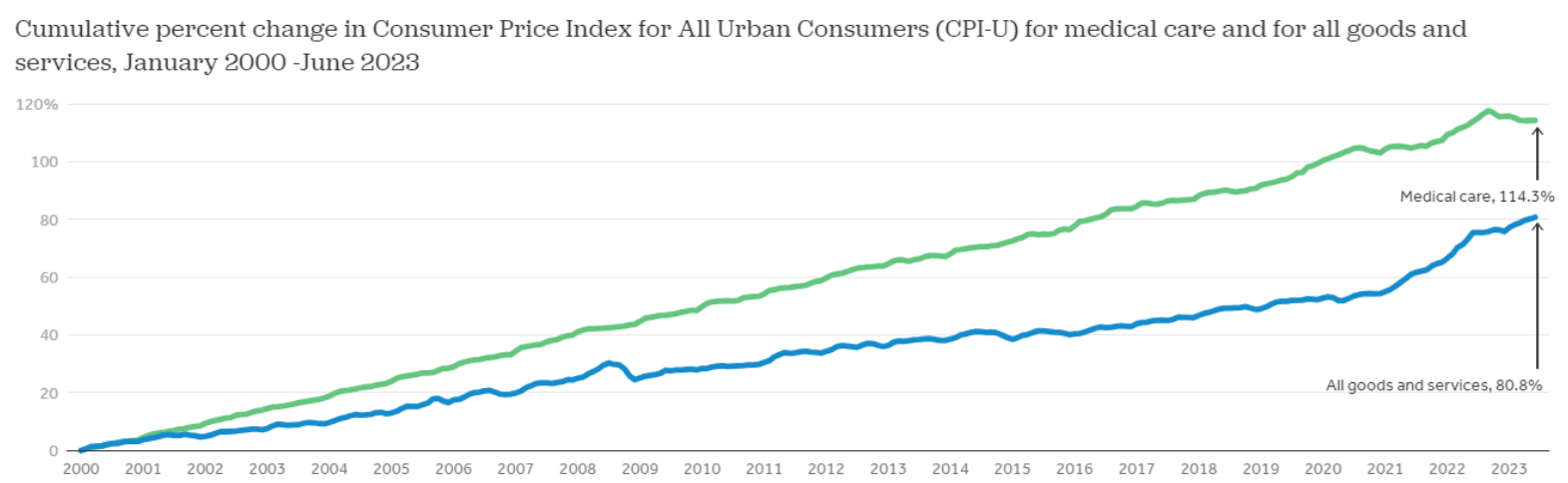
Source: FY 2022-23 data via HCPF Annual Report

Fiscal year 2022-23 trend



Challenges in managing Medicaid trend

- **Balancing access and provider needs:** across-the-board (ATB) rate increases 1% (FY 2024-25 request), **3%, 2% and 2.5% last 3 years,** plus pending targeted provider reimbursement rate increases
- **Medical costs increase faster:** Consumer Price Index (CPI) 80.8%, Medical CPI 114.3% (KFF, CYs 2000-2023)
- **Aging Population:** Colorado 2nd fastest growing state for 65+; 70% of people over 65 will need long term care at some point, 20% for >5 yrs
- **Specialty drugs — U.S. biggest driver of healthcare costs**
  - $1.6B in Medicaid pharmacy costs last FY (gross of rebates); >8.8M Medicaid pharmacy claims paid; <2% of drugs so expensive, driving 49%



Recent actions to address provider hardship

- **Nursing Home:** $131M investment over 2 years (HB 1228)
- **HCBS:** $12.41 to $15 (1/1/22) to $15.75/hr (7/1/23) to $16.55/hr thru this recommendation (Denver $17.29/hr to $18.29/hr eff 7/1/24)
- **Rural Hospitals:**
  - **Rural Access and Affordability Grants** - $10.6M
  - **Rural Support Fund** - $60M over 5 yrs ($12M/yr) for 23 hospitals
  - **CHASE Prepayments** to help cover payroll for 2 hospitals
  - **Rural Connectivity and Virtual Care** - $17.4M over 4 years; **100%** of rural safety net providers now connected to state HIE, plus funding to maintain connection
- **Denver Health safety net:** $5M to help with IT advances, i.e., HIE connectivity, eConsults and eligibility processing support
- **Parkview joins UCHealth -** $26M CHASE funding continued
- **General workforce recruitment and support**

Value Based Payments (VBPs)

Target: 50%+ in VBP by 2025 (currently 30%)

Part	Program	Participation
Hospital	Hospital Transformation Program	100% of hospitals
Primary Care	→ capitation, 16% rate increase	~530k/37% members
Prescription Drugs	Value-based arrangements Prescriber Tools	4 (+50%) ~11k/50% prescribers (+15%)
Maternity Care	Bundled payments care episodes	~30% deliveries (+7%) Denver Health joined 11/1/23

Also:

- **Behavioral Health**: ensure safety net accountability - in development
- **Nursing Homes**: pay-for-performance program to increase quality

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
- **Complex case management**: high need, high cost members
- **ACC Phase III:** Medicaid system evolution
- **Innovations**: Prescriber Tools, eConsults, cost and quality indicators to drive better provider decisions, quality, efficiency, equity
- **Fraud, waste, abuse, global attacks**: software, Recovery Audit Contractor (RAC)
- **Value based payment advances**

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.

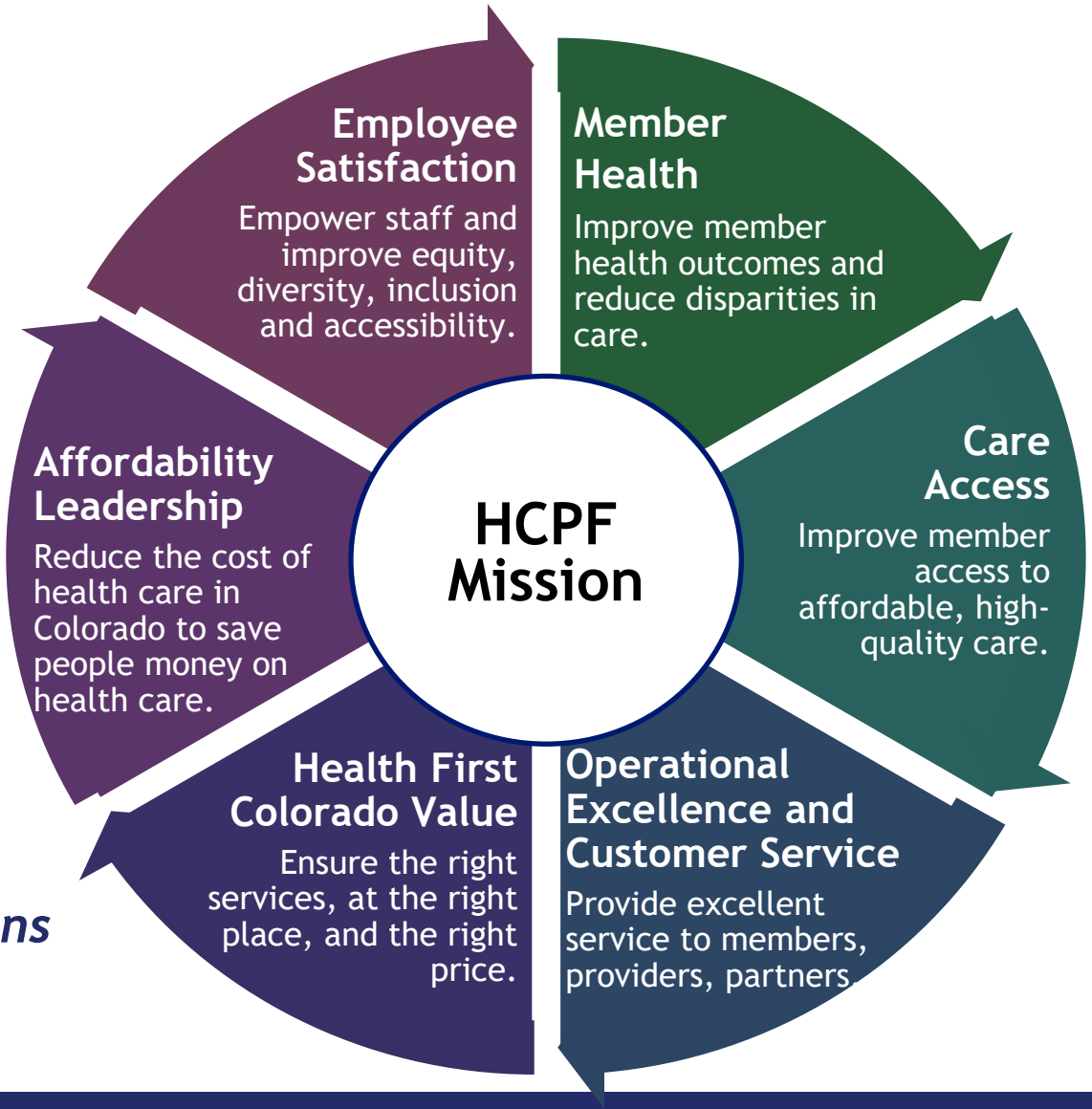
Dynamic Change — Big Boulder Focus

- **Balancing:** inflation, provider rates, workforce and access gaps; mitigate struggling provider risks
- **Keep Coloradans Covered:** post PHE continuity of coverage
- **Transform behavioral health**
- **Transform long term care for people with disabilities and older adults:** HCBS thru American Rescue Plan Act; nursing homes; case management redesign
- **Promote health equity:** behavioral health, maternity, prevention
- **Advance value based payments** to reward quality, equity, access, affordability
- **Drive innovations:** eConsults, Prescriber Tools, social determinants of health, cost and quality indicators
- **Modernize how Medicaid delivers care:** Accountable Care Collaborative Phase III
- **Modernize Medicaid Systems**
- **Saving people money on health care**

Dynamic Change — HCPF Response

- Agility: fewer vendors, more FTE; maintaining 4% admin (0.44% staff) (carriers 13.5%+ admin)
- 10 offices to hold ourselves and vendor partners accountable
- Advance infrastructure
- Productivity: 45 goals supported by 95 projects

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



HCPF FY 2024-25 Budget

- **$16.4B Total Funds, $5.0B General Funds**
  - **31%** of state's GF operating budget
  - **96%** continues to go to providers, 4% admin, 0.44% HCPF staff
- Increase of $934M TF, $402M GF, most from:
  - $320M GF — normal year-over-year growth in Medicaid
  - $76M GF and $249.2M TF — provider rate increases as subset of $82M GF discretionary requests
- Discretionary budget requests ($282M TF and $82M GF):
  - R6 | Increase Provider Rates
  - R7 | Behavioral Health Continuum
  - R8 | Eligibility Compliance
  - R9 | Access to Benefits
  - R10 | Third Party Assessments for Nursing Services
  - R11 | Program Support
  - R12 | Administrative Resources
  - R13 | Convert Contractor Funding to State FTE
  - R14 | Increase the Budgets of Two Critical Contracts
  - R15 | Continuing Support for Denver Health and Hospital Authority

Discretionary budget requests respond to provider and member needs

Provider Rate Increases

- 1% across-the-board rate increase
- Targeted adjustments for Pediatric Behavioral Therapies, ambulatory surgical centers, surgical, behavioral health, maternal health, dental services and anesthesiology
- Increase direct care workforce base wages
- Support eligibility processing, IT/innovation advances of largest safety net provider, Denver Health

Better Care and Access

- Support individuals with disabilities and older adults on waivers and other long term care programs
- Make significant investments to continue transforming the behavioral health system
- Advance provider tools to improve whole-person health
- Modernize eligibility, claims systems
- Resources to improve quality and ensure compliance

Children and Youth

- Support families of youth with high-acuity behavioral health needs
- Cover Autism Spectrum Disorder treatment for CHP+
- Accounts for Health First Colorado coverage of pregnant adults and children who are DACA recipients, pending federal requirements

Common Questions for Discussion 1-3

Behavioral Health

Kim Bimestefer, Executive Director
Cristen Bates, Behavioral Health Initiatives and Coverage Office Director

Behavioral Health

- Medicaid behavioral health investments from $630M to $1.2B/year in last 5 years
- Close collaboration with the Behavioral Health Administration (BHA)
- Behavioral Health Administrative Service Organizations (BHASO) and Regional Accountable Entities (RAEs) alignment in policy and practice
- New provider types, service provisions, associated funding
- Integrating primary care, mental health, substance use
- Improving the crisis continuum with focus on community delivered services, reducing the reliance on law enforcement and ERs
- Prioritizing gaps in care: children and youth, persons with disabilities, co-occurring intellectual or developmental disabilities, people who are unhoused, and people who have been incarcerated
- Increasing high-intensity outpatient and transition services
- Adding adult beds, youth residential beds, tribal substance use disorder facility

Behavioral Health Questions 1-2

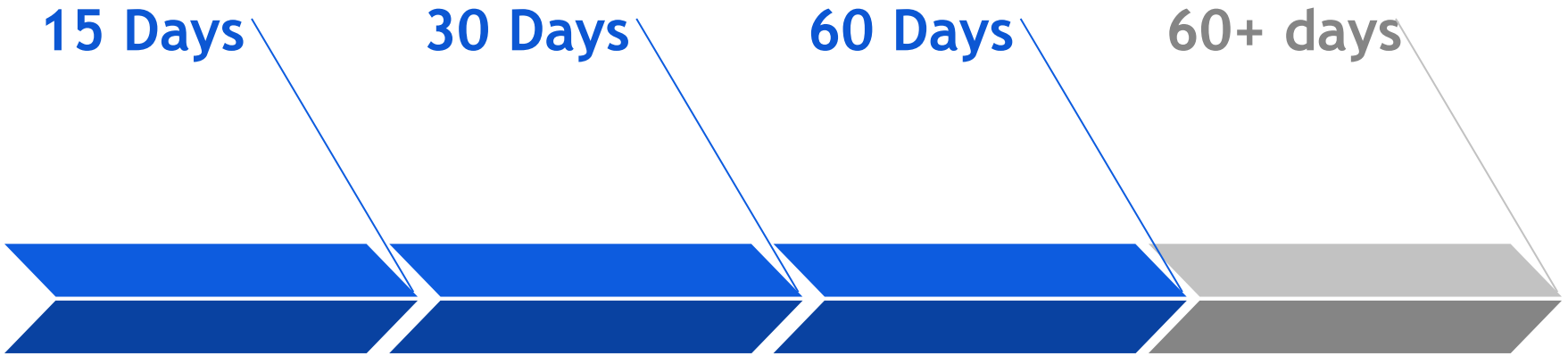
Inpatient Mental Health Services

Who needs the expansion beyond 15 days:

- 3.2% of stays in an IMD had a **single length of stay** between 16-30 days, which currently may not be reimbursed because they exceed 15 days in a calendar month.
- While 96% of stays in an IMD are less than 15 days, a member with **multiple episodes of care** in an IMD in the same calendar month, which combined exceed 15 days, occurs on average 15 times per month.

Looking at both multiple and single stays, this impacts 24 visits (or 15 members) per month.

Associated Costs for IMD Expansion Beyond 15 days



Currently cover only if LOS ends here. Cost to cover for 15 days regardless of LOS: $2,450,304 Total, $582,769 GF.

Covering an average LOS of 30 days: $7.2 million Total, $1.8 million GF. All other approved states use this standard.

A "30 Day" waiver as approved in other states also covers inpatient up to 60 days.

60+ Days would be required, but not receive a federal match. Very rare, but needs GF only funding, <$20K.

Regional Accountable Entities (RAEs) / Accountable Care Collaborative (ACC) Phase III Questions 3-4

RAE Accountability

Contract Management

- All RAE contracts approved by CMS
- Contracts include stringent statements of work
- Regular contract amendments in response to environmental changes, state priorities, etc.
- Corrective actions

Quality

- RAE and provider performance measured on:
  - Quality metrics
  - Stakeholder feedback
  - Customer service standards
  - Independent audits
- Incentive payment program

Performance Monitoring

- HCPF reviews RAE deliverables to assess operations, finances, program strategy, etc.
- Action monitoring plans or corrective action plans
- Grievances and appeals process
- Independent Managed Care Ombudsman

RAE Provider Engagement

Strategies:

- Managed care provider complaint form
- Program Improvement Advisory Committees (PIAC)
- Stakeholder meetings
- Targeted Independent Provider Network (IPN) engagement
- Technical assistance
- Executive Director site visits

Provider feedback results:

- Contract amendments.
  Ex: 90 days to contract and credential new providers
- Public reporting.
  Ex: HCPF 2023 report BH Rates, RAE performance dashboard
- Streamlined and standardized policies.
  Ex: pre-licensure, ASAM education, credentialing

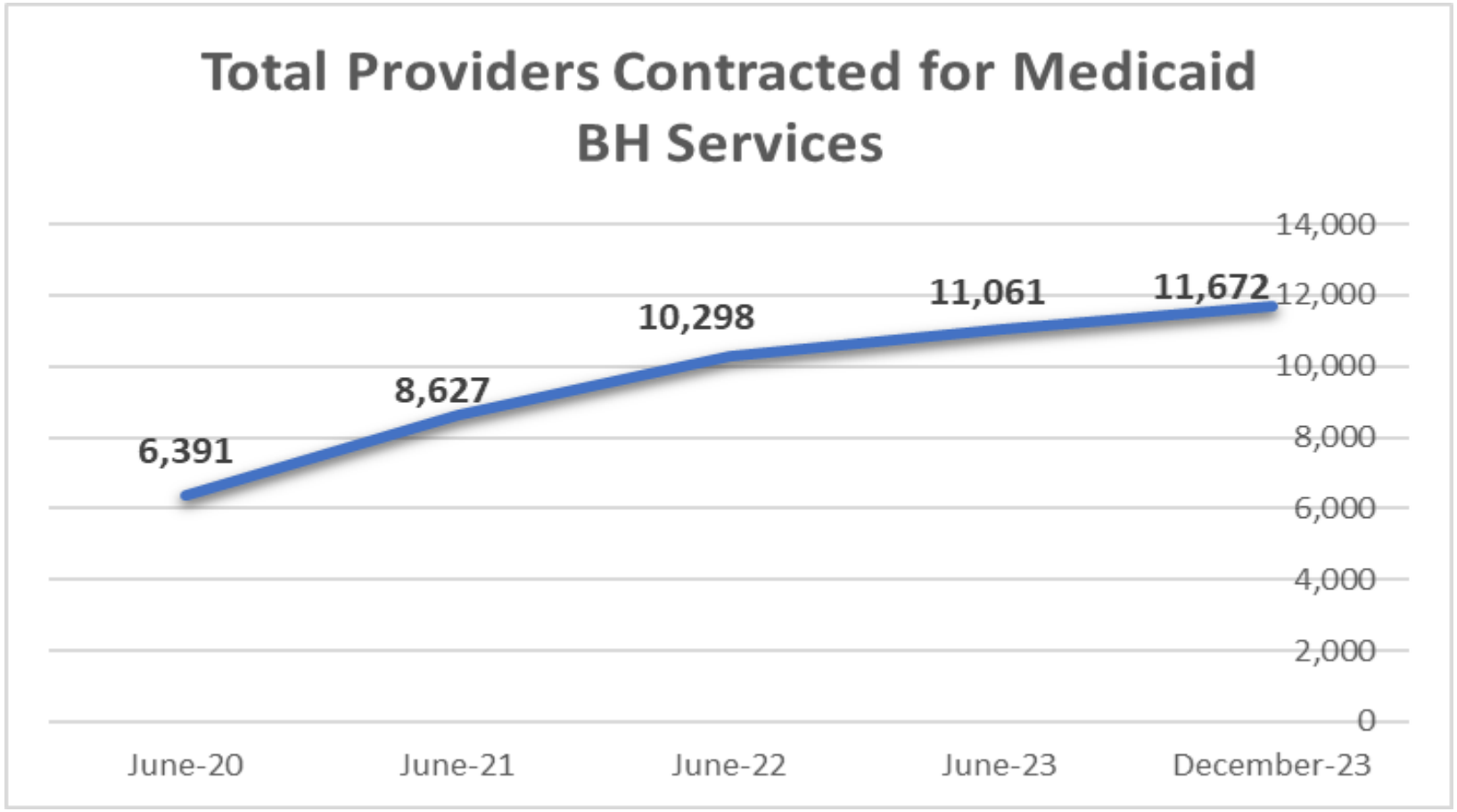
RAE Standardization

- Identical contracts
- RAE deliverables
- Independent audits
- Quality metrics
- Directed payments
- Universal contracting provisions

Why be a Medicaid Provider?

- No co-pay, no deductibles, no authorization for most outpatient services - most comprehensive coverage package of services in the state
- New safety net provider rules, provider types
  - Essential Safety Net Providers
  - Comprehensive Safety Net Providers
- HCPF works closely with providers and RAEs to continue expanding the provider network, strategies include:
  - Educational campaigns with DORA to reach BH providers not contracted with Medicaid
  - BH safety net transformation
  - Increased reimbursements rates in FY 2022-23
  - Centralizing credentialing and streamlining contracting
- Between 2021 and 2022, provider satisfaction scores increased for both RAEs and HCPF

Providers may be a single therapist or a large facility, and cover almost every service in the BH continuum of care



Building BH Networks

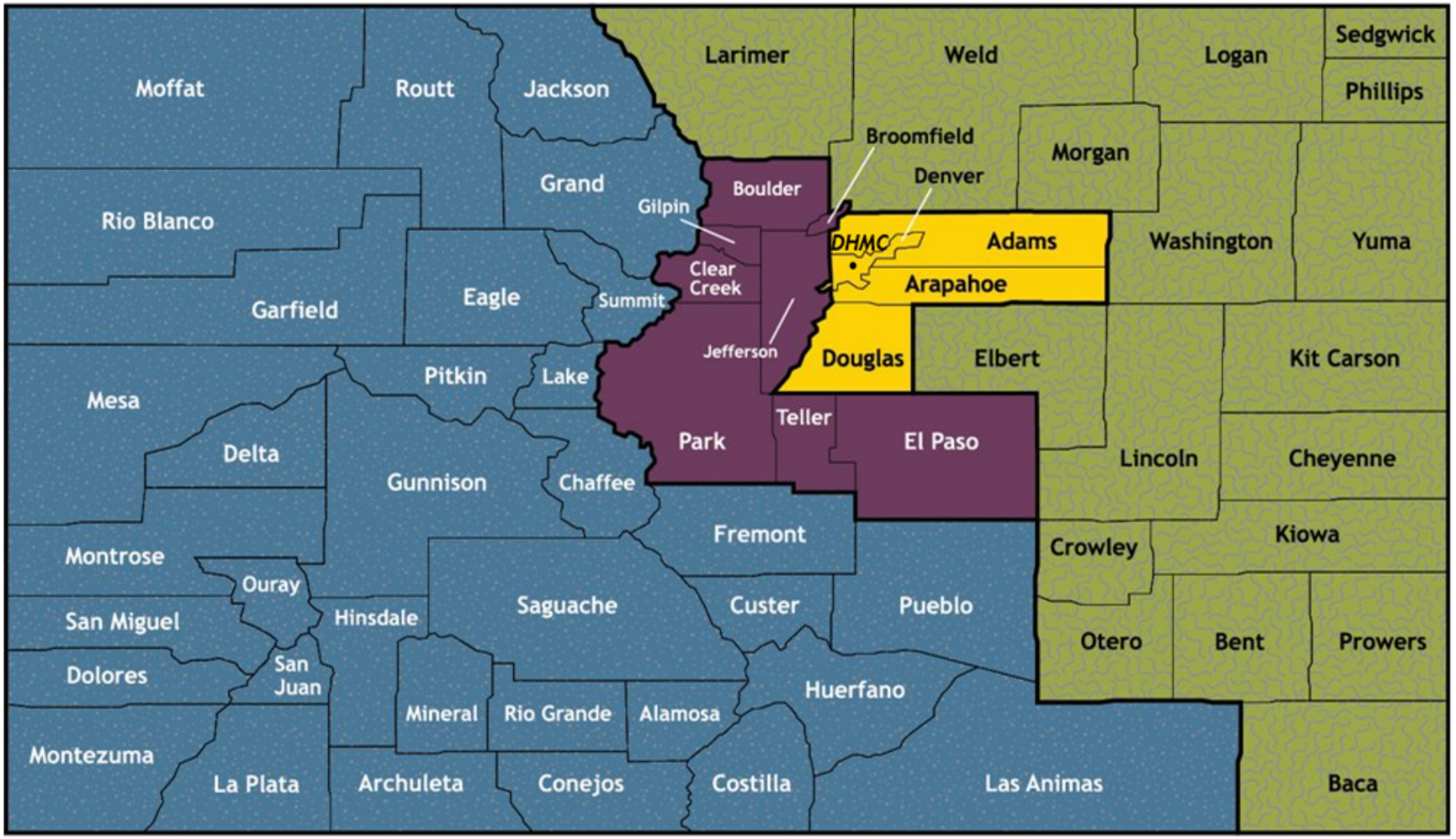
Total Number of RAE Contracted Behavioral Health Providers by Fiscal Year

	FY 21-22	FY 22-23	FY 23-24
RAE 1	3,293	3,361	6,248
RAE 2	3,100	3,298	4,175
RAE 3	6,118	5,662	8,405
RAE 4	3,097	3,297	4,176
*RAE 5	6,211	6,742	8,408
RAE 6	3,921	5,999	8,103
RAE 7	3,921	5,999	8,103

*Includes Denver Health Behavioral Health

- **Since FY 2021-22, all RAEs have expanded their BH provider networks**
- **HCPF has also targeted key services for members:**
  - High-Intensity Outpatient
  - Peer Support
  - Residential Substance Use Disorder Service Providers
- **New Safety Net Providers**
  - 6 provider organizations intend to be comprehensive
  - 72 interested in essential
  - 44 new licenced agencies with 53 sites
  - 52 new locations for existing licensed providers
- **We still have a lot of work to do!**

Final ACC Phase III RAE Map



Public Health Emergency, County Administration & Appeals Questions 5-22

Partnering to Keep CO Covered

PHE Unwind Goals

1. Member continuity of coverage
2. Smooth transitions in coverage
3. Minimize impact to eligibility workers and staff

Initial Focus:

- Maximizing auto-renewals (~30%)
- PEAK investment
- Robust communication resources
- Stakeholder education and engagement
- Provider partnership
- Member update your address campaign: 34% increase in emails and text sign ups
- Support for counties
- RAE engagement
- Auto enrolling children into CHP+ if they disenroll from Medicaid, when eligible

Question 5:
Change in Medicaid population

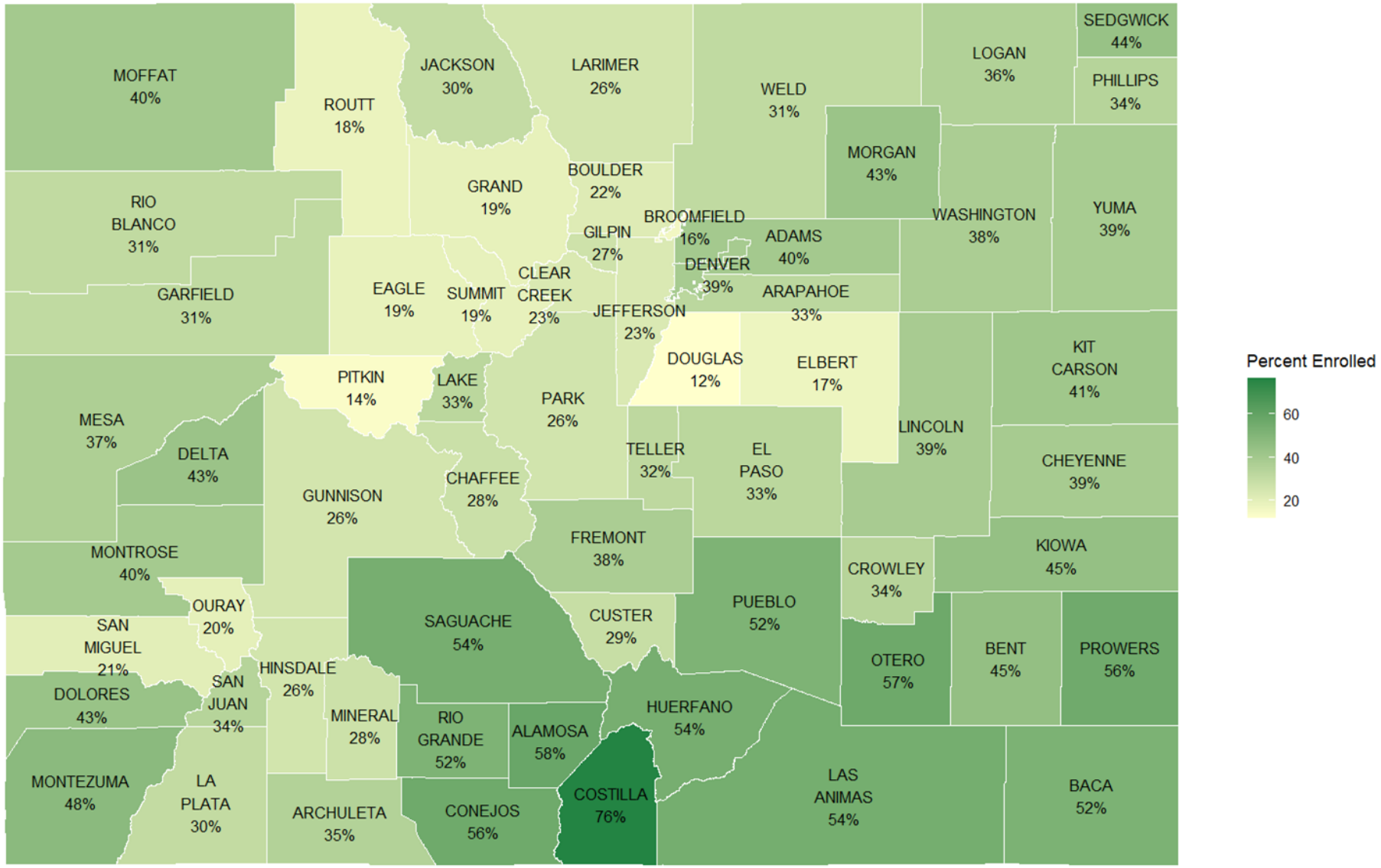
ACA Expansion
(2014-2016)

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2012-13	682,994	5,194,662	13%
2015-16	1,296,986	5,446,593	24%

COVID-19 Pandemic
(March 2020-April 2023)

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2018-19	1,261,365	5,676,913	22%
2022-23	1,719,393	5,838,736	29%

Question 5: Medicaid Enrollment % of County Population (2022 data)



Question 6-7: Minimizing Disenrollments, Supporting Long-Term Services & Supports (LTSS) members through unwind

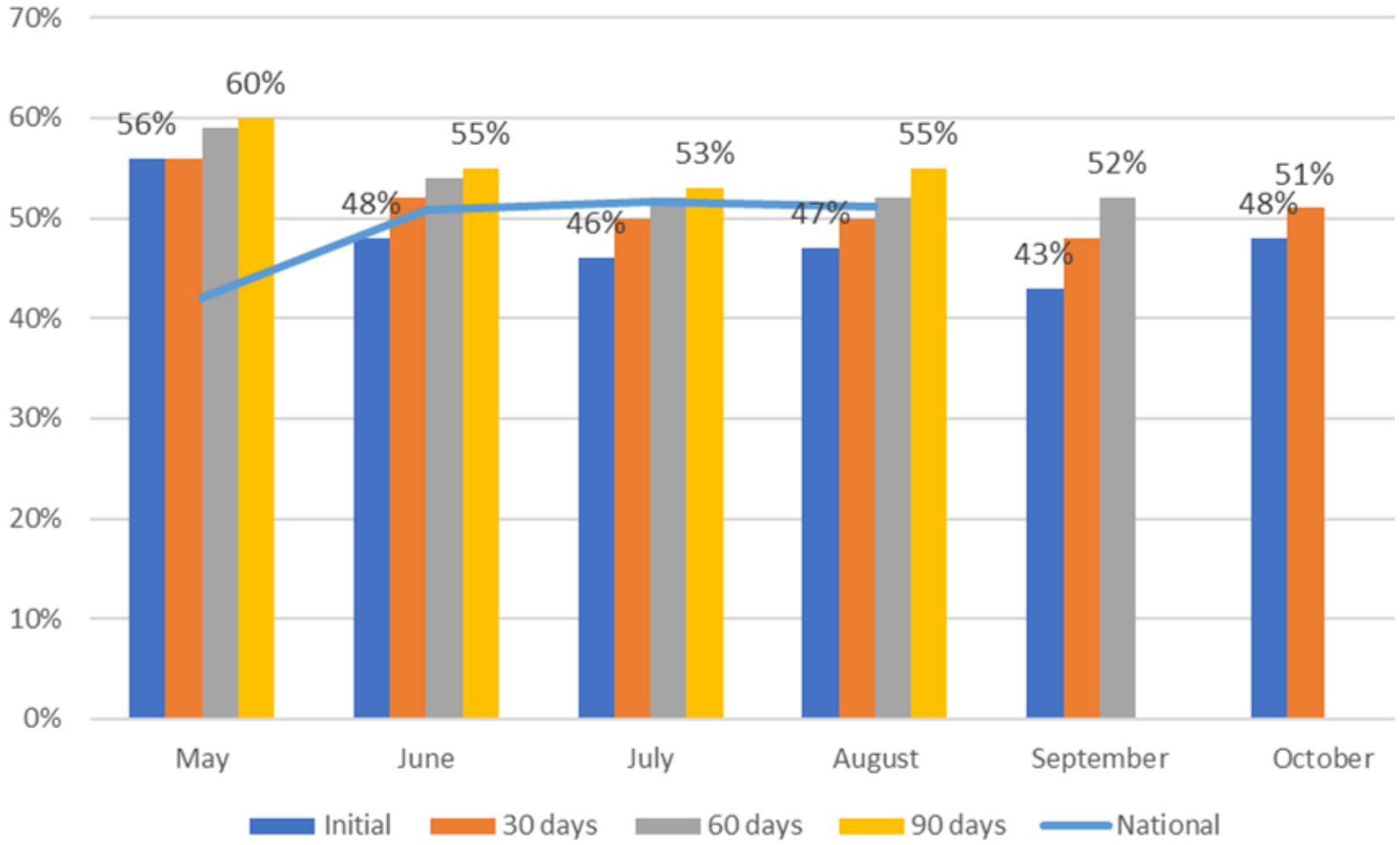
- **Renewal packet return rate** increased for non-Modified Adjusted Gross Income (MAGI) since start of unwind from 46% to 65%
- **Redesigned renewal packets -** 33% shorter, Colorado State seal
- **Ex parte at individual level**, reinstated 7,510 retroactively affected by change
- **60-day extension for vulnerable populations through June 2024**
  - Long-term care, members on waivered services, buy-in
  - Additional outreach from new Outbound Contact Center
  - Members have 60 day extension + 90 day reconsideration period to complete renewal
  - Created streamlined escalation process
  - Website LTSS specific resources - LTSS FAQ page and LTSS one-pager
- **4 outreach toolkits** - developed with members and advocates, translated into top 11 languages, statewide PSA campaign in partnership with C4
- **Massive partnership with providers and stakeholders**
- **Improved digital tool** (PEAK), correspondence improvement projects
- **Contracting with MA sites to work renewal backlogs and support counties**
- **Working with nursing facilities** to provide data on members needing more support
- **Reduced "whereabouts unknown"** 26% to 6% with eligibility system processing improvements, consolidated Return Mail Center, and collaboration with partners

Question 8: National Comparisons - Colorado made it a top priority to get people who lost their jobs during COVID induced economic downturn onto Medicaid

Date	National (In Millions)	% Change month	% Change aggregated	National Unemployment Rate	HCPF (In Millions)	% Change month	% Change aggregated	CO Unemployment Rate
Jan-20	70.97			3.5%	1.28			3.0%
Jul-20	75.72	6.69%	6.7%	10.2%	1.37	7.64%	7.6%	6.4%
Jan-21	80.59	6.43%	13.6%	6.3%	1.49	8.46%	16.7%	6.3%
Jul-21	83.77	3.95%	18.0%	5.4%	1.56	4.62%	22.1%	5.6%
Jan-22	86.98	3.83%	22.6%	4.0%	1.62	4.22%	27.3%	4.0%
Jul-22	89.82	3.27%	26.6%	3.5%	1.70	4.71%	33.3%	2.7%
Jan-23	92.97	3.51%	31.0%	3.4%	1.79	5.34%	40.4%	2.8%
Jul-23	91.51	-1.57%	28.9%	3.5%	1.72	-3.85%	35.0%	2.9%

NOTE: This chart does not include retroactivity

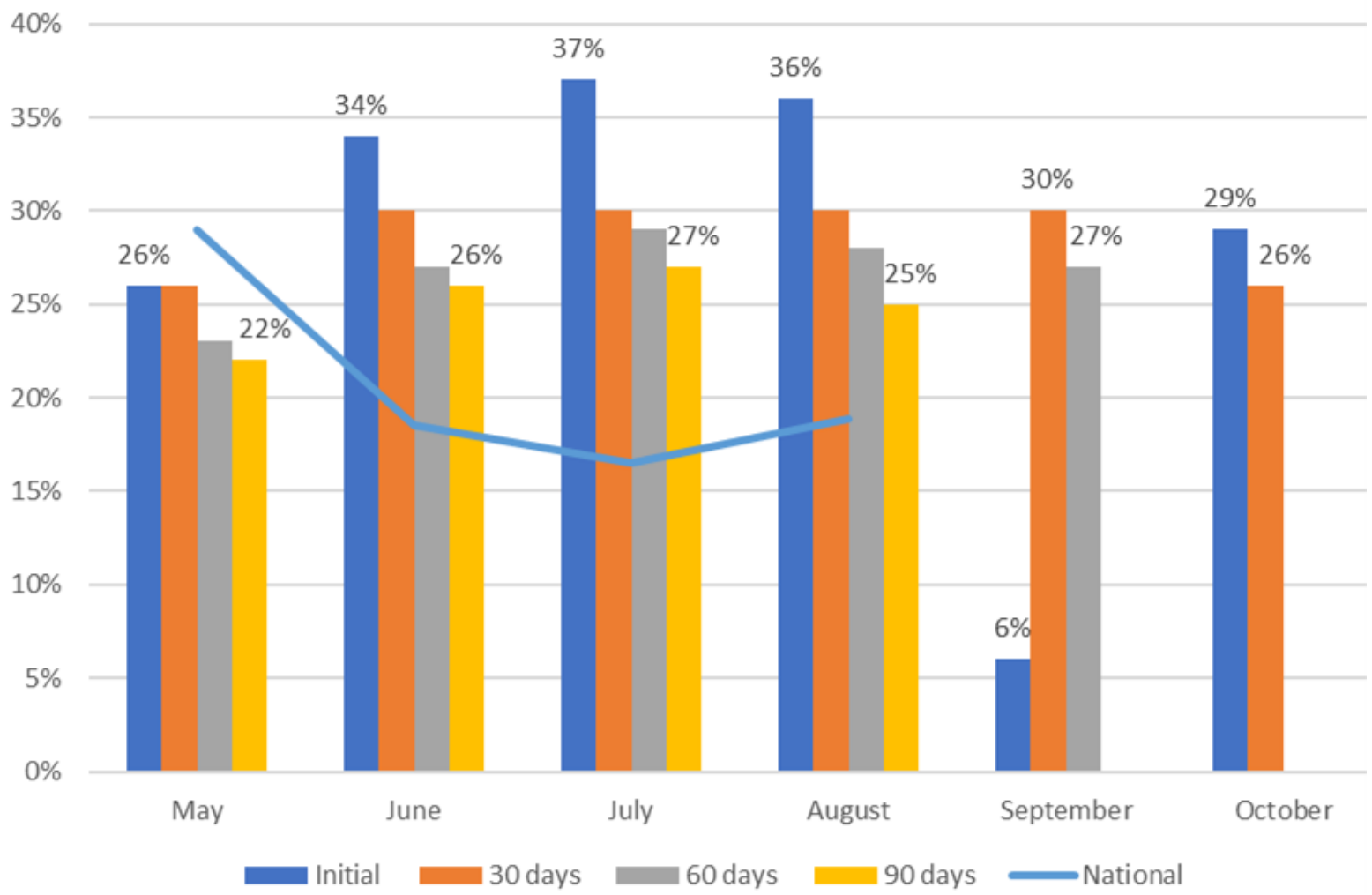
Question 8: Renewal rate improves over 90 day reconsideration period



Question 8: Colorado PHE Unwind Compared to Historic

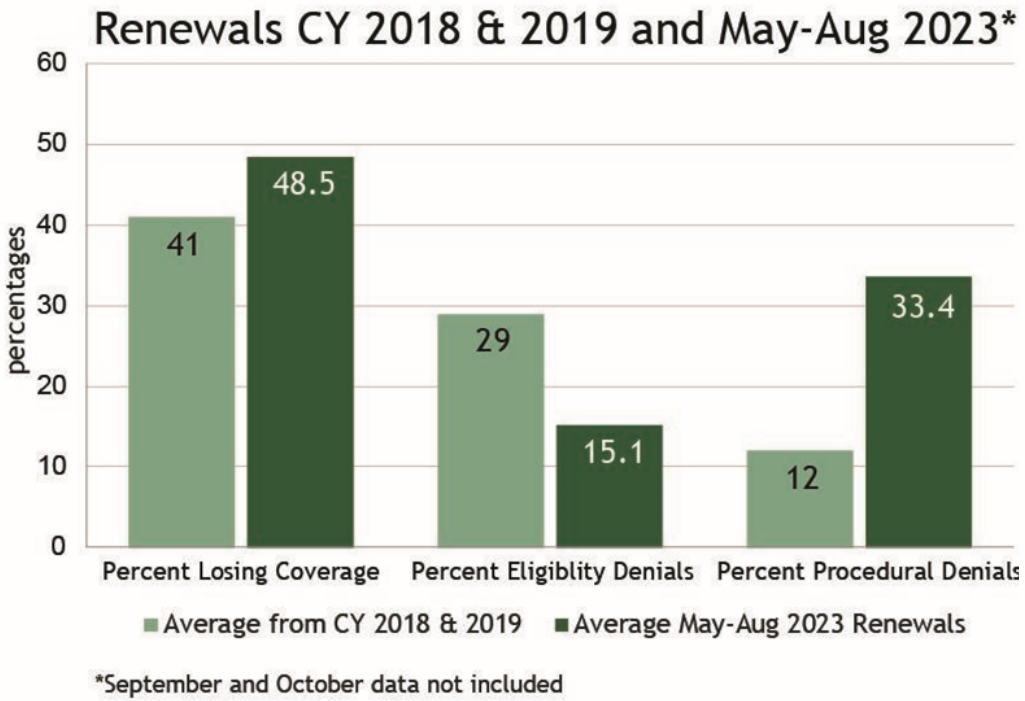
- **Colorado's 57% pre-pandemic (calendar year 2018 and 2019) average renewal rate** closely aligns with Colorado's PHE Unwind average renewal rate of about 55% (based on May 2023 through August 2023, including the 90 day reconsideration period)
- **Colorado's 41% pre-pandemic (calendar year 2018 and 2019) average disenrollment rate** closely aligns with Colorado's PHE Unwind average disenrollment rate of about 43% (based on May 2023 through August 2023, including the 90 day reconsideration period)

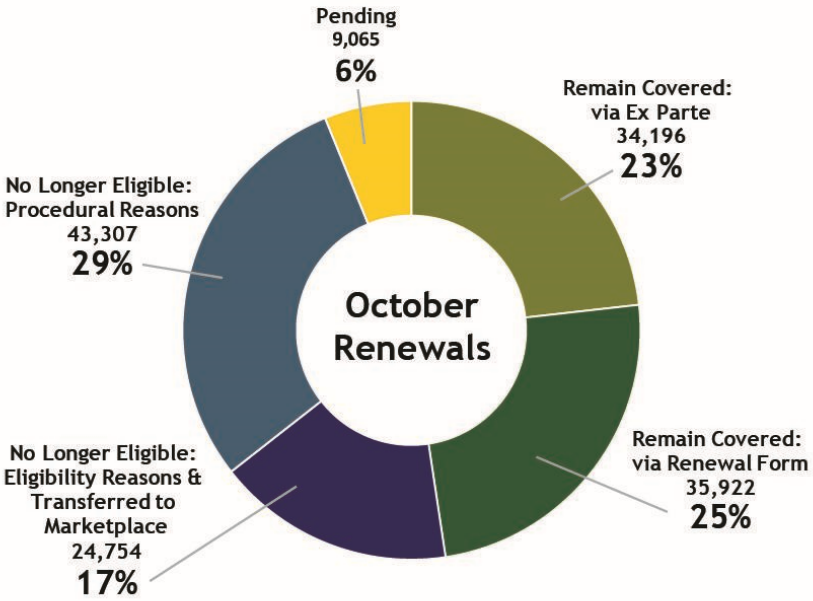
Questions 8-9: Procedural denials drop after the 90 day reconsideration period



Our procedural denials will be higher than the national average because our pending rate is so low (historically 1-3% vs national 20%+).

Question 9: Procedural denials





Based on pre-pandemic data, on average about half of those losing coverage become eligible for Medicaid again within two years. More information at https://hcpf.colorado.gov/ccu

Questions 10-18: County Administration

SB 22-235 - Year 1 Report Recommendations Overview

Transformative Recommendation #	Transformative Recommendation
Transformative Recommendation 1	Develop service delivery standards for public and medical assistance programs
Transformative Recommendation 2	Make work accessible and portable
Transformative Recommendation 3	Improve hiring and retention practices
Transformative Recommendation 4	Optimize PEAK
Transformative Recommendation 5	Improve policy documentation and dissemination
Transformative Recommendation 6	Continue with improvements to the current training model

Quick Win #	Quick Win
Quick Win 1	Create opportunities for state and county collaboration
Quick Win 2	Increase communication and collaboration between CDHS and HCPF
Quick Win 3	Align administrative requirements

Year 2 Report includes Funding Model due in November 2024.

Questions 19-22: Appeals

The Health First Colorado appeals process has seven steps:

1. Send your request for a formal hearing or expedited (faster) hearing to the Office of Administrative Courts.
2. Office of Administrative Courts sets hearing date.
3. Prepare for the hearing.
4. Attend the hearing.
5. Get the judge's initial decision.
6. What to do if you disagree with the judge's initial decision.
7. Get the final agency decision.

Up to 90 days to complete the process (can take longer if a member requests schedule change). Untimely appeals have declined with support from temporary PHE appeals staff.

Value Based Payments Questions 23-30

Value Based Payments Questions: 23-28

Value based payments:

- Move us from paying for volume to paying for value
- Support improving access, member outcomes (quality), closing health disparities (equity), control costs
- Support providers in their transition away from fee for service through innovations and tools, to help them achieve shared goals and earn value based payments while stabilizing their revenue
- Manage total cost of care through a longer term vision, keeping people healthy while addressing chronic health concerns and social determinants of health
- Help pay for a more coordinated, team based care delivery model (case management, coaching, care coordination, connection to supports)

Questions 29-30: VBP for BH Safety Net Providers

Comprehensive Community Behavioral Health Provider

Provide care coordination and **all of the following services**:

- Emergency/Crisis
- Outpatient SUD and MH
- Intensive Outpatient
- Recovery Supports
- Care Management
- Outreach, Engagement, Education
- Outpatient Competency Restoration

Eligible for cost-based **Prospective Payment System** (PPS) from HCPF July 1, 2024.

Essential Behavioral Health Safety Net Provider

Provides care coordination and **one or more** of the following services:

- Emergency/Crisis
- Outpatient SUD and/or MH
- Intensive Outpatient
- Residential
- Withdrawal Management
- Inpatient
- Integrated Care

Eligible for **Enhanced Rates Model** from HCPF July 1, 2024.

Questions 29-30

HCPF

Contracts with RAEs

- State pays incentives to the RAEs for meeting quality outcomes (KPIs, BHIP Measures)
- Based on national metrics, essential for benchmarking
- HCPF requires RAEs to pay safety net providers based on BHA approved safety net status
- State shares tools, data, TA support

RAEs

Pay providers

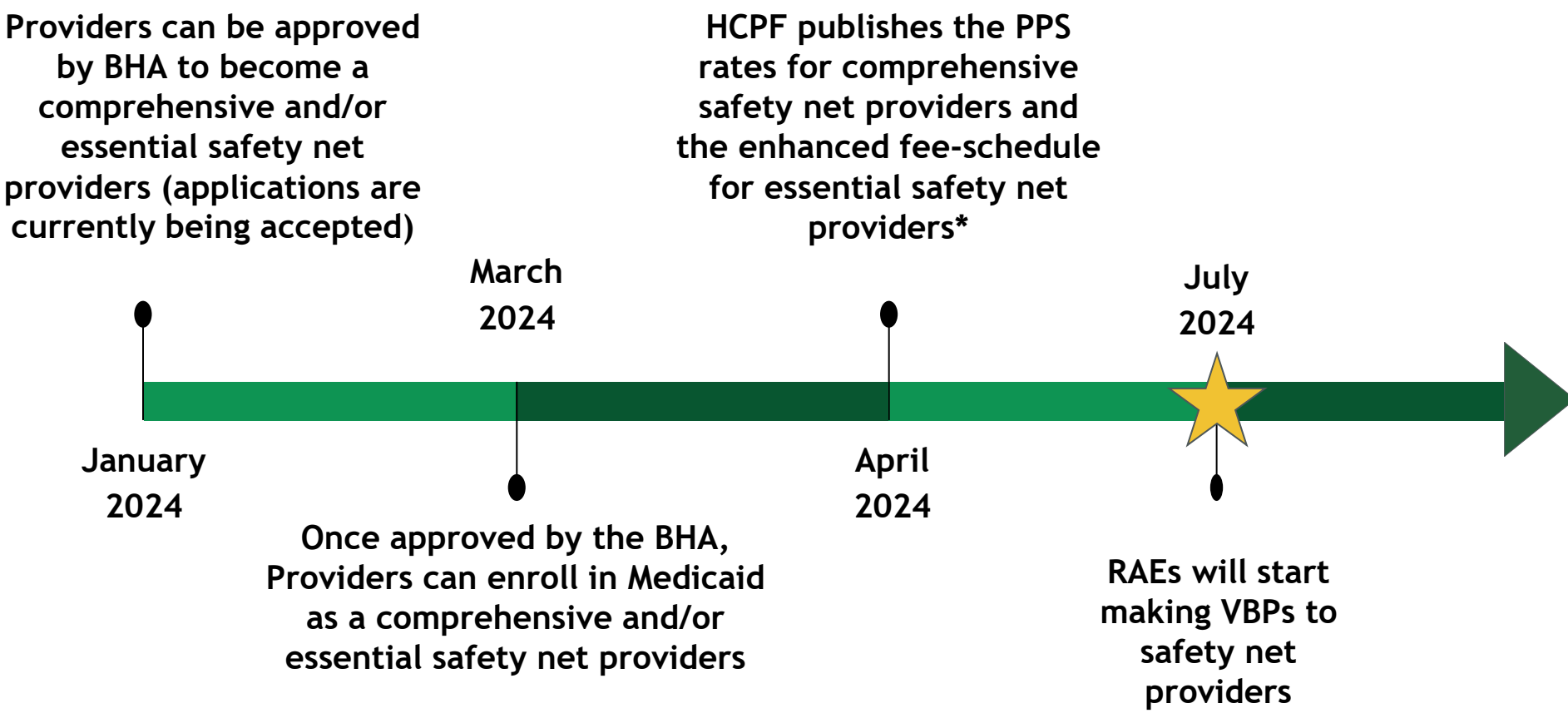
- RAEs pay Safety Net Providers based on statewide approved model, developed with BHA/HCPF
- RAEs provide technology, tools, technical assistance, and data with providers to measure regional success
- Creates additional value-based payment arrangements based on needs of the region

Providers

Serves patients

- Creates plans and policies to meet incentive goals and shared payments with the RAEs
- Sets budgets based on sustainable and flexible cost models or enhanced rate schedules

Questions 29-30: Implementation Timeline for Value Based Payments



*New comprehensive providers will receive a "statewide PPS" rate until their cost reporting can be completed

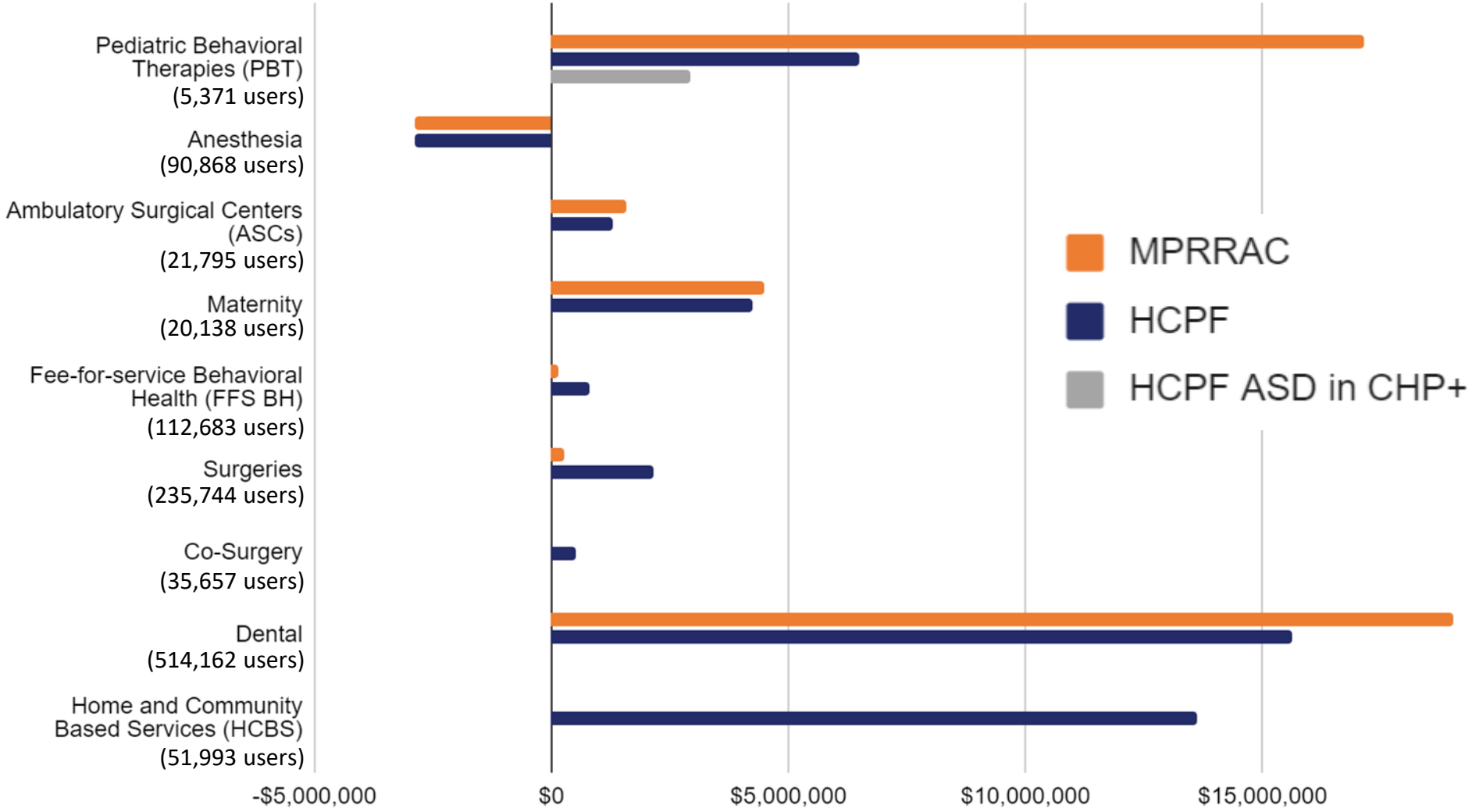
Provider Rates Questions 31-48

Questions 31-32
2023 MPRRAC Review – Overall Fiscal Impact

	MPRRAC	HCPF	Difference	HCPF HCBS Off Cycle Increase	Total HCPF	HCPF Difference
Total Fund	$144,027,428	$112,395,679	($31,631,749)	$53,856,751	$166,252,430	+ $22,225,002
General Fund	$39,718,024	$28,271,871	($11,446,153)	$13,605,949	$41,877,820	+ $2,159,796

- However, HCPF provider rate increases also include HCBS Direct Care workforce base wage increase
- Not shown, HCPF is also adding Autism Spectrum Disorder (ASD) treatment services for CHP+ (additional investment: $13.9M TF, $2.9M GF)

Questions 33-34: General Fund Difference



*Items reviewed by MPRRAC with rate adjustments of <$200 General Fund not listed; FY 2024-25 impact is lower due to cash flow adjustment

Questions 35-38: HCBS Direct Care workforce base wage challenges

Current starting wages in the Denver metro area as of 9/7/23 research		
Amazon	$15-$19.10	Warehouse specialist (fulfilling orders) starting pay in Colorado per Amazon website
McDonalds	$14-$19	Cashier ($14-$19 for Crew Member) starting pay in CO per Glassdoor
King Soopers	$14-$20	Cashier/Front End starting pay in Denver area per their website
Walmart	$15-$20	Cashier/Front End starting pay in CO per Glassdoor
FedEx	$14-$19.10	Package handler to courier starting pay in CO per Indeed

- HCBS is not on the MPRRAC list this year. HCPF is suggesting a shared, multi-year strategy to address HCBS worker shortage, which was 82% workforce turnover pre-pandemic.
- CO is 2nd fastest growing state for older adults; HCBS serves and supports the bulk of our covered individuals with disabilities.
- HCBS base wage now $15.75/hour. That would increase to $16.55/hr through this recommendation.
- HCPF recommendation covers HCBS to match Denver min. wage, rising from $17.29/hr to $18.29/hr effective 1/1/24. (Cost to cover = $2.3M GF. Every $0.10 of non-Denver base wage increase $1.4M GF.) Consideration: Look for more municipal wage adjustments to come.

Questions 39-41: Future review

2024 Review	2025 Review
Home and Community Based Services Waivers	Physician Services
Home Health Services	Dialysis and Nephrology Services
Pediatric Personal Care	Durable Medical Equipment
Private Duty Nursing (No Medicare Coverage)	Physical Therapy and Occupational Therapy and Speech Therapy
Emergency and Non-emergent Medical Transportation	Laboratory and Pathology Services
FFS BH SUD Services	Prosthetics, Orthotics and Disposable Supplies
Physician - Sleep Studies	Eyeglasses and Vision
Psychiatric Residential Treatment Facilities	Injections and other Miscellaneous J-Codes
Qualified Residential Treatment Programs	Targeted Case Management
Dental Services	

Questions 42-43: Historical Across-the-Board (ATB) rate increases

- HCPF is 38% of operating TF budget, 31% of GF.
- From FY 2010-11 through FY 2023-24, the average Medicaid ATB rate increase was 0.9%.
- ATB rate increases were higher in the last three years due to an unusual influx of federal stimulus funding. Prior to this unusual period of federal stimulus, the average was about 0.5% per year.
- FY 2024-25 returns the state to typical budget cycles. Given the ATB history, a 1% ATB (double the 0.5% historic average) is what HCPF is recommending, given inflationary challenges.
- **Every 1% ATB costs $29M GF.**

Fiscal Year	ATB
FY 2010-11	-1.00%
FY 2011-12	-0.75%
FY 2012-13	0.00%
FY 2013-14	2.00%
FY 2014-15	2.00%
FY 2015-16	0.50%
FY 2016-17	0.00%
FY 2017-18	1.40%
FY 2018-19	1.00%
FY 2019-20	1.00%
FY 2020-21	-1.00%
FY 2021-22	2.50%
FY 2022-23	2.00%
FY 2023-24	3.00%

Questions 44-46: Targeted rate increases

Fully Annualized Impact	Total Funds	General Fund	Unique Users FY 2021-22
Pediatric Behavioral Therapies	$13,019,386	$6,509,693	5,371
Anesthesia	($9,897,967)	($2,896,344)	90,868
Ambulatory Surgical Centers (ASCs)	$4,366,634	$1,277,764	21,795
Maternity	$8,494,404	$4,247,202	20,138
Behavioral Health FFS	$1,644,157	$822,078	112,683
Surgeries	$7,389,047	$2,162,184	235,744
Co-Surgeries	$1,759,670	$514,915	35,657
Dental	$85,620,023	$15,634,217	514,162
Total Impact	**$112,395,679**	**$28,271,871**	(some members receive multiple services)

Questions 47-48: Methodology

- The Department used a statistical methodology to establish whether any of the states used in the comparison were mathematical outliers.
  - The Department used this methodology to examine other states' rates across all service categories in the development of the benchmark rates.
  - The Department removed high statistical outliers in developing benchmark rates for certain surgeries and abortion services.
- For pediatric behavioral therapy rates, Nebraska was the only mathematical outlier.

Denver Health Questions 49-52

Questions 49-52
Denver Health Financials

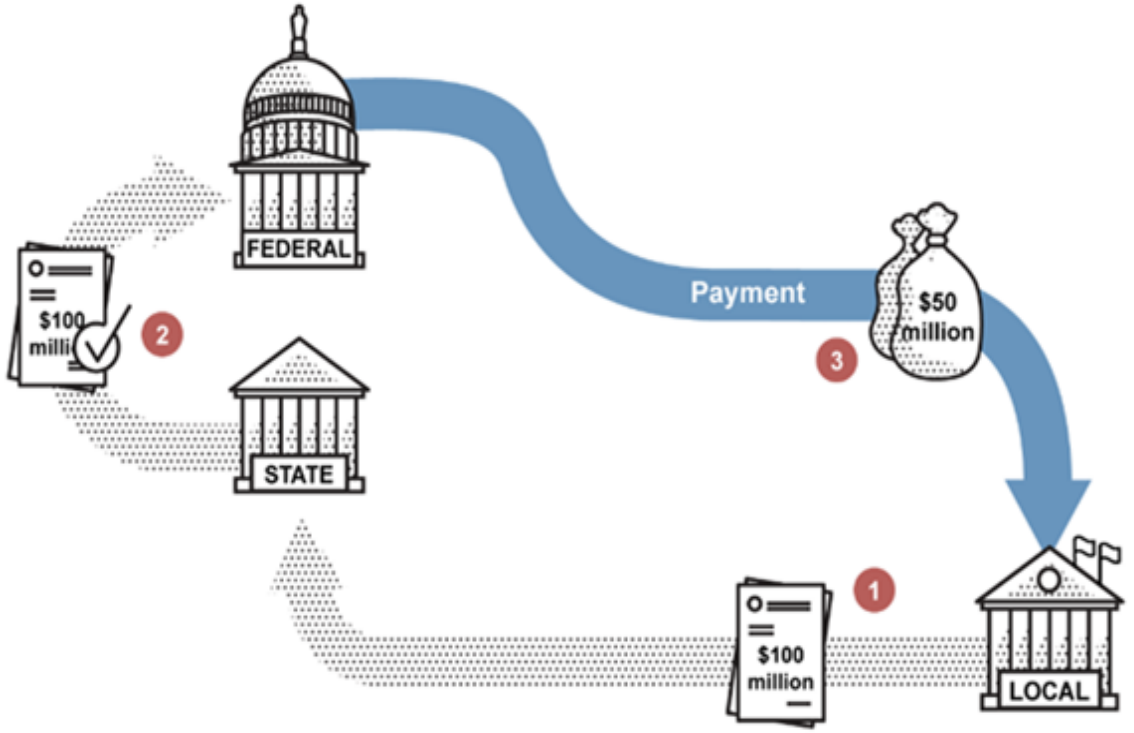
System	Calendar Year	Days Cash on Hand	Reserves
Denver Health	2019	131	$364 M
	2020	159	$441 M
	2021	117	$381 M
	2022	87	$302 M
	2023 Q1, 2 & 3	82	$297 M

System	Calendar Year	Operating Profit Margin	Operating Profit[1]	Total Profit Margin	Total Profit (including investments)
Denver Health	2019	4.8%	$54 M	11.4%	$127M
	2020	-0.1%	($1 M)	9.1%	$99M
	2021	-0.8%	($9 M)	1.2%	$15M
	2022	-1.9%	($24 M)	-4.4%	($57 M)
	2023 Q1,2& 3	0.2%	$3 M	0.8%	$8 M

General Financing Questions 53-58

Question 55: Example of a State Medicaid Payment Financed Using Certified Public Expenditures and Federal Funds

1. A local government provides Medicaid services and submits a CPE of $100 million to the state Medicaid agency for the costs of services.
2. The state reports the $100 million CPE to the Centers for Medicare & Medicaid Services.
3. Federal government provides matching federal funds in the amount of $50 million.[a]



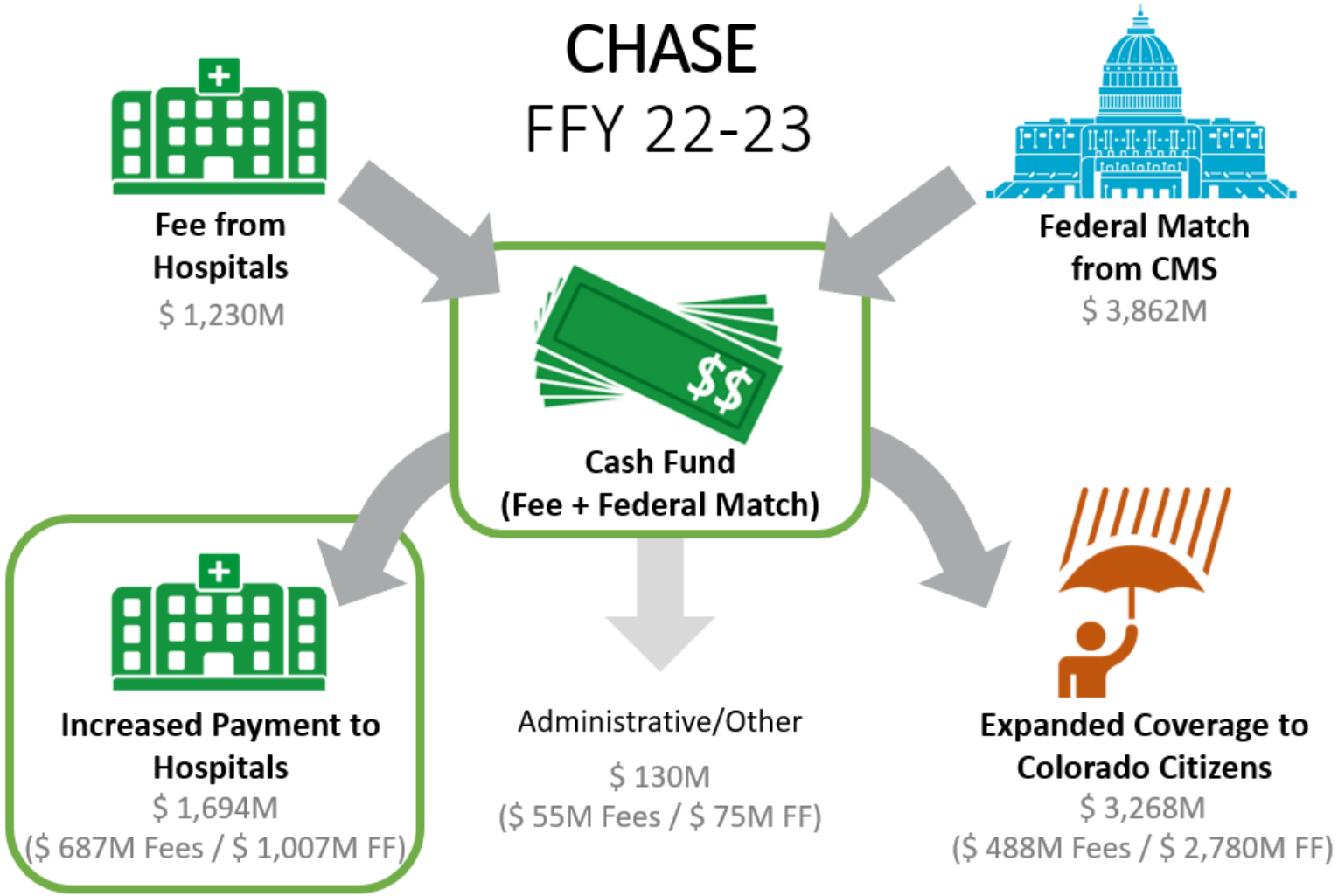
BOTTOM LINE

Federal government spent **$50 million.**
State spent **$0** in state general funds.
Local government spent **$100 million.**
Net effect on the local government: The local government spent a net of **$50 million**.

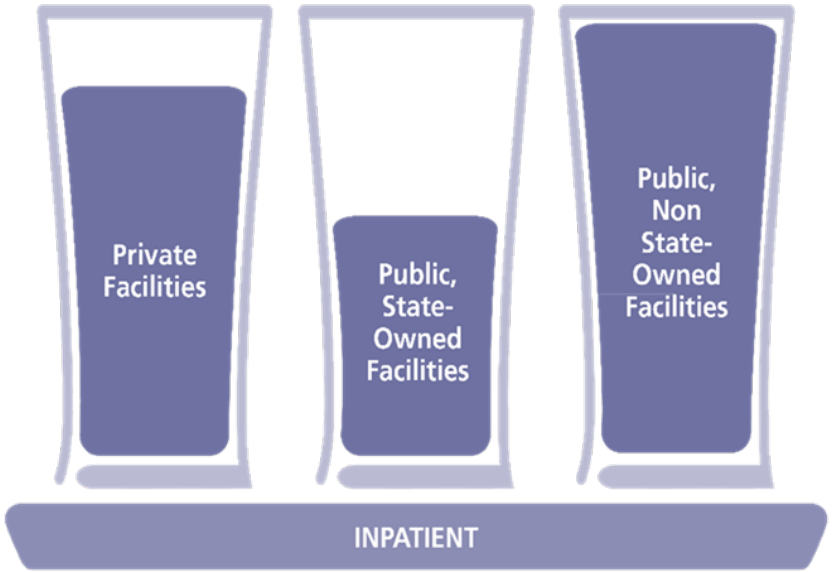
Federal share (federal government)

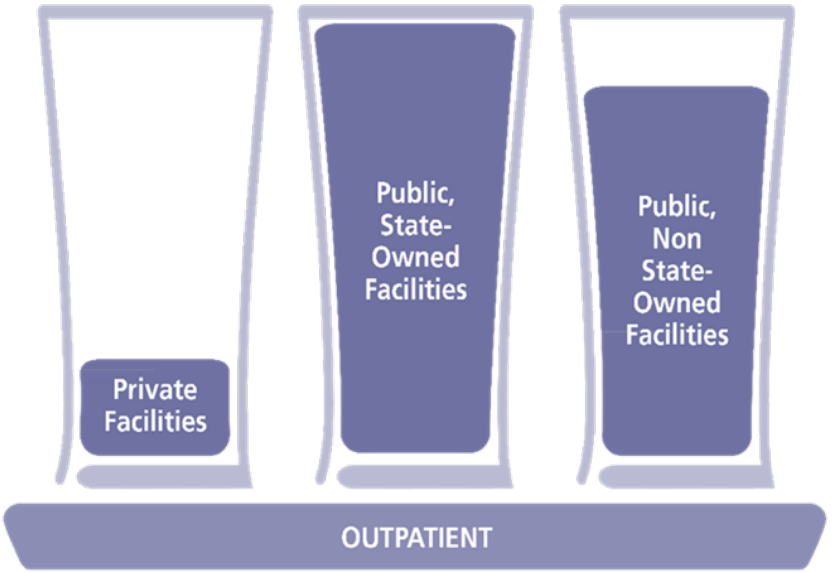
Source: Government Accountability Office, Medicaid Primer on Financing Arrangements, July 14, 2020. gao.gov/assets/gao-20-571r.pdf

Question 56

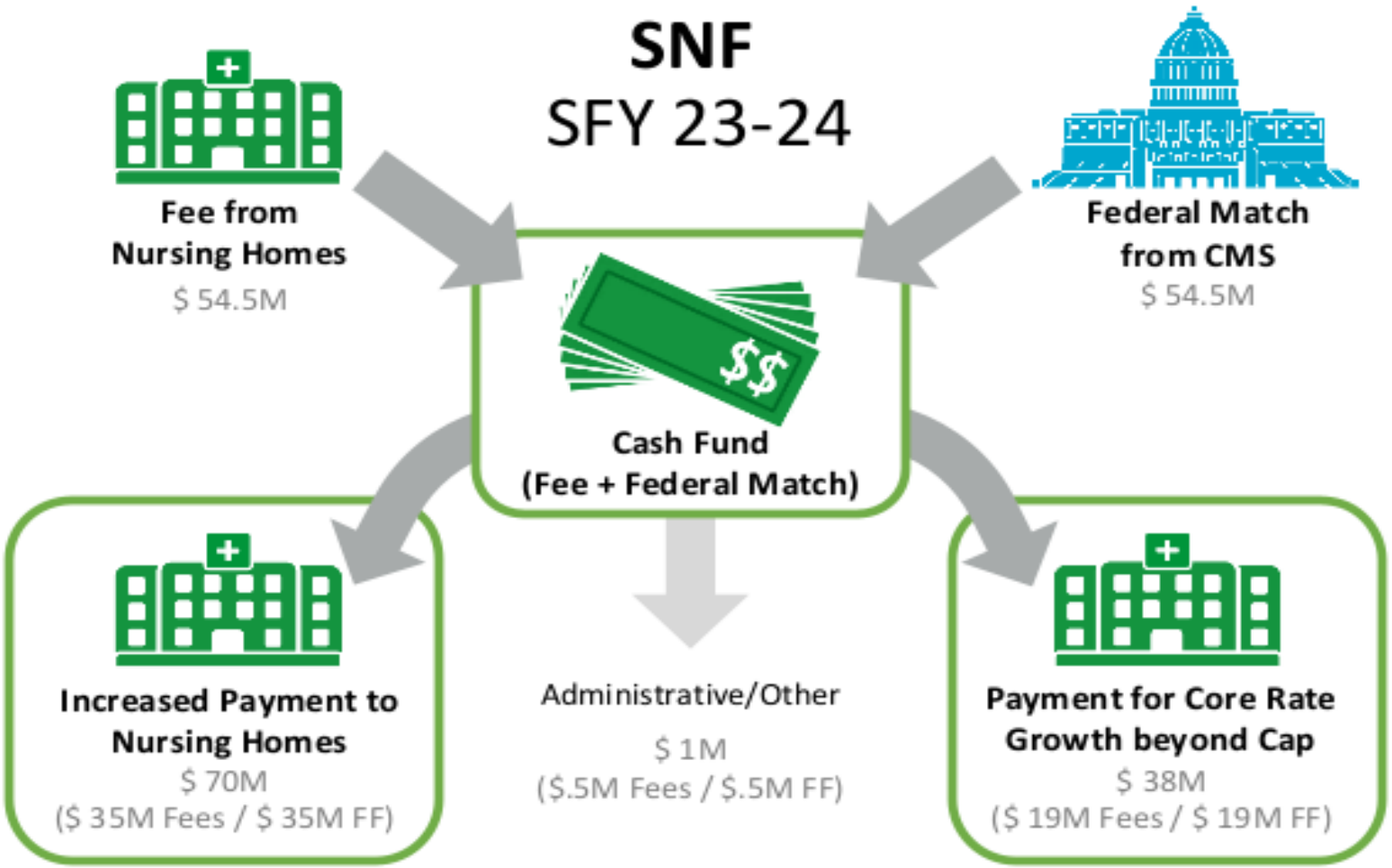

CHASE
FFY 22-23
Fee from Hospitals
$ 1,230M
Federal Match from CMS
$ 3,862M
Cash Fund (Fee + Federal Match)
Increased Payment to Hospitals
$ 1,694M
($ 687M Fees / $ 1,007M FF)
Administrative/Other
$ 130M
($ 55M Fees / $ 75M FF)
Expanded Coverage to Colorado Citizens
$ 3,268M
($ 488M Fees / $ 2,780M FF)

Question 56: Hospital Upper Payment Limits





Questions 57-58: SNF Supplemental Payments



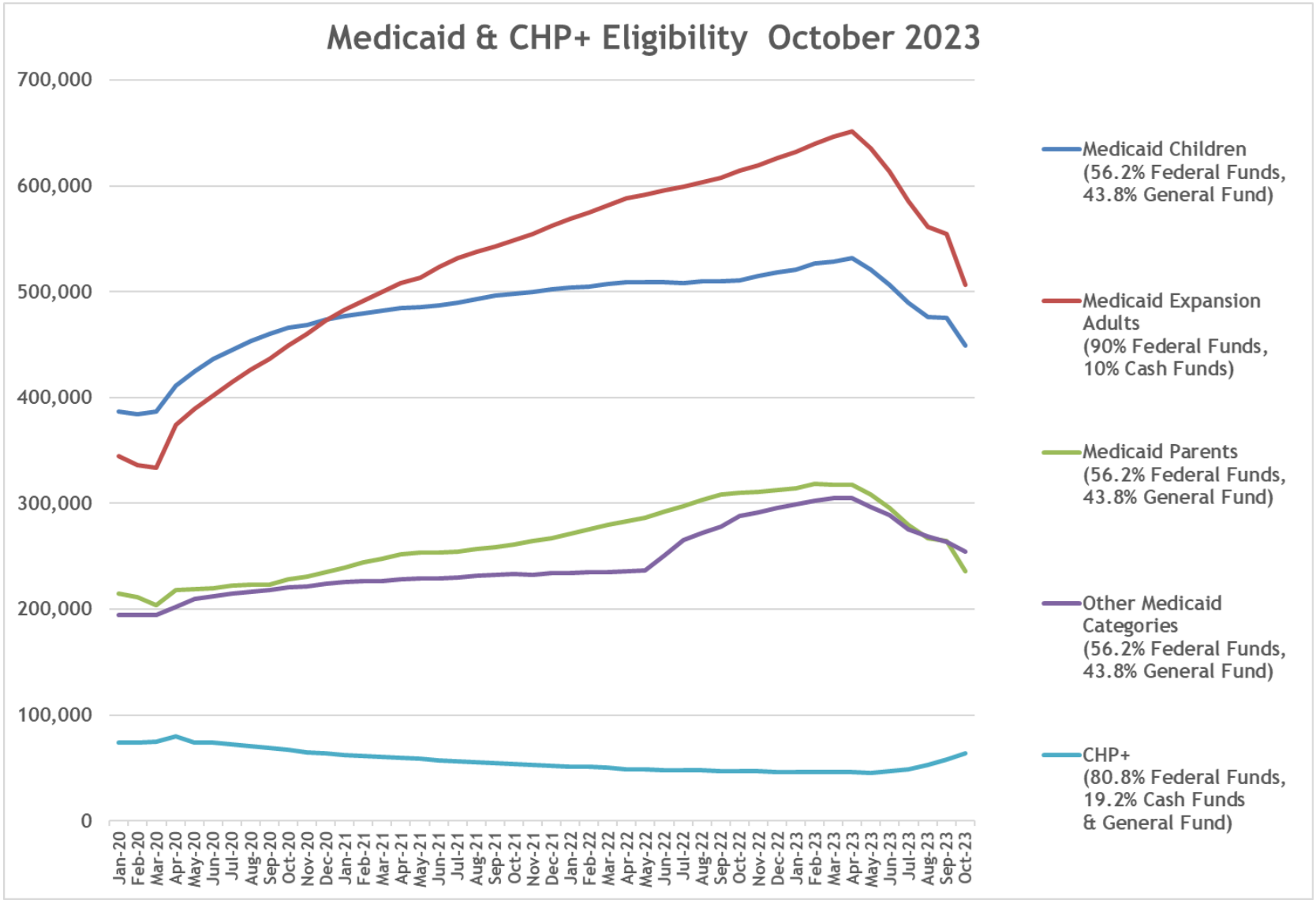
R12-14 and General Eligibility Questions Questions 59-67

Child Health Plan *Plus* Benefit Questions 68-70

Questions 68-69: CHP+ and Medicaid Differences

	CHP+	Medicaid
Authority	Title XXI of the SSA	Title XIX of the SSA
Federal Matching	65%	50% children and parents 90% expansion adults
Finance Structure	State spending matched up to a capped allotment	State spending matched with no cap
Eligible Members	Children under 19 and Pregnant People	Children & Adults
Recent Enrollment Numbers[1]	57,406	1,506,863
Income Eligibility as percent of FPL	143%-260%	147% FPL for children 138% FPL for adults under 65 195% FPL for households
Delivery System	Fully capitated managed care 4 managed care organizations, county overlap in Metro Area	Regional Accountable Entities manage capitated behavioral health benefit and care coordination Fee-for-service physical health
Additional Similarities	12-month post-partum expansion 1289 Look-alike program 0$ enrollment fee	

Question 70: Membership impact of COVID and the end of the PHE Continuous Coverage requirement

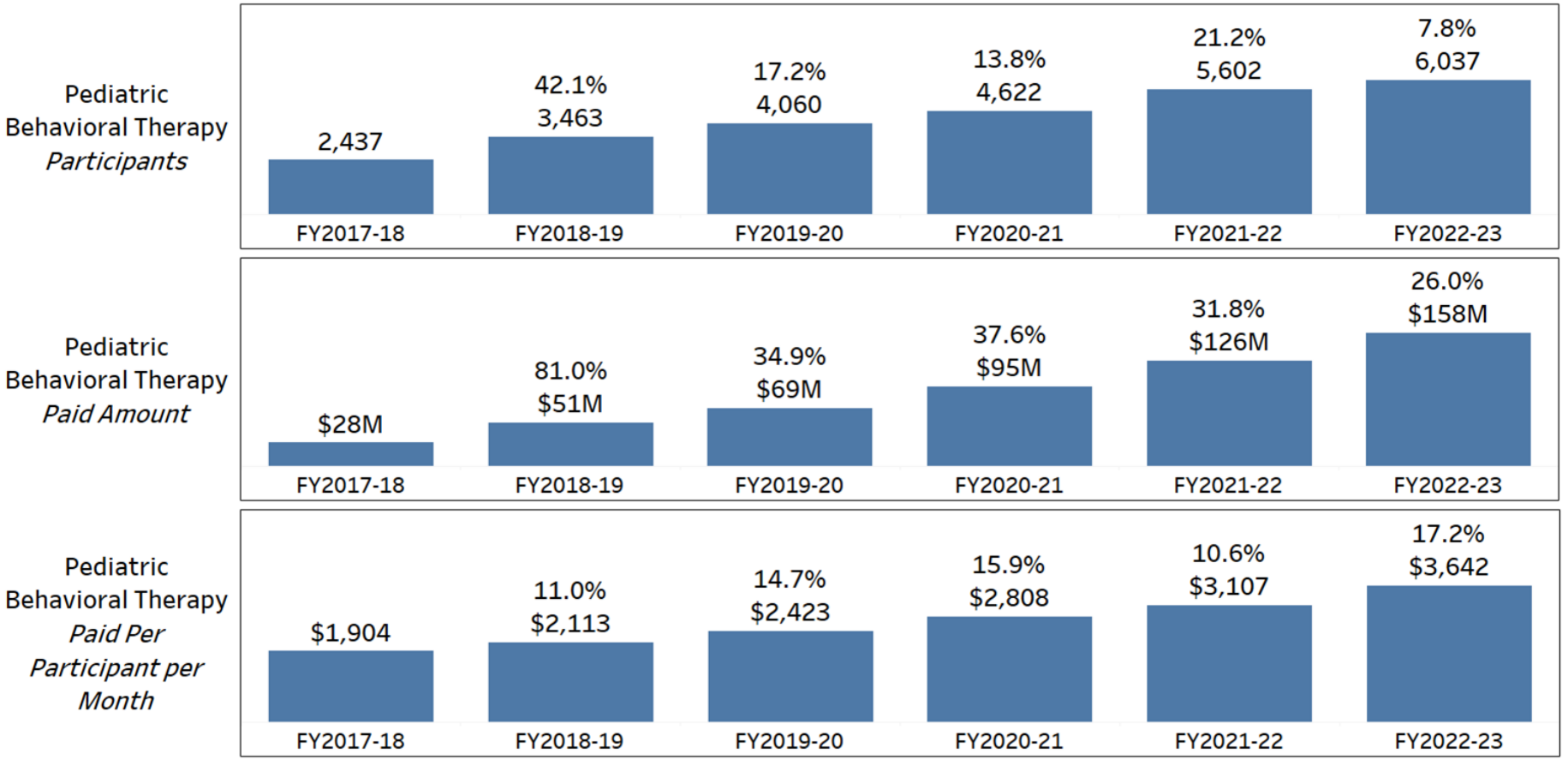


Autism Providers Questions 71-76

Pediatric Behavioral Therapy (PBT)

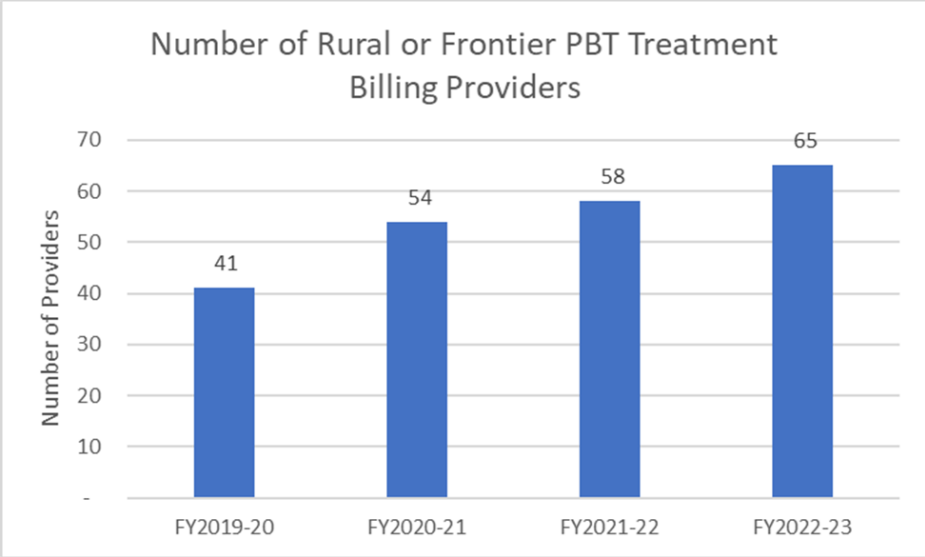
Significant increases in PBT

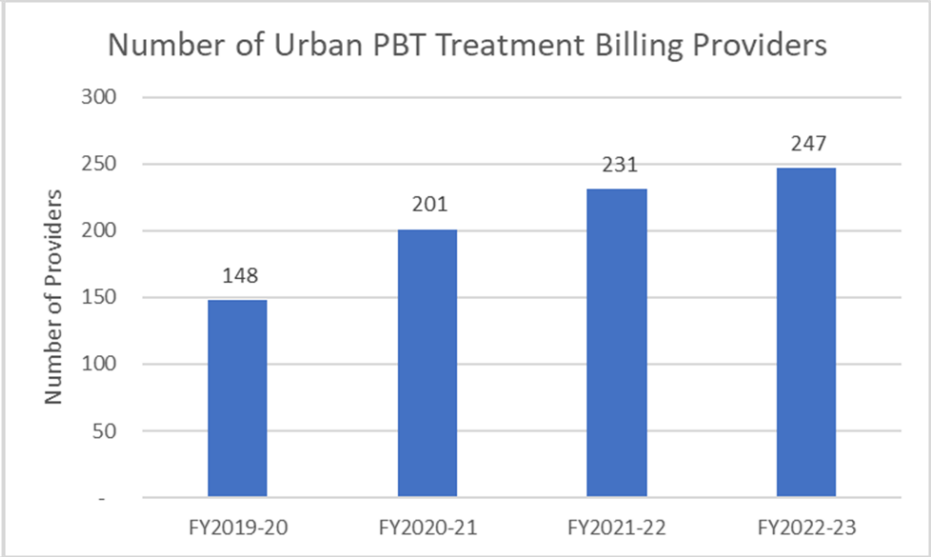
- # of children served more than doubled
- Amt. spent increased fivefold



*The percents on the top are the change from the prior FY

Rural and Urban PBT Providers





Center for Economic and Policy Research June 2023 report on private equity in autism

Office of Community Living

Kim Bimestefer, Executive Director
Bonnie Silva, Office of Community Living Director
Colin Laughlin, Office of Community Living Deputy Director

Who Receives Long-Term Services & Supports?

13%

Children & Adolescents
ages 20 & younger & qualifying former foster care youth

43%

Adults
ages 21-64

44%

Older Adults
ages 65 or older

Cross Disability

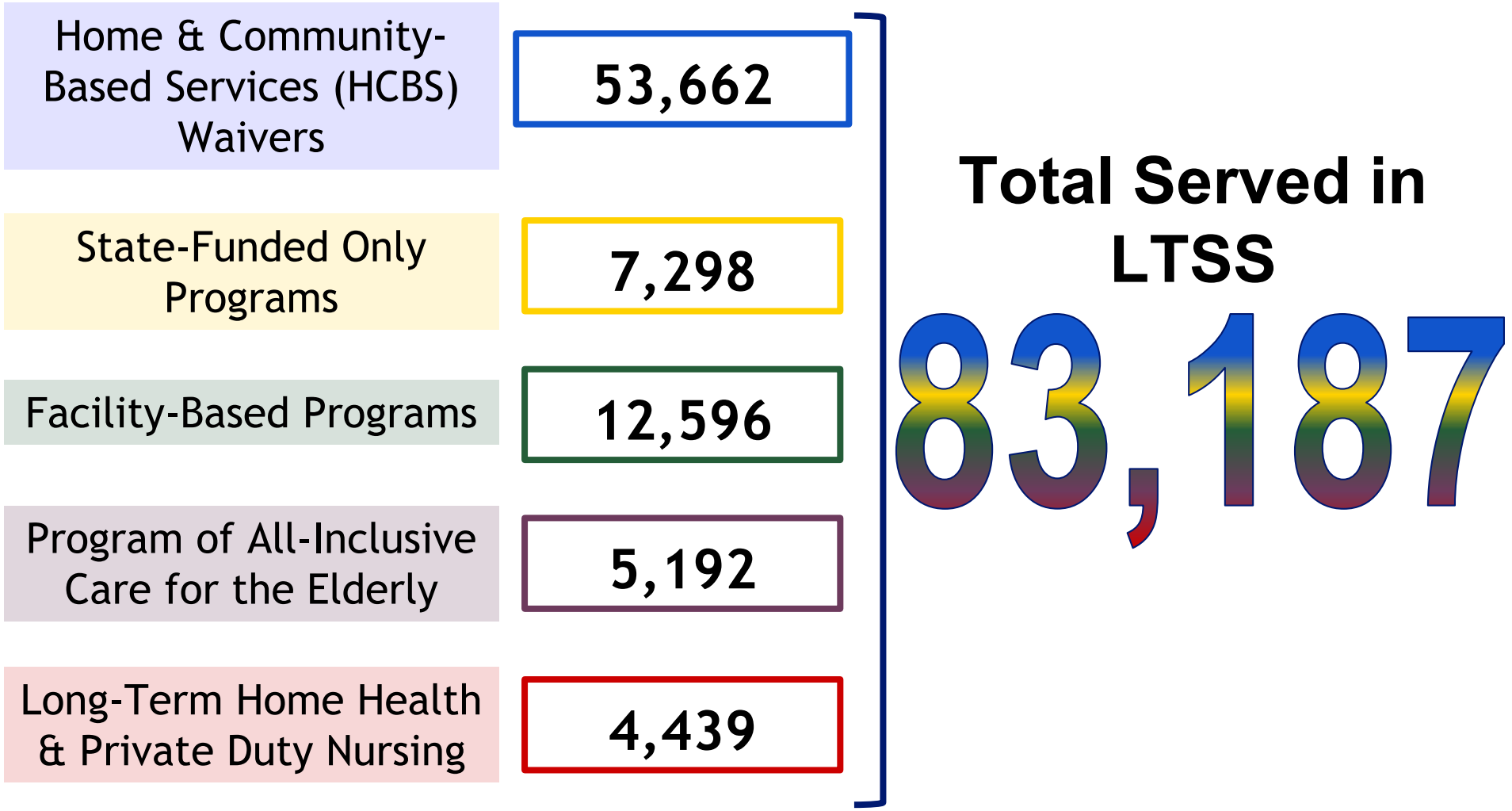
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

86% have a **chronic condition** (compared to 29% of all Medicaid members)

37% have 5 or more chronic conditions

FY 2022-23; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Long-Term Services & Supports Programs



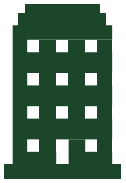
SOURCE: FY 2022-23; based on claims in MMIS.

Long-Term Services & Supports

Community-Based Care

Including Home & 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 Back-Up Program

Community-Based Program Growth Questions 77-78

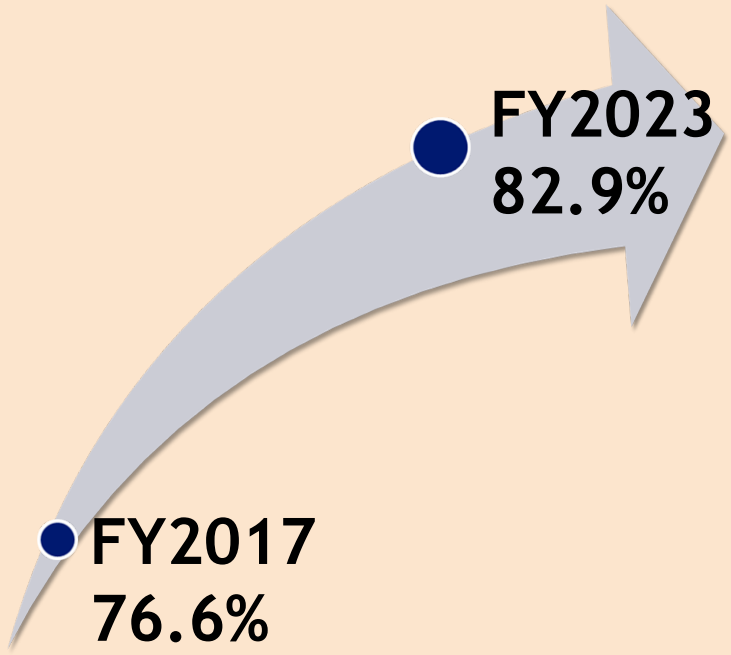
Community-Based Program Growth

Program Growth by HCBS Waiver From FY 2017 – FY 2023

Brain Injury	Children With Life Limiting Illness	Children's Extensive Supports	Children's Habilitation Residential Program	Children's HCBS
+70%	-22%	+67%	+743%	+56%

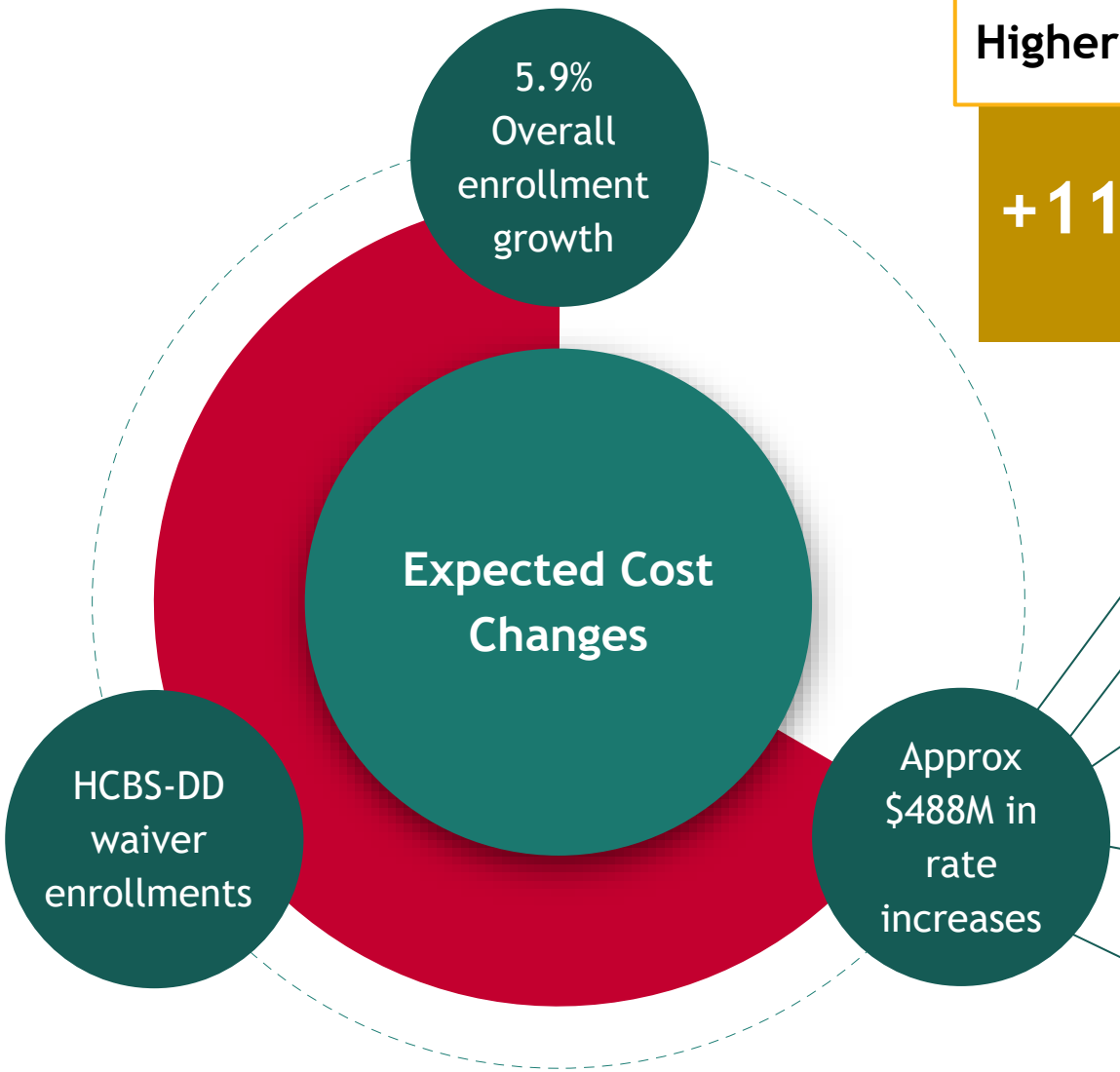
Community Mental Health Supports	Developmental Disabilities	Elderly, Blind, & Disabled	Compl. & Integrative Health	Supported Living Services
+2%	+53%	+15%	+200%	0%

% of LTSS Population Receiving Services in the Community vs. Institutions



LTSS Cost Growth Questions 79-80

FY19-20 to FY22-23 LTSS Cost Growth



Higher than Expected Cost Changes

+115% In Home Support Services expenditures as members have shifted to this service to better meet their needs

- LTSS Base Wage
- Local Minimum wage adjustments
- Across the board provider rate increases
- Targeted rate increases
- Statutorily required rate increases

Strategies for Sustainable Growth

Electronic Visit Verification

Utilization Management

Continued analysis & policy adjustments

Federal financing opportunities in alignment with other states

- Community First Choice
- Money Follows the Person
- ARPA Section 9817

Third Party Assessor
R-10
Questions 81-92

R-10 Third Party Nurse Assessor

R-10

- A request for funding to use a 3rd party nurse **assessor**
- The **assessor** will evaluate members for LTHH, PDN &/or HMA
- The implementation of the new **assessor** can occur with current process/assessment tools

ARPA HCBS

- Development of a new Skilled Care Acuity Tool (assessment tool)
- Funding approved through SB 21-286

The assessment tool is NOT part of the R-10 budget request

New Skilled Care Acuity Tool

(assessment tool)

ARPA Funded

Piloting of the tool in 2024; Implementation 2025

Tool Development
University of Massachusetts Chan Medical School (UMASS) is developing the tool with ARPA HCBS funding

Tool Strengths
Valid & Reliable
Based on research from over 50 state's tools which will objectively evaluate individual needs

Stakeholder Engagement
Began in May 2023 & will continue through 2024. Feedback built into tool development

Can be used with adults or pediatrics

Tool portions are based on the CSN & the PAT

R-10 & New Assessment Work Together

Skilled Care Services	PDN	LTHH	HMA
Assessment (ARPA HCBS)	Unvalidated PDN tool	PAT - children No tool - Adults	LOC/Task Worksheet
	Skilled Care Acuity Tool		
Assessor (R-10)	PDN provider	LTHH provider	Case Manager at CMA
	QIO 3rd Party Nurse Assessor		
URUM	Acentra		Telligen
	Single Contracted Entity		**N/A**

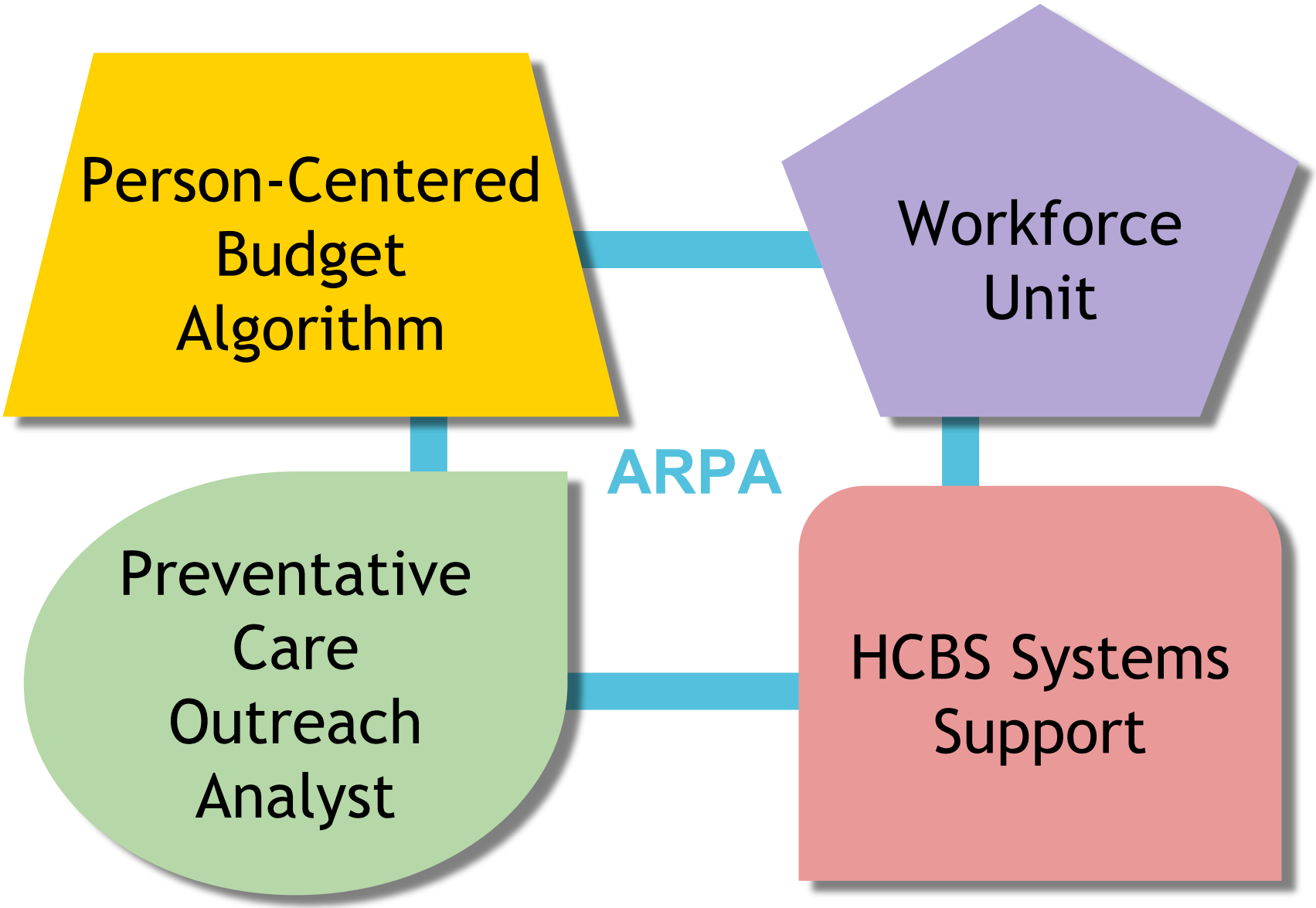
Current State Future State

Goals of R-10: Third Party Nurse Assessor

1	Member Benefits	• Reduced burden on members & their families • Enhanced expertise & education from assessor • Whole-person review- holistically skilled assessment will demonstrate the entirety of a member's needs, including a combination of services
2	Provider Benefits	• Decreased burden in determining appropriate service levels • Ability to provide scope of services with one assessment • Equitable service delivery across agencies
3	HCPF Benefits	• 75% cost match by using a QIO • Mitigate overlapping utilization & duplication across modalities of service • Eliminate potential provider conflict of interest

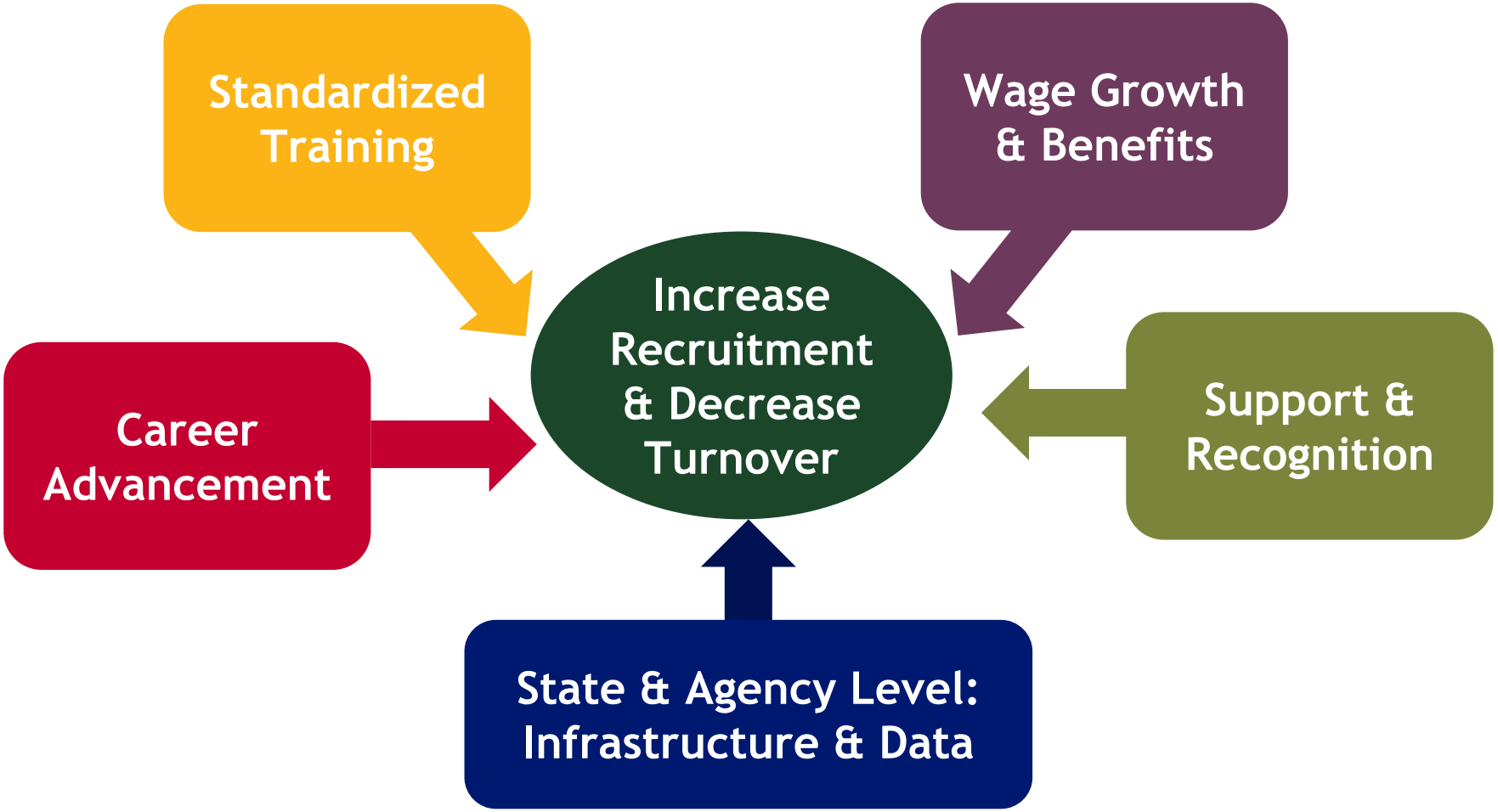
R-11
Questions 93-94

R-11 Request Overview



Direct Care Workforce Strategies

Strategies Employed by the Unit to Address the Direct Care Workforce Crisis



Stakeholder Voices

01	People Engaged	Advocacy organizations, workers, worker organizations, providers, members/ representatives of members, & representatives of state departments
02	Outreach Meetings	Active outreach through multiple strategies; engaged in nearly 100 meetings with other agencies/entities to identify areas of intersection, ways to align, & partner
03	Committee Participation	Represented on the four state-agency health care workforce committees to coordinate efforts & reduce siloed work; organized & hosted ongoing stakeholder committees
04	Regular Engagement	Routine engagement with key partners to ensure relationship building & partnership

Developmental Disabilities (DD) Waitlist Question 95-99

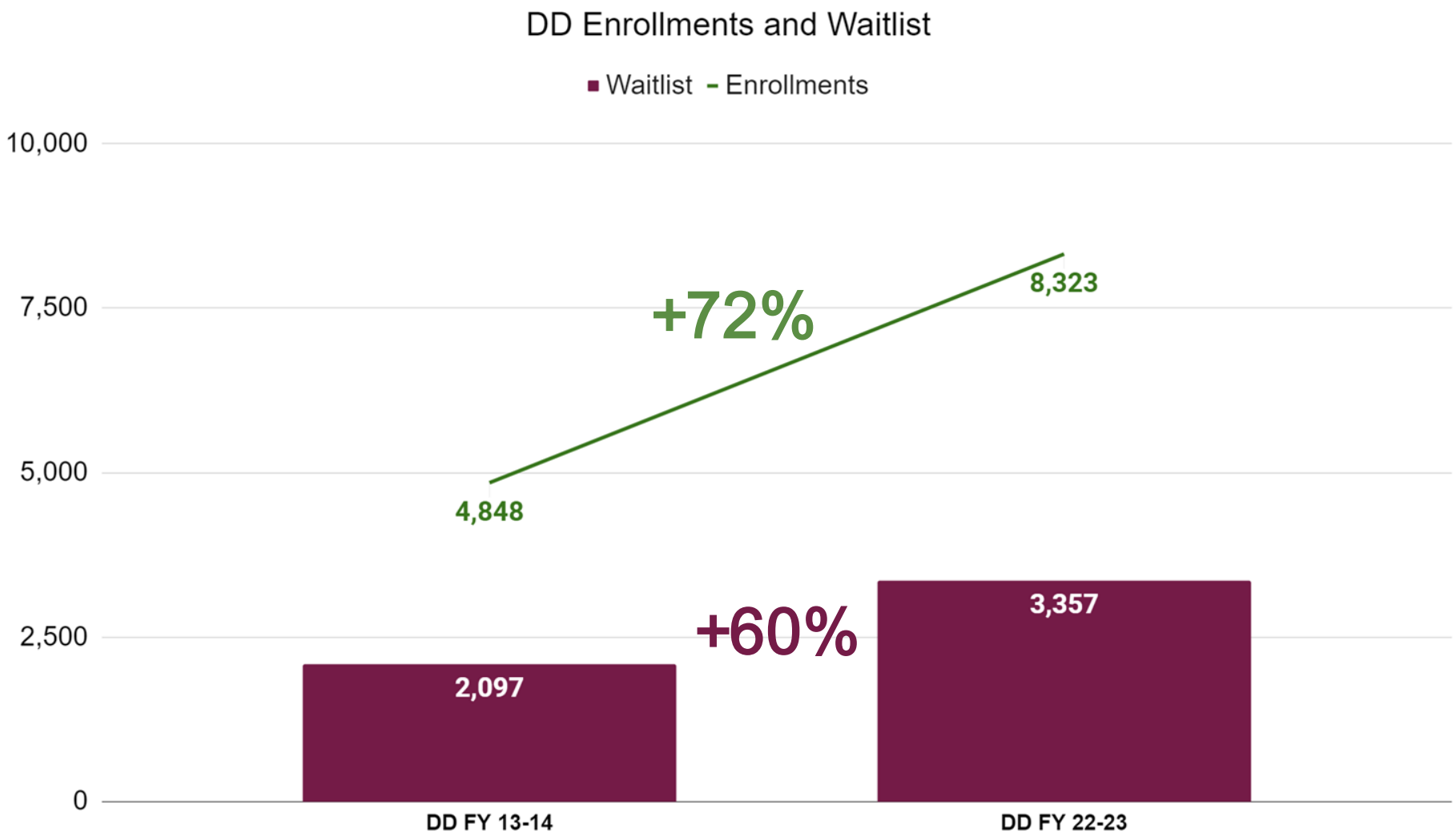
Managing the Waitlist

The Department submitted the **Intellectual & Developmental Disabilities (IDD) Strategic Plan on Nov. 1, 2014** in response to HB 14-1051 & 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 authorized through legislation
- Efficient management of the churn
- Reserve capacity enrollments

Waiting List Progress



DD = Developmental Disability Waiver

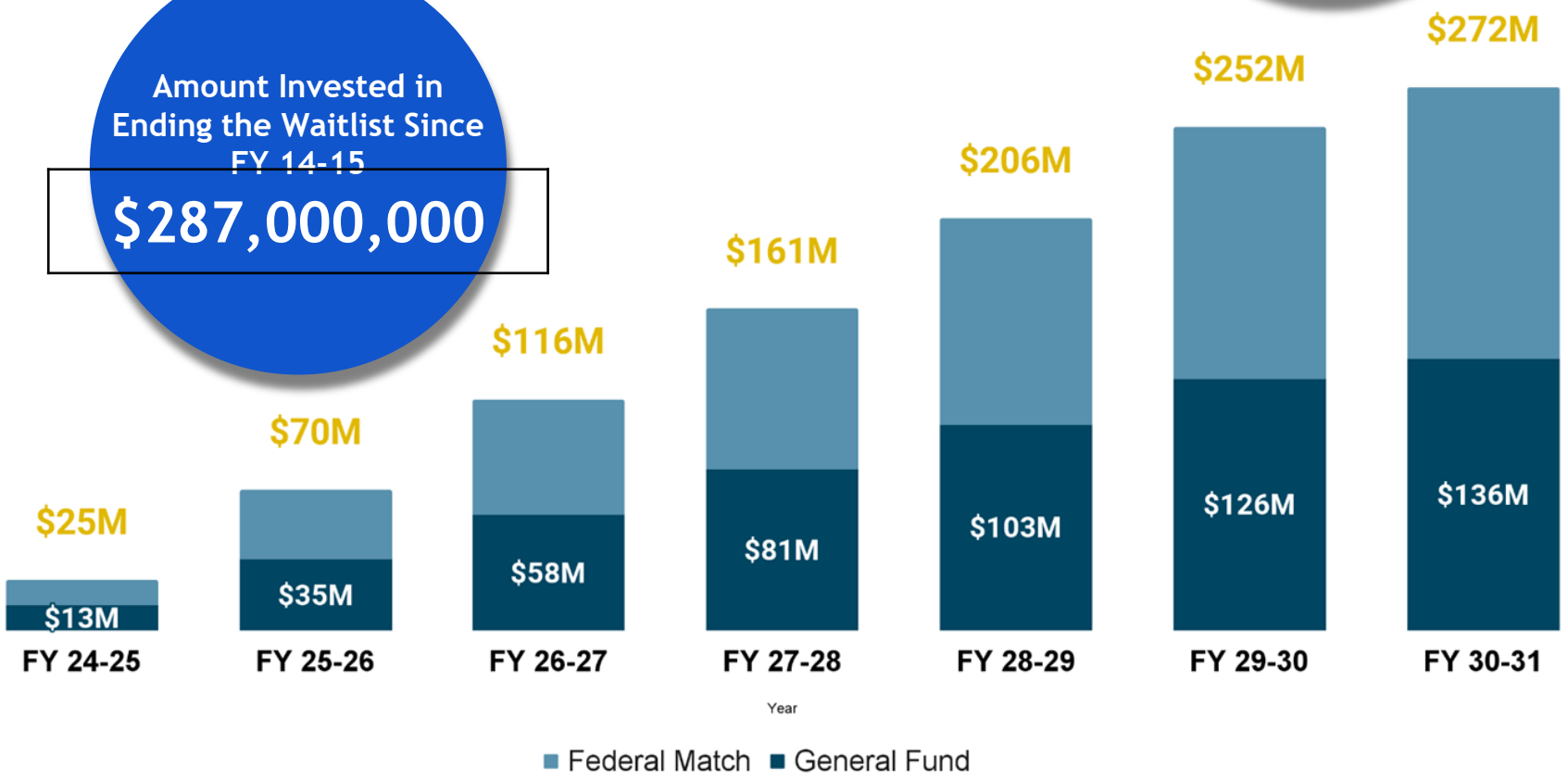
Investment for Enrollment Growth

Total cost to end the waitlist by 2031 & ~~ongoing~~

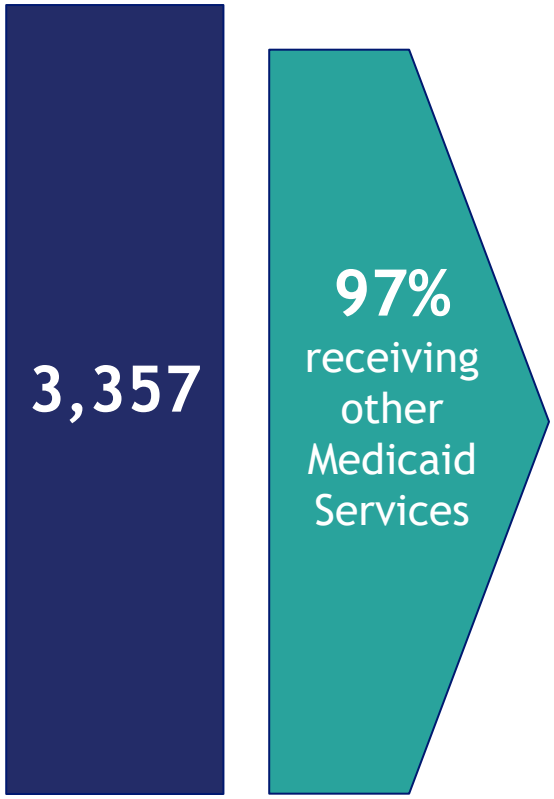
$272,000,000

Amount Invested in Ending the Waitlist Since ~~FY 14-15~~

$287,000,000

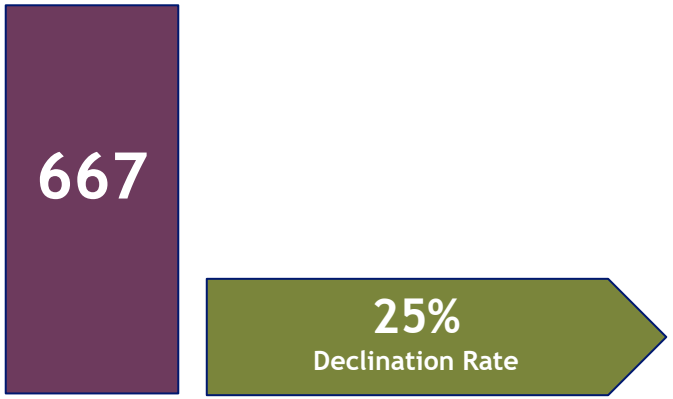


Meeting The Needs of Members



"As Soon As Available" DD Waiting List

Primary Declination Reason: Individuals reporting they are happy with their current services



New Enrollments Authorized through SB21-205

Care & Case Management System Questions 100-102

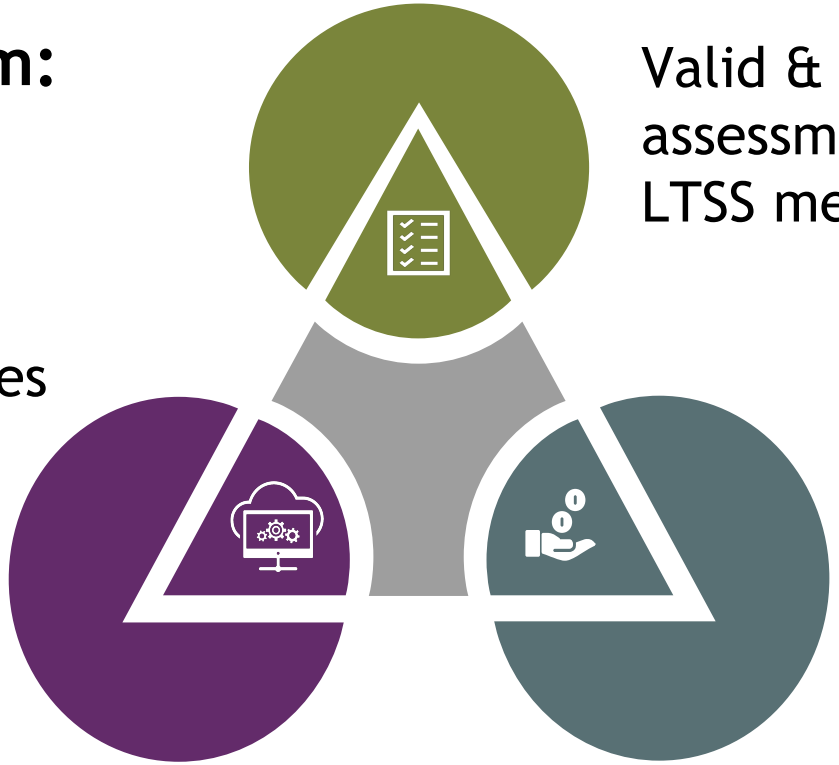
Care & Case Management System

Single Assessment Tool

Valid & reliable assessment for all LTSS members

New IT System: Care & Case Management

Supports interdependencies to streamline case manager & member experience



Person-Centered Budget Algorithm

Individualized budget range for members based on assessed needs

Thank You