DEPARTMENT OF HEALTH CARE POLICY & FINANCING
FY 2021-22 JOINT BUDGET COMMITTEE HEARING AGENDA
Thursday, Dec. 16, 2021
9 a.m. – 5 p.m.

10:00-10:20 INTRODUCTION

Main Presenters:

- Kim Bimestefer, Executive Director
- Bonnie Silva, Office of Community Living Director

Topics:

- Questions 1-4, pages 3-8, slides 19-34
- Public Health Emergency
- County Administration (R8)
- Office of Community Living

10:20-12:00 HEALTH CARE POLICY & FINANCING DISCUSSION QUESTIONS

Main Presenters:

- Kim Bimestefer, Executive Director
- Bettina Schneider, Chief Financial Officer
- Dr. Peter Walsh, Chief Medical Officer
- Tracy Johnson, Medicaid Director

Topics:

- Questions 5-28, pages 9-34, slides 35-61
- Value Based Payments
- Reproductive Health Care

12:20-1:30 LUNCH

1:30-4:30 HEALTH CARE POLICY & FINANCING DISCUSSION QUESTIONS, CONT,

Main Presenters:

- Kim Bimestefer, Executive Director
- Bettina Schneider, Chief Financial Officer
- Dr. Peter Walsh, Chief Medical Officer
- Tracy Johnson, Medicaid Director

Topics:

- Questions 29-36, pages 35-43, slides 62-64
- Provider Rates

- Medicaid Provider Rate Review Advisory Committee

3:00-3:10 BREAK

Topics:

- Questions 37-51, pages 43-62, slides 65-80
- Behavioral Health
- Other Discussion Questions: Adult Dental, Other Benefits, Home Health Prior Authorizations, Utilization Management, Prescription Drug Importation, All Payer Claims Database, Medicaid Management Information System, Compliance FTE, Contractor FTE

4:30-4:45 COMMON QUESTION RESPONSES & CLOSING REMARKS

DEPARTMENT OF HEALTH CARE POLICY & FINANCING
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DEPARTMENT DISCUSSION QUESTIONS

PUBLIC HEALTH EMERGENCY

1. **[Sen. Moreno] Please discuss how member co-pays are able to be changed if the public health emergency is still in effect.**

RESPONSE

The proposed implementation date of July 1, 2022, is not contingent on whether the public health emergency ends. The Department's R-10 budget request, which includes a request to increase co-payments for non-emergency use of an emergency room, assumes that the public health emergency will end by July 1, 2022. As a result, there would be no potential conflict between the policy and the requirements associated with the public health emergency.

However, if the public health emergency is still in effect, the increase in co-payments may still be allowable. The Centers for Medicare and Medicaid Services (CMS) has re-interpreted their earlier guidance of section 6008(b)(3) of the Families First Coronavirus Response Act and now permits the Department to increase member co-payments during the public health emergency without jeopardizing the enhanced 6.2 percentage point increase to the federal medical assistance percentage (FMAP) available during the COVID-19 public health emergency (PHE).

The Department remains prohibited from imposing cost sharing on COVID-19 related testing, treatment, or vaccination services. The Department can increase member co-payments for non-emergency hospital emergency room services while still not imposing member co-payments for COVID-19 related testing, treatment, or vaccination services.

2. **[Sen. Rankin] Please discuss the federal requirements related to the enhanced federal match rates that the state is receiving and how those requirements affect Medicaid enrollment during the public health emergency.**

RESPONSE

The Families First Coronavirus Response Act (FFCRA) stipulates what conditions states must follow in order to receive the enhanced 6.2 percentage point increase to the federal medical assistance percentage (FMAP) during the COVID-19 public health emergency (PHE). Specifically related to Medicaid eligibility during the PHE, the Department is prohibited from changing eligibility standards that make eligibility more restrictive, and the Department cannot disenroll any member even if they no longer financially qualify for Medicaid, unless the individual voluntarily terminates eligibility, is no longer a resident of the state, or in the instance of death. This provision is often referred to as the "continuous coverage" requirement. In response to any changes in circumstances during the public health emergency period, states can increase the level of assistance provided, such as moving an individual to another eligibility group that provides additional benefits, but states cannot move an individual to a group that is eligible for fewer benefits.

Once the PHE ends, the Department will begin a renewal process to verify that all members enrolled qualify to remain on Medicaid. During the PHE, the Department has maintained our traditional processes to collect updated information on members on an annual basis or when the member supplies additional information for another program they are enrolled in, such as the Supplemental Nutrition Assistance Program (SNAP). In addition, the Department will utilize information from external data interfaces that are already integrated into the Colorado Benefits Management System (CBMS), such as wage information from the Colorado Department of Labor and Employment, Equifax, and the federal data hub, to help identify if members are eligible for Medicaid. Individuals who are no longer Medicaid eligible or no longer qualify for a higher benefits program during the PHE (often referred to as the "locked-in" population) will be notified through the renewal process. At that time, they will have the opportunity (an additional 60 days) to supply updated eligibility information (such as income, resources, etc.) and documentation not available to the Department through our external data interfaces to verify that they qualify for Medicaid.

The Health and Human Services (HHS) Secretary's public health emergency declaration for COVID-19 was effective on Jan. 27, 2020, so the emergency period as defined under FFCRA began then and continues through any renewal of the HHS Secretary's public health emergency declaration. The emergency period expires after 90 days, unless further extended by the Secretary. The emergency period will end upon termination of the public health emergency, including any extensions. The PHE has been renewed several times in the past 23 months and now extends through Jan. 16, 2022, meaning states will receive the FMAP bump through March 2022. The HHS Secretary has assured states that when a determination is made to terminate the PHE or let it expire, HHS will provide states with 60 days' advanced notice.

The table below outlines the specific conditions under the FFCRA to maintain the enhanced federal match.

FFCRA Authority	Provision	Termination Date
6008(b)(1)	Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of Jan. 1, 2020 (maintenance of effort requirement).	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(2)	Not charge premiums that exceed those that were in place as of Jan. 1, 2020.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(3)	Ensure that individuals who were enrolled for benefits under the Medicaid state plan or waiver as of or after March 18, 2020, are treated as eligible for such benefits through the end of the month in which the PHE ends, unless the individual voluntarily terminates eligibility, is no longer a resident of the state or dies.	Expires the first day of the month following the month in which the PHE ends.
6008(b)(4)	Cover, without imposition of any cost sharing, testing, services, and treatments for COVID-19, including vaccines, specialized equipment, and therapies.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.

COUNTY ADMINISTRATION (R8)

3. **[Sen. Rankin] Please discuss the effectiveness of the county administration pay for performance initiative. Are the FTE for which funding is requested related to the oversight of this county incentive program? If so, please explain how the additional FTE will support and/or improve the program.**

RESPONSE

The County Incentives Program has successfully refocused counties on critical Department initiatives, while emphasizing ongoing federal and state compliance. Each year, the Department sets contract priorities with county partners and implements new performance benchmarks and deliverables. These performance standards have:

- Reduced application and redetermination backlog from FY 2014-15 through FY 2017-18, including a 32% decrease in county application backlog and a 41% decrease in county redetermination backlog.
- Made demonstrable improvements in the timely processing of long-term services and supports (LTSS) applications, with the statewide LTSS application timeliness average increasing from 67% in FY 2016-17 to 88% in FY 2019-20.
- Set new standards for county staff to complete ongoing training, with 75% of county eligibility technicians required to complete six hours of annual training. The Department recorded a 41% increase in the amount of training hours completed by county staff from baseline to FY 2017-18.
- Implemented cyber- and information security standards for county human services departments that are necessary to safeguard applicant and member information. In FY 2019-20, 81% of counties completed their remediation plans.

The FY 2021-22 County Incentives Program contracts were completely revised to align with the Department's Oversight & Accountability Program. As a result, new contract measures around the accuracy of eligibility determinations and county compliance with the Medical Assistance Performance (MAP) dashboards were added. The accuracy measures are critical to the Department's efforts at addressing county error rates.

Only one FTE was requested for the County Incentives Program; this FTE will oversee the new incentives program funding, contracts and deliverables resulting from any new quality and accuracy, customer service and other performance benchmarks the Department would establish in consultation with counties with the new funding. This position would help create contract performance benchmarks around county customer service and call center wait times and new/revised contracts, helping to achieve a lower average-speed-to-answer (ASA) wait time and increasing timeliness of LTSS eligibility determinations and redeterminations, while addressing county quality and accuracy concerns. The administrative workload to manage 64 individual county contracts often means the review of hundreds of pages of deliverables. This FTE would be critical in managing that workload and working closely with counties to successfully implement the new performance standards.

The remaining FTEs in the request are focused on addressing systems and policy errors (2 FTE), reducing the county on-site compliance cycle (1 FTE), increasing the amount of quality assurance reviews (1 FTE) and managing the county administration program (1 FTE). All these activities work in tandem to address eligibility error rates, increase compliance, and improve member experience, and are the foundation for the County Incentives Program. Additional details on those positions are in the Department's R-8 budget request.

OFFICE OF COMMUNITY LIVING

4. **[Rep. McCluskie] Please discuss the delays related to the implementation of S.B. 16-192 (Single Assessment Tool).**

RESPONSE

SB 16-192 set out an ambitious multi-year transformational goal—one that will affect nearly 60,000 Coloradans with disabilities.

At the time SB 16-192 was created, the Department estimated, with the information known at the time, it would take approximately five years to implement. However, the language in the bill directs the Department to implement as soon as practicable, understanding a specific deadline with such a complex project with so many unknown variables would be difficult to predict. Now, with the work fully scoped, it remains largely on track for implementation within the expected timeline.

The intent of SB 16-192 was to develop a comprehensive assessment and support planning process for Coloradans who need long-term services and supports (LTSS). This work includes creating not just the single assessment tool, but also a person-centered budget algorithm, both of which require a sophisticated IT system that is integrated with other systems.

The process of designing and implementing a customized IT system that replaces multiple legacy systems, while also interfacing with other existing systems, is complex and requires extraordinary coordination. This project also involves eligibility determination and the authorization of services. The goal has been and will continue to be for the Department to implement this work in a way that does not create unforced errors, and ensures confidence for the nearly 60,000 people with disabilities whose services depend on the accuracy of these tools.

The implementation of SB 16-192 requires three distinct and interdependent projects—each with its own complexities that are critical to get correct:

1. Development of an assessment and person-centered support plan.
2. Development of the person-centered budget algorithm (PCBA) based on the new assessment.
3. Implementation of a new IT system to house the new assessment and person-centered support plan, the PCBA, and all case management business requirements. Key sub-projects of this work include:
    - Development of interfaces with other systems, including the Bridge and interChange, and establishment of streamlined eligibility between Colorado Benefits Management System via PeakPro;
    - Data migration and decommissioning of the Benefits Utilization System (BUS) and DDDWeb systems.

Accomplishments to Date

To date, the Department has made substantial progress toward these goals and this project is largely on target for implementation.

- The Department, in collaboration with stakeholders, developed, piloted, and finalized a new single assessment tool and person-centered support plan using nationally recognized standards in 2020.
- The Department completed requirement verification sessions for all system functionality/business needs in 2021.
- The Department is on track to finalize technical design specifications for all case management functions and the assessment documents, mapping legacy data points, testing completed functionality, and developing member communications and case management training materials by the end of December 2021.
- The Department has engaged stakeholders in early discussions on the PCBA and will develop and begin to pilot the PCBA over the next year.
- Due to the COVID-19 pandemic, the Department requested and was approved for roll-forward authority of SB 16-192 implementation funding for FY 2021-22 to ensure adequate data collection prior to development of the PCBA.

Implementation Complexity

While substantial progress has been made, given the complexities of this project, there have been some challenges to the implementation of SB 16-192. With the critical impact to the members served through LTSS programs, the Department is committed to a successful implementation. These complicating factors for implementation specifically include:

- Identification of a previous vendor's lack of expertise in automation which required the Department to secure a new vendor mid-development
- Insufficient data from the new assessment to inform the building of the PCBA
- Extended time and diligence required to connect the IT system with current systems
- Complexity of consolidating current systems into the IT system
- Adequate resources and time required to fully prepare case management agencies and their individual case managers for the roll-out of the new tools

To mitigate for these challenges, the Department adjusted the implementation date to ensure adequate time to test the IT system functionality for the assessment and support plan, mitigate any defects and align interfaces. An implementation date of April 2022 also provides extensive time for training and preparation for Case Management Agencies and allows for a data driven approach for the PCBA development to fully realize the goals of SB 16-192.

We anticipate a successful implementation of the IT system, including the single assessment tool which includes the level of care screen, the needs assessment and the person-centered support plan in April 2022. After successful implementation, critical data used to build the PCBA can be collected, and development and finalization of the algorithm can begin in earnest.

VALUE BASED PAYMENTS/R6

5. **[Rep. McCluskie] Does the Department plan to participate in a Centers for Medicare and Medicaid demonstration project during which the effectiveness of the alternative payment models in the three practice areas for which funding is requested will be evaluated? If so, please provide information concerning the evaluation of the project(s).**

RESPONSE

The Department intends to participate in a Centers for Medicare and Medicaid Services (CMS) demonstration project through a State Transformation Collaborative (STC). Colorado was selected in December 2021 as one of only four states to participate in the STC. Should the General Assembly support the Department's budget request, the STC would provide for primary care collaboration, aligning the Department and the Medicare program in the proposed partial capitation model. All CMS demonstration projects, including this proposed project, have a formal evaluation component.

That evaluation would be performed by the Center for Medicare and Medicaid Innovation (CMMI), which is the administrative subdivision of the CMS that runs the STC demonstration and many other demonstrations. The evaluation will follow the statutory guidelines provided for at section 1115A(b)(4) of the Social Security Act, which have certain required components, but otherwise give broad latitude to the CMMI in terms of evaluation approach and design. The required components are an evaluation of the quality of care provided and the change in spending occurring because of the implementation of the model. Furthermore, CMMI is statutorily required to release its evaluations to the public.

However, the CMMI evaluation would only include what Medicaid and Medicare align on. This would only be some portion of the primary care portion of R-6. Any details of the CMMI evaluation are unknown at this point and may be on a long time horizon given the multi-year nature of Alternative Payment Model (APM) design and implementation. Exact details must be developed for when alignment will occur and on which part of the model. Due to the unknown scope and timeline, to be transparent to stakeholders and to make improvements to the partial capitation model that funds for a state funded independent evaluation are critical to success. Therefore, the Department has requested funding for an independent evaluation as part of the R-6 request for all of the programs included in the request, and would share results of the evaluation publicly to inform updates to the programs through an annual stakeholder engagement process for each program.

6. **[Rep. McCluskie] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established models focused on shifting health care from fee-for-service to value-based care. Please discuss any models established at the federal level specific to Medicaid or the three practice areas for which funding is requested.**

RESPONSE

Regardless of the models established at the federal level, the Centers for Medicare and Medicaid Services (CMS) has encouraged state Medicaid agencies to adopt value-based payments and stated their expectations in State Medicaid Director Letter 20-004.[1] State Medicaid agencies lag far behind Medicare and commercial insurers in the adoption of APMs and CMS is strongly encouraging states to ramp up their adoption. This may become a requirement in the future, but at this time is not a federal requirement. CMS is pushing states to meet the targets for the adoption of advanced APMs set by the Health Care Payer – Learning and Action Network, which would require 25% of payments be made through advanced APMs by 2022 and 50% of payments be made through advanced APMs by 2025. Nationally in 2019, only 8.3% of Medicaid payments went through an advanced alternative payment model versus 30.1% payments made by commercial payers and 40.9% of payments made by the Medicare program. The R-6 request is paramount to meeting the goals that CMS has set for state Medicaid agencies.

Except for the State Transformation Collaborative initiative discussed in the prior response, CMS does not have any current models either under MACRA or in its Center for Medicare and Medicaid Innovation (CMMI) that are specific to the proposed alternate payment methodologies.

7. **[Rep. McCluskie] The request indicates that the alternative payment models will be developed in partnership with the Division of Insurance and the Department of Personnel to establish an aligned approach to value-based payments in the State. Please discuss the roles of each of the Departments.**

RESPONSE

The Division of Insurance (DOI) and Department of Personnel & Administration (DPA), who represents the state employees' health plan, are working with the Department to find payment

[1] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf

policy alignment between government health plans such a Medicaid and the state employee plan, as well as commercial insurers regulated by the Division of Insurance. Fragmentation between different payers' alternative payment models (APMs) makes it difficult for providers to engage in multiple APMs due to the many different quality measures or focus areas. Fragmentation also reduces the success of the goals the policy intends to achieve, such as affordability, health equity, or improved outcomes. Specifically, many health systems and providers report upwards of 50-60 quality metrics to different payers, which limits the impact of the alternative payment models. To ease administrative burden on doctors and providers and to maximize effectiveness of alternative payment models, the different state agencies are working together to align where possible.

The Division of Insurance is responsible for coordinating and gathering feedback from commercial insurers and for formulating regulation in line with their authority from HB 19-1233. The Division is also responsible for working with commercial health plans and the Colorado Business Group on Health on securing employer input and engagement. The Department of Personnel and Administration is responsible for actively participating in alignment discussions and, if possible, to incorporate agreed upon areas of alignment into the state employee health plan to drive improved results. The Department is responsible for leading the strategic development of the payment policy to drive results; ensuring its compliance with federal and state regulations; hosting Medicaid stakeholder engagement; contracting with third party Medicaid consultants and actuaries who assist in this work; housing and accessing the utilization data to run the performance models; securing approval for future payment policies by CMS and the state; coordinating with CMS to engage Medicare where appropriate; calculating the impact of Value Based Payment (VBP) models on Medicaid trend, quality, equity, outcomes; and actively participating in alignment discussions.

8. **[Rep. McCluskie] The Department intends to make provider participation in the alternative payment models mandatory. Since participation in Medicaid itself is not mandatory, how will the Department ensure that the number of Medicaid providers will not decrease when the models are implemented?**

RESPONSE

The Department is modeling this initiative off the alternative payment model program with mandatory provider participation used by Tennessee. Tennessee has had zero providers drop out of serving Medicaid members due to their mandatory alternative payment models. The Department will actively monitor the provider network to ensure network adequacy for Medicaid members.

The Department believes that the alternative payment models have positive factors, which may increase provider participation in Medicaid. For instance, value-based payments give providers

flexibility away from traditional fee-for-service revenue and are a way to earn additional revenue by improving quality outcomes. Additional revenue is generated from reductions in avoidable clinical events such as avoidable hospital readmissions, not from services rendered only in the provider's own location. In addition, the Department is supporting providers in the mandatory alternative payment models by requesting funding for data systems to provide actionable clinical information to providers, helping to influence their success in the alternative payment models.

9. [Rep. McCluskie/Sen. Moreno] Please describe the Department's stakeholder engagement process and level of stakeholder engagement to date.

RESPONSE

The Department employs a robust stakeholder engagement process for all alternative payment models developed, which includes engagement from providers, organizations which represent providers such as the Colorado Hospital Association or the Colorado Medical Society, consumer advocates, key partners (i.e.: RAEs) and Medicaid members. The Department has engaged with providers from both rural and urban areas to capture the challenges and differences in care for rural areas. The Department has performed stakeholder engagement for each of the models proposed in the R-6 request. An in-depth explanation for each program is included below.

Maternity Bundled Payment:

Stakeholders have been and will be consistently involved in the design and operation of the Maternity Bundled Payment program. During the first program year from October 2020 to November 2021, the Department formed a new Maternal Advisory Committee (composed of primarily Black, Indigenous and People of Color Health First Colorado members with lived experience in Colorado Medicaid maternity care) to bring members' perspectives, insights, and knowledge to the program. The Committee has been involved in the selection and approval of the quality measures for the second program year and will continuously contribute to the program operation and evaluation moving forward with a focus on patient experience and health equality.

The Department also collaborated with a diverse group of consumer and member advocates to learn about emerging concerns and care models in maternal care. The Department has updated the program's incentive payment model to address substance use disorder and mental health issues, as well as promote midwifery care based on their valuable input. The Department has also made numerous changes based on stakeholder feedback to promote health equity through the maternity bundled payment including adding a health equity gateway to incentive payments and requiring providers who join the program to take cultural competency training. In future program years, the

Department is devoted to implementing a formal program evaluation through collaboration with the advocacy groups to measure and ensure program effectiveness. Key program stakeholders for the Maternity Bundled Payment program include:

- Health First Colorado members: Maternal Advisory Committee , etc.
- Consumer advocates: Colorado Perinatal Care Quality Collaborative (CPCQC); Elephant Circle, Colorado Children's Campaign, Colorado Consumer Health Initiative (CCHI), Colorado Center on Law and Policy (CCLP), Colorado Organization for Latina Opportunity and Reproductive Rights, Family Forward Resource Center, Colorado Community Health Network (CCHN), etc.
- Maternal care providers/specialists: urban and rural obstetrical providers, certified nurse midwives, mental health & substance use disorder clinicians, Regional Accountable Entities (RAEs), etc.
- Professional networks: Colorado Medical Society (CMS), American College of Obstetricians and Gynecologists (CO-ACOG), Colorado Academy of Physicians, etc.
- Other state agencies: Department of Public Health & Environment, Division of Insurance, Department of Personnel & Administration etc.
- The Department's internal advisory committees/SMEs: Program Improvement Advisory Committee (PIAC), Maternal Advisory Committee, Maternal Child Health team, etc.

Partial Capitations to Primary Care Providers (APM 2):

Stakeholders have been and will be consistently involved in the design of the APM 2 program. The APM 2 program convened a stakeholder group to collaboratively design the payment model included in this request. The group consisted of physicians (family medicine and internal medicine physicians, and pediatricians), consumer advocates, practice administrators, and RAE representatives. The group consisted of providers and practice administrators from both urban and rural areas of the state. The 41 members of the Model Design Team (MDT), together with members of the Department and the Department's actuary, held eight work group sessions from March 2021 to June 2021, where they fleshed out all components of the partial capitation and chronic condition episodes. Members of the model design team came from diverse backgrounds such as:

- The Colorado Medical Society
- Colorado Academy of Family Physicians
- A scholar from the Farley Health Policy Center at CU
- Colorado Chapter of the American College of Physicians
- Practice Innovation Program at CU
- Colorado Association for School-Based Healthcare
- Denver Health
- University of Colorado School of Medicine
- Children's Hospital Colorado

- Healthcare Consulting Inc.
- Pediatric Care Network
- SCL Health/Saint Joseph Hospital GME Community Clinics
- Summit Medical Clinic
- Primary Care Partners
- Miramont Family Medicine
- Gunnison Valley Family Medicine
- Pediatric Partners of the Southwest
- Planned Parenthood of the Rocky Mountains
- Nextera Healthcare
- Every Child Pediatrics
- Stepping Stone Pediatrics
- Children's Medical Center
- Colorado Community Health Alliance
- Colorado Access
- Rocky Mountain Health Plans
- Community Reach Center
- Sunrise Community Health

In addition to the MDT, the Department attended two Member Experience Advisory Council (MEAC) meetings to gain valuable insight into primary care access from the member perspective. The Department also engages in a public annual stakeholder process for the quality framework portion of the APM 2. Primary care providers, consumer advocates, representatives of professional organizations, and the general public are invited to give feedback on which quality measures will be used in the program.

The Department is committed to making changes based on stakeholder feedback and we have made many changes to the model design based on the collaborative process outlined above. Changes the Department has made based on stakeholder feedback include: removing any risk to primary care doctors from both the partial capitation and chronic condition episode design, a strong focus on health equity, having three mandatory quality measures as part of the quality framework, and the addition of a pediatric focused APM to meet the needs of this unique population based on feedback from pediatricians about differences between adult and pediatric patients.

Moving forward, the Department will be continuously engaging with all stakeholders through our annual stakeholder engagement activities. Key program stakeholders for the APM 2 program include:

- The general public
- Health First Colorado Members
- Regional Accountable Entities (RAEs)

- Consumer Advocates: Colorado Center on Law and Policy and the Colorado Consumer Health Initiative
- All Primary Care Medical Providers (PCMPs) enrolled in the ACC
- Professional Networks: Colorado Medical Society, Colorado Academy of Family Physicians, American Academy of Pediatrics- Colorado Chapter
- University of Colorado School of Family Medicine
- Practice Innovation Program
- Pediatric Care Network
- Children's Hospital Colorado
- Boulder Community Hospital

Pharmacy Prescriber Tool Alternative Payment Model:

Stakeholders have been and will be consistently involved in the design of the Prescriber Tool alternative payment model. The stakeholder engagement process for the Prescriber Tool alternative payment model has been ongoing and has occurred in phases. The Department began the process by convening "key informant interviews" with internal and external groups and organizations in August and September 2021. This initial engagement was designed to inform the Department of the landscape of utilization of the Prescriber Tool across Colorado, as well as identify outstanding challenges related to prescribing, both for providers as well as members. This engagement was also designed to preview the design of the alternative payment model to get feedback on preliminary considerations for the model design. These include representatives from diverse backgrounds such as:

- Colorado Academy of Family Physicians
- Colorado Hospital Association
- Colorado Community Health Network (CCHN),
- One Colorado
- University of Colorado Department of Family Medicine
- Individual medical providers (specialists and primary care) enrolled in Medicaid
- Disability advocates
- Colorado Center on Law and Policy

The next engagement period involved a statewide survey that was administered electronically in September 2021 to provide a wider group of practices with an opportunity to share if they are using the tool, self-reported timelines about expected implementation if the tool was not currently functional with their electronic health system, and overall familiarity with the tool and its functions. This survey provided further context for operational considerations of the alternative payment model design. It also gave the Department information to consider in developing educational and outreach materials for practices to inform them about the Prescriber Tool and the corresponding alternative payment model.

The most recent stakeholder engagement involved small workgroups. This initiative gave the Department feedback on the proposed model design and the Department made changes to the design based on the valuable stakeholder feedback received. These groups were convened for three weeks in October and November 2021, and included diverse participants from both urban and rural areas such as:

- Colorado Chapter of the American College of Physicians
- University of Colorado Family Medicine
- SCL Health
- Mountain Blue Cancer Center
- Centura Health
- Highlands Health for Family Medicine Clinic
- Peak Vista Community Health Center
- Mountain Family Community Health Center
- Valley Wide Health Systems
- Salud Family Health Centers
- Colorado Community Health Network (CCHN)
- Independent Specialists
- Regional Accountability Entities (RAEs)

The Department plans to continue stakeholder engagement that will center around provider education about the model and the Tool in the form of public webinars sent to all Medicaid providers in Colorado in spring of 2022, as focused by the feedback articulated by stakeholders in the mentioned engagement activities. The Department plans to engage all providers who are prescribers serving Medicaid members through the public webinars as well as the general public. The Department also plans to design a program to support peer-to-peer education about the model and Tool before the launch of the alternative payment model. This engagement will provide further support for Tool uptake in the provider community across Colorado.

Providers of Distinction:

The proposed Providers of Distinction initiative is at an earlier phase of the planning process than the other three items in the request. It has not yet had the extensive stakeholder review and involvement at the level of the three other initiatives above. However, the Department's planning does include an expectation of a similarly extensive process. The budget request reflects this fact; the funding requested for use in Providers of Distinction is greater than the other three. This is because the large majority of that stakeholder work is in the future under the Department's project planning assumptions. The Department has gone through two public stakeholder engagement processes, the first from March - September 2020, with public listening sessions and targeted meetings with providers, professional networks, and advocates. The second public stakeholder engagement process was from July - October 2021. The Department conducted two public

listening sessions to provide program updates and collect feedback and met with maternal care providers, specialists, professional networks, and consumer advocates to learn about current clinical challenges and solutions in maternal care for potential future program adjustment. The Department has also been reaching out to both urban and rural providers for potential program participation and partnership with the goal of making the program thoughtful and responsive to providers' diverse needs and challenges across the state.

PHARMACY PRESCRIBER TOOL

10. [Rep. McCluskie] What formal evaluation of the Pharmacy Prescriber Tool has been or is being performed and what metrics are evaluated in the process? Specifically, what metrics are evaluated in measuring utilization management?

RESPONSE

In order to evaluate use of the Prescriber Tool and to support an alternate payment model, the Department is developing monthly reporting in collaboration with our vendors. The goal of the Prescriber Tool is to make it easier for prescribers to see Medicaid patients by enabling ePrescribing, while automating prior authorizations (insights as to which drugs are preferred as well as the process) to improve the patient experience, drive affordability and, ultimately, increase compliance with the Medicaid Preferred Drug List (PDL). The PDL is crafted and maintained by the Department's prescription drug experts in collaboration with the Department's Pharmacy & Therapeutics Committee (P&T), which acts in an advisory role to the Department. Drugs on the PDL – and therefore use of the PDL - drives better health outcomes for our members as well as affordability, with a priority on quality and outcomes. For FY 2020-21, compliance with the PDL averaged 91.2%. For every one percent increase in PDL utilization, the Department's prescription drug cost is reduced by approximately $16 million, net of rebates (i.e., impact to our total funds budget). If the Department were to achieve a 96.2% PDL compliance rate, as an example, the rate could translate into approximately $80 million in annual savings. Given that prescription drugs are the leading driver of rising health care costs, the Prescriber Tool is a critical part of the Department's quest to improve patient health and well-being, drug compliance, and affordability. The Department cannot expect PDL compliance without providing Medicaid preferred drug insights in a usable manner to prescribers. The Department has a far better chance of the providers taking the time to use the tool, if it provides them with an incentive to do so. This PDL utilization factor is keenly monitored by the Department and could be used to structure provider incentives.

Concurrent with this, the Department is working on a host of other insight reports with our Prescriber Tool vendor partner (our Pharmacy Benefit Manager (PBM) intermediary) and expects the reports to be finalized in early 2022. The reports will include a wide range of data including:

number of pharmacy benefit checks, in the aggregate and per prescriber; number of prescribers which have performed a benefit check; number of members whose pharmacy benefits have been checked; the specific drugs which are checked for benefit coverage; the suggested alternative drugs provided to prescribers; estimated cost savings; preferred drug list compliance per prescriber and practice; number of electronic prior authorization requests submitted; and, the number of electronic prescriptions transmitted to pharmacies. For evaluating utilization management, the preferred drug list compliance measure and the number of electronic prior authorization requests will be especially informative.

11. [Rep. McCluskie] How is the preferred drug list developed? What factors are considered when adding a drug to the list? How frequently is it updated? What involvement do pharmaceutical companies have in the development of the preferred drug list?

RESPONSE

The Preferred Drug List is developed based on recommendations from the Pharmacy and Therapeutics Committee[2], stakeholder feedback, and input from the Department's pharmacists and Chief Medical Officer. Several factors are considered during development of the Preferred Drug List including utilization data, drug effectiveness and cost. The Preferred Drug List is updated quarterly. Drug manufacturers participate in the process by providing drug information, testimony at the Pharmacy and Therapeutics Committee meetings, and by submitting supplemental rebate offers for the Department's consideration.

12. [Rep. McCluskie] If evaluations of the Pharmacy Prescriber Tool indicate that the desired outcomes are achieved, are the incentive payments to prescribers intended to continue in perpetuity?

RESPONSE

[2] The Pharmacy and Therapeutics (P&T) Committee is an advisory board established pursuant to Executive Order D004-07. The committee performs clinical reviews of drug classes and makes recommendations which help the Department develop and manage the Medicaid Preferred Drug List (PDL). The P&T Committee is required to consider clinical criteria such as drug safety and efficacy when making its recommendations. The committee also considers public comments and testimony related to the drug classes being reviewed or other PDL-related agenda items. The P&T Committee consists of 7 physicians, 4 pharmacists and 2 member representatives, who are appointed by the Department's Executive Director. More information on the committee is on the Department's website: hcpf.colorado.gov/pharmacy-and-therapeutics-committee

Yes, the Department intends to perpetually incentivize providers to support choosing drugs on the Preferred Drug List as well as lower cost alternatives that meet the prescriber's clinical needs. The preferred drug list is updated quarterly, which sometimes results in the addition of new drugs or changes to a drug's preferred status. For that reason, incentives need to continue over time to ensure that providers utilize the prescriber tool. The structure of incentive payments may change when the goal of tool implementation and adoption is fully reached.

13. **[Rep. McCluskie] In which line item do under-expenditures exist that are allowing the Department to develop and prepare to implement the model within existing resources in FY 2021-22.**

RESPONSE

The Department received resources beginning in the FY 2019-20 Long Bill to implement alternative payment models as a result of its approved FY 2019-20 budget request R-9 "Primary Care Alternative Payment Models." As part of the approval of that budget request, the Department received 2.0 permanent FTE associated with electronic clinical quality measures and implementing value-based payments. No under-expenditures were necessary to absorb this work.

PRIMARY CARE PARTIAL CAPITATION

14. **[Rep. McCluskie] What strategies has the Department considered to encourage more primary care physicians to serve the rural counties/regions of the state? Has the Department considered how the payment model might affect the Rural Training Track?**

RESPONSE

The Accountable Care Collaborative is one strategy the Department utilizes to encourage the participation of primary care providers in Medicaid, particularly in rural areas. Participating primary care medical providers receive an administration payment for each enrolled member in addition to fee-for-service reimbursement. They also have access to practice support, data and technology assistance, and care coordination services by the Regional Accountable Entities (RAEs). These types of resources can be particularly valuable to smaller practices with limited resources, such as those in rural communities.

The Regional Accountable Entities are very active in identifying practices in rural areas not enrolled, as well as identifying areas with the greatest need for services. Some of the Regional Accountable Entities have engaged the support of local entities operating in more rural areas, such as Rocky Mountain Rural Health in Park County and Aspen Mine Center in Teller County, to assist with outreaching providers and establishing warm hand-offs.

In response to one of the Governor's Wildly Important Goals last fiscal year, the Department achieved an increase of more than 11,000 new providers enrolled with Medicaid, mostly by improving the enrollment experience for providers and proactively engaging providers. One of the state's best recruitment tools for rural, frontier and underserved areas is the loan forgiveness program offered by the Colorado Health Services Corps managed by the Department of Public Health & Environment. The Department actively participates in this program in a non-voting role.

Regarding the Rural Training Track, participating practices receive assistance by having residents train in the rural practice as a means of encouraging residents to work in a rural area after they complete their training. The payment to participating practices is separate from any reimbursement for services.

The Department does not see that a value-based payment arrangement, such as a partial capitation, will have any conflict with the Rural Training Track.

15. **[Rep. McCluskie] The partial capitation payments will provide physicians the opportunity to spend additional time with Medicaid members, reducing the number of patients a physician may need to see in a given day to cover the overhead costs of the practice and presumable improving patient outcomes. Has the Department analyzed the impact of reduced practice capacity in rural areas in which there may only be one provider? Does the Department anticipate reduced access to care resulting in increased health care costs for a period of time as the market readjusts and additional providers can be incentivized to move into those areas?**

RESPONSE

Partial capitation payments provide primary care providers and practices with a reliable source of income to incentivize more effective and efficient care practices. This in turn enables providers to invest in team-based care and other lower cost services and resources that can complement the primary care provider in delivering more comprehensive care. The Department believes this will support providers in expanding practice capacity and will increase access in rural areas. Evidence

strongly supports the benefits of team-based care approaches regarding provider and member experience, patient adherence, and health outcomes. Most of the services provided by care coordinators and community health workers cannot be billed fee-for-service, and so reimbursement is only possible through value-based payment arrangements such as partial capitation. In team-based models, primary care providers may not spend more time with a member, but the overall team spends more time with the member. And the primary care provider is able to focus on the medical needs while leveraging other clinical and non-clinical staff to address members' other needs. The Department also believes that this model will allow and incentivize providers to invest in technology-enabled care through certified electronic health record technology, such as asynchronous chat over a secure portal (a relatively common piece of functionality in electronic health record software), eConsult technology, and the Medicaid Prescriber Tool. These solutions enable the physician greater efficiency, improve outcomes and affordability, which further increase revenue earned through value-based payments as well as practice capacity in rural areas.

Clinical initiatives that reduce chronic disease, as incentivized in the Department's proposal, will reduce sick visits, and by doing so will also increase practice capacity. Lastly, providing a financial incentive for lowering hospital, pharmacy, specialist and other costs related to chronic disease means that participating physicians will have the potential to have a total payment that is greater than what would have been paid otherwise. This increased payment may both increase the willingness of individual providers to see additional Medicaid members within their panels and also provide a market signal, through higher payment, that should increase the number of physicians contracted with Medicaid.

Given the above factors, which enhance provider capacity, the Department believes its proposal will mitigate, not exacerbate, existing and future provider access issues.

16. [Rep. McCluskie] Is the monthly revenue upon which the capitated payment is calculated based on historical/current actual revenue, or is it based on what it actually costs the provider to do business?

RESPONSE

Monthly revenue upon which the capitation payment is calculated is based on historical data from FY 2017-18 and FY 2018-19 with an actuarial adjustment to make the data reflective of current revenue. The Department engaged its contracted actuary to calculate the capitation payments for participating providers and make sure the payments are consistent with current and future appropriated amounts. The partial capitation is intended to cover provider costs for services

provided to Medicaid members within given appropriations. The Department does not have the ability to know what it costs providers to do business without the implementation of a cost reporting process for primary care doctors. The Department currently utilizes cost-based rates for both federally qualified health centers and nursing facilities and these are very administratively burdensome for the provider. Since the rates are based on historical utilization, any reduction or increase in provider rates requires authorization from the General Assembly beyond appropriated amounts.

17. **[Rep. McCluskie] How will the Department account for diminished patient outcomes in chronic conditions that result from things that are beyond the physician's control (such as patient behavior) when developing the algorithm for incentive payments?**

RESPONSE

The Department does not expect diminished patient outcomes in chronic condition management in this alternative payment model and expects the proposed payment model to improve patient outcomes. The Department has modeled its chronic conditions after the successful mandatory episode of care program used by the State of Tennessee Medicaid program, which has improved patient outcomes and lowered costs for Tennessee. An "episode of care" for chronic conditions can include a variety of services provided from a primary care physician, a specialist, or a hospital.

The chronic conditions episodes "assign" accountability to a primary care medical provider (PCMP) for members who are attributed to a PCMP's patient panel in the Accountable Care Collaborative. PCMPs can earn incentive payments for improving the quality of care, in addition to the stable revenue provided by the partial capitation, and cover services which are not currently reimbursed in Medicaid, such as physician extenders like care managers and community health workers. The Department expects this will improve patient outcomes, address health disparities, and overall support PCMPs to better manage their patients' care. To determine incentive payments the Department first ensures that quality goals are met, and, if they are, aggregates all care related to chronic conditions episodes for members attributed to the PCMP. This includes both care the PCMP provided as well as hospital-based care. To protect PCMPs from factors outside their control, the Department will apply the following process:

- Targeted inclusion of member cost: Only the spend for diagnoses that are defined by each chronic condition are included in the calculation of the member's chronic condition cost. For services that are provided by other providers, but included in the episode, the PCMP still plays an important role in terms of care coordination (such as providing screening, service recommendation and referral, and treatment follow-up, etc.)

- Exclusion of high cost outliers: Members with extremely high spending related to chronic conditions (above the 95 percentile), which may indicate a unique or highly uncommon event, are excluded from the payment model.

- Exclusion of ineligible members: If a member is diagnosed with a chronic condition less than three months before the start of a program year, then the PCMP will not be responsible for reducing costs associated with the episode until the following program year. The Department received stakeholder feedback that treatment for chronic conditions tends to be very costly in the beginning due to more services being utilized. Therefore, a PCMP should not be held accountable for the initial costs, which are outside their control.

- Risk adjustment: A risk adjustment process created by the Department's contracted actuary captures the difference in member costs across age groups (adult vs. child), gender (male vs. female), and comorbidity factors. The risk adjustment contributes to the fairness of the member spend comparison that underlies the incentive payments for reducing chronic conditions spending.

18. [Sen. Rankin] Please explain in detail how providing capitated payments equates to a physician spending more time with patients.

RESPONSE

The industry is delivering - and the Department is enabling - critical tools that support physicians in their quest to improve the effectiveness of their care delivery. These innovative tools include eConsults, the Prescriber Tool, and asynchronous chat functionality, as well as cost and quality insights that better inform where to refer care to achieve better outcomes. It is appropriate to ensure that the Primary Care Medical Providers - who represent the core of the health care delivery system but have lower average revenues than specialists – have the resources to work such tools into their systems of care for the betterment of closing health disparities, improving the health of Medicaid members, and being part of the affordability solution.

Partial capitation payments provide physicians and practices with a reliable source of income to invest in care supports and resources, such as diabetes and nutrition counseling, depression screening and behavioral health referrals, and other physician extenders that complement the physician in delivering more comprehensive and effective care – care that gets to the root of the condition or concern and drives better outcomes. In these team-based models, physicians may not spend more time with a member, but the overall care team spends more time with the member. Partial capitation in primary care supports a more effective, team-based model. Evidence strongly

supports the benefits of team-based care approaches regarding provider and member experience, patient adherence, and health outcomes. Most of the services provided by care coordinators and community health workers cannot be billed fee-for-service, so are only possible through value-based payment arrangements such as partial capitation. Additionally, the physician is able to focus on the medical needs while leveraging non-clinical staff to address members' other needs.

Further, because this model has such a large focus on quality and outcomes accountability, the practice has an incentive to spend more time with patients since reimbursement is directly linked to these outcomes and improved performance. The practice has an incentive to provide patients with as much care that is necessary to improve on these metrics.

Given the complexities of Medicaid members, the innovative tools available to providers in the evolving care delivery model, the Department's quest to improve outcomes and close disparities, and cost control goals, this partial payment capitation is imperative.

PROVIDERS OF DISTINCTION

19. [Rep. McCluskie] Please discuss the implementation process and purpose of the Providers of Distinction programs proposed by the Department.

RESPONSE

Given that the Department represents 30% of the state's General Fund expenditure (and 37% of total funds), at a time when the state is constrained by the TABOR revenue cap and during a period of high medical inflation, the Department must pursue innovations that better control claim costs. The alternative is to reduce benefits or provider reimbursements in order to achieve balanced state budgets – and neither of those alternatives are preferred. Covering one in four Coloradans, the Department also needs to recruit more providers who will see Medicaid patients – especially specialists - while driving payment policies that reward the provider behavior that the Department needs to see, including better outcomes, higher quality, affordability, and improved patient satisfaction and health equity.

The Providers of Distinction approach helps the Department achieve all these goals, while improving provider participation, delivering higher payments to higher performing providers, and mitigating claim trend during times of lower state budget revenues. Specifically, the purpose of the Providers of Distinction Program is to identify and recognize primary care, specialty, and hospital providers that deliver high-quality, safe, equitable and efficient care by appropriately shifting utilization from lower performing providers to higher performers who help us achieve our objectives. The Providers of Distinction Program concept is not new; it simply helps Medicaid

catch up with all other major payers which have been identifying and rewarding preferred referral patterns for their primary care Accountable Care Organization (ACO) or PCMP provider partners for years.

Through the Providers of Distinction Program, provider performance will be measured across the care continuum using episodes of care and measures that are developed as part of the R-6 mandatory APM initiatives as the units of analysis. Providers of Distinction are the highest performers in terms of episode performance, quality, outcomes, health equity, access to Medicaid members, patient satisfaction, and use of the Department innovations, such as the Prescriber Tool.

In a similar vein to larger commercial payers, data that informs provider performance in these episodes will be aggregated, summarized, and disseminated in a way that enables both Medicaid members and their primary care provider to make informed care decisions. This will include making better health care provider selection decisions through the Find-a-Doctor tool on the Health First Colorado website, which will prioritize higher performing providers. Similar data will also be disseminated to members' Primary Care Medical Providers and their RAEs to help inform referrals to the relevant Provider of Distinction in the member's region that drives better outcomes for their patients and better cost controls as well, thereby helping us protect Medicaid benefits and mitigate claim trend. The Department is concurrently implementing an eConsults system which is highly suitable to enable more informed referrals for this purpose. The eConsults system is integrated into the providers care management or the electronic health record systems that each provider routinely uses, facilitating ease of use. The implementation of Providers of Distinction will build upon the program implementation from other state Medicaid agencies that have previously invested in building episodes of care systems and demonstrated success. Such systems will enable the Department to pay higher payments (rewards) to both referring PCMPs who are part of the quality improvement and cost control solution, as well as the receiving providers who are identified as Providers of Distinction, while saving the state money.

The Department is committed to an extensive stakeholder engagement process to customize the program for the State of Colorado, which consists of technical advisory groups comprising of RAEs, primary care providers, specialists, hospital representatives, consumer advocates, and Medicaid members to discuss and obtain feedback on episode definitions, performance measures, risk adjustment, and program design. The Department will implement reasonable changes recommended by stakeholders in the technical advisory groups to design the program to support providers enrolled in Medicaid and to better serve our members in receiving high quality, cost effective care.

MATERNITY BUNDLE

20. **[Rep. McCluskie] How will the Department account for diminished patient outcomes that result from things that are beyond the physician's control when developing the algorithm for payment distribution?**

RESPONSE

Medicaid members experience worse outcomes than commercially-insured members across a wide range of perinatal measures ranging from prenatal care access, preventable maternal mortality, and premature delivery to low birth weight infants. The Department's maternity strategy includes data analytics, quality improvement and health equity strategies, and intentional stakeholder engagement. The maternity bundle seeks to align financial incentives with this broader strategy because improving outcomes requires optimizing care across the entire prenatal, delivery, and postpartum periods of a person's maternity care. The Maternity Bundled Payment program is in its second program year with three OBGYN practices already committed and another four to six practices that are in the process of participating in the program this year. All existing and interested practices are excited to partner with the Department through this program to improve Medicaid outcomes and the health and well-being of pregnant and birthing parents as well as babies born under the Medicaid program. The program will cover about 25% of all qualified Medicaid births by the end of the second program year. The Department is confident that the program design and operation reflect the expectations of the provider and member community.

The Department has modeled its maternity bundled payment after the successful mandatory maternity bundled payment used by the Tennessee Medicaid program, which has improved perinatal outcomes and lowered costs for Tennessee. The maternity bundled payment "assigns" accountability to the obstetrical provider who delivered the baby or provided prenatal services due to their ability to influence member outcomes. Obstetrical providers can earn incentive payments for improving the quality of care and can use this reimbursement to get upstream of the problems, which are traditionally not covered by fee-for-service reimbursement, but cause poor birth outcomes. To determine the incentive payments, the Department first ensures that quality and equity are improved as a gateway and, if they are, aggregates all the care provided by an obstetrical provider for the members for whom they delivered the baby. This is inclusive of prenatal, delivery, and postpartum expenses. To protect obstetrical providers from factors outside their control the Department applies the following algorithm:

- Targeted inclusion of member cost: During the entire maternal care journey of a member, expenditures for services (e.g., diagnoses, procedures, and medications) that are closely related to the maternal episode are included in the calculation of the episode cost. Most services included in a member's episode rely on the obstetrical provider's decision-making responsibility. For services that are provided by other providers (other than the obstetrical provider) but are included in the episode, the obstetrical provider still plays an important

role in terms of care coordination (such as providing screening, service recommendation and referral, and treatment follow-up, etc.)

- Exclusion of high outlier episodes: Members with high episode spend (above the 95 percentile), which may indicate a unique or highly uncommon event, are excluded from the payment model.
- Exclusion of ineligible members: Members who have payment or eligibility rules (e.g., third party liability, inconsistent enrollment, dual eligibility), provider characteristics (e.g., out of state, certain provider types), unique characteristics (e.g., long-term care residents), or missing or exceptional claims information (e.g., long hospitalizations, incomplete claims) are excluded from the payment model.
- Risk adjustment: The Department applies a risk adjustment process, which captures the impact of members with documented clinical risk factors that might lead to higher cost and poorer outcomes. These members should receive additional care during an episode and the existing risk factors (e.g., acute and unspecified renal failure, allergic reactions, etc.) are outside the control of the obstetrical provider. By minimizing the effect of those clinically documented medical risks on member spend and outcomes, risk-adjustment contributes to the fairness of the different member spends that underlie episode-based payment models. Note that the risk adjustment process only applies once the program becomes mandatory with universal cost and quality performance goals for all obstetrical providers in the program.

21. [Rep. McCluskie] The target budget for the "entire maternity episode" will include all services related to "that condition." Is there only one set budget for all risk levels of this type of episode, or are there variable budgets that account for members who are experiencing high-risk pregnancies? How do payments to providers who see a larger percentage of patients with high-risk pregnancies compare with payments to those who see fewer at-risk patients?

RESPONSE

The current target budget setting methodology includes variable target budgets based upon providers' specific historical experience, which varies due to the providers' own patients' risk levels and the Department's goal of decreasing preventable maternal mortality. The Department would expect providers serving a high volume of higher risk patients to have higher historical costs, and therefore a higher target budget than those who serve mostly lower risk patients. Once the program covers all Medicaid births, due to the increase of the number of participating providers as well as the volume of episodes, the program will have a single set of target budgets that holds all participating obstetrical providers accountable. A risk adjustment process will be applied during

the budget setting process to ensure the comparability and fairness of the episode costs calculated for comparison across providers and to providers serving a larger percentage of high-risk members. The Department resets the budget for the maternity episodes on an annual basis.

Suicide within a year of giving birth, followed closely by accidental overdose, are the leading causes of preventable mortality in Colorado. The Department has taken an innovative approach and created budgets specific to patients who are experiencing substance use disorder and mental health conditions to address these. This policy was created to incentivize obstetrical providers to increase screening, referral, and follow through to treatment for both mental health and substance use disorder services with higher reimbursement based on historic medical spending.

22. [Rep. McCluskie] What quality goals are measured in this program? Is there a formal evaluation of the effectiveness of the program in both reducing costs and improving patient outcomes? How will patient quality expectations and experience be factored into the evaluation of the alternate payment model?

RESPONSE

The quality measures for the current program year (FY 2021-22) include:

- Closing health disparities (gateway to incentive payment)
- Postpartum Depression Screenings (tie-to-payment)
- Unexpected Complications in Term Newborns (tie-to-payment)
- Severe Maternal Morbidity (tie-to-payment)
- Contraceptive Care - Postpartum (tie-to-payment)
- Percentage of Low Birthweight Births (tracking)

Each provider will have their own annual quality improvement goals set for each of the four tie-to-payment measures above. A provider's performance in quality improvement is measured by their own progress made each year to close the gap between their historical/current performance and the desired target performance, which is set based on national benchmarks, when available. The Department also created with stakeholders a permanent measure designed to measure health disparities as a gateway to payment. Specifically, an obstetrical provider cannot provide more services to white members versus non-white members. If there is a statistically significant difference between lower cost and number of services provided to non-white members, the obstetrical provider does not qualify for incentive payments.

The five quality measures for the current program year are selected and determined through an extensive series of program stakeholder engagement activities as well as the Department's internal validation process. Program stakeholders, including obstetrical providers, mental health clinicians, hospitals, certified nurse midwives, and consumer advocates, first proposed candidate quality

measures, then the Department's internal validation process screened all candidate measures based on measure standardization (nationally recognized and CMS core measures are preferred for future program alignment across payers), and then evaluated the reportability of each candidate measure based on data availability and accessibility. The final determination of which quality measures should be tied to payment is based on the result of a collaborative voting process that includes participation by all program stakeholders. The Department's stakeholder process for the maternity bundle is described in detail in question 09 about the stakeholder process and engagement done to date. Input has been also been solicited from a newly formed Maternal Advisory Committee (MAC). The MAC is composed primarily of people of color who are Health First Colorado members with lived experience in Colorado Medicaid maternity care. The MAC's continued involvement in the measure selection process and the approval of the five quality measures brings members' perspectives into the program design and implementation.

The five current quality measures are not permanent for the program moving forward. Through ongoing collaboration with program stakeholders and members, the Department will annually evaluate participating providers' overall performance and the effectiveness of existing quality measures and make necessary updates (remove or add measures) based on stakeholders' feedback, MAC's approval, and program evaluation results (once available).

The Department recognizes the value of a formal evaluation of the program's effectiveness in both reducing costs, improving the patient experience, closing health disparities, and improving patient outcomes. Program participation is currently voluntary, and the program is in a pilot phase with three OBGYN practices already committed to and another four to six practices that are in the process of participating in the program the second program year. All existing and interested practices are excited to partner with the Department through this program to improve Medicaid outcomes and the health and well-being of pregnant and birthing parents as well as babies born under the Medicaid program. The program will cover about 25% of all qualified Medicaid births by the end of the second program year and aim to cover more in the following years, and thus will have more program data available for the program evaluation moving forward. As part of the Department's R-6 budget request, the Department is requesting funds for an independent program evaluation which will evaluate if the program has the intended effects and measure the program's impact on factors both within and outside of claims, such as the patient experience. To track the patient experience, the Department has added specific questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to collect data on patient experience. The updated CAHPS survey will be launched late December 2021 and run until April 2022 with reportable data by the end of the FY 2021-22. Stakeholders requested that the Department more comprehensively track the patient experience beyond the CAHPS survey and, if the R-6 request is funded, the Department will adopt validated survey tools [e.g., Mothers on Respect Index, Mothers Autonomy in Decision Making scale, and the Patient Reported Experience Measure of Obstetric Racism (PREM-OB) scale] to administer to all people who deliver as a Medicaid member.

23. Has the Department considered how maternal health homes should be factored into this alternative payment model? If so, please discuss.

RESPONSE

Yes, the Department has considered how the maternal health homes may affect alternative payment models; however, authorization for maternal health homes has not yet been authorized in federal law by Congress.

Because of the contingent and uncertain future of the federal and state authorization of maternal health homes, the Department believes it is prudent to think of the interaction between its proposed budget and those maternal health homes in two specific ways: First, the Department believes it is necessary for its proposed budget action to be able to be successfully implemented as a standalone initiative, because the maternal health homes may not be enacted by Congress. Second, the Department has sought to structure its budget action so that it would be able to be successfully aligned with the maternal health homes if that initiative successfully navigates the federal and state law making processes.

There are important factors that Colorado decision makers should consider before marrying maternal health homes with the alternative payment model proposed in the budget. These factors include:

1. Consideration of cost and quality research on maternal health homes, which has been mixed. Several states have piloted Maternal Health Homes, and the Department will continue to monitor those pilots.
2. The final bill language and requirements, which are currently unknown. The Department also notes there are likely to be additional requirements promulgated through future federal executive branch rulemaking.

The Department believes the alternative payment model it proposes will improve patient outcomes, close disparities, and improve the patient experience, regardless of possible federal legislation. Furthermore, the Department believes that progress in maternity care should be an immediate Colorado priority, since large health disparities currently exist. It should not wait 24 or more months for an uncertain federal approval, and near-term progress in Colorado is beneficial regardless of what ultimately happens at the federal level.

24. [Rep. McCluskie] If the Department only pays 50 percent of the savings to the providers who meet all quality goals, and it pays nothing to those that do not, what will the Department do with the remaining funds?

RESPONSE

The Department would use the regular budget process to account for expected savings from the maternity bundled payment. The Department does not anticipate having excess funding in its appropriations that could be repurposed, because the Department submits multiple forecasts each year for the expected cost of Medicaid programs, which account for the expected savings achieved. The Department would use the regular budget process to request spending authority for any new initiative that required funding based on savings achieved.

REPRODUCTIVE HEALTH CARE PROGRAM SB 21-009

25. [Sen. Moreno] Please discuss the proposal to delay implementation of S.B. 21-009 and explain why the bill is the one piece of Health First Colorado legislation for which the Department suggests delayed implementation.

RESPONSE

The implementation of the undocumented reproductive health care program, as created by SB 21-009, is delayed due to the time required to make necessary changes to the Colorado Benefits Management System (CBMS). Six bills passed in the last legislative session have a CBMS impact, including the three Maternal and Reproductive Health bills (SB21-009, SB21-025, and SB21-194). The Department is also working on other projects that have a significant CBMS impact, i.e., expansion of Buy-in program to >65 (SB20-033), Behavioral Health (SB21-137) and adding the DD waiver to the Medicaid Buy-In program (SB21-039). While some of these deadlines are feasible in isolation, when many bills pass at once -all without taking into account bills needed to implement from prior sessions, audit findings needing implementation or emerging federal law requiring implementation, such as the public health emergency eligibility requirements- deadlines become more challenging to make in aggregate. Senate Bill 21-009 had the most aggressive deadline. The other bills had July 2022 deadlines or only required the Department to seek authorities from the federal government by January 2022.

The Department is unable to meet the Jan. 1, 2022, statutory deadline due to the backlog and complexity of CBMS changes required. CBMS is a shared system with CDHS, so there is a predetermined schedule for projects and changes to the system, which is scheduled in advance. Further, there is a limit to the number of projects that can be under construction at any given time to ensure quality and to be able to fully test new programming to prevent unintended consequences. Currently, a significant portion of the Department's resources, as well as the CBMS vendor's resources are committed to the unwind of the COVID-19 public health emergency (PHE). Because

of the magnitude of the PHE/COVID-19 unwind project, and the unexpected demand on Department and vendor resources to ensure quality and to allow for adequate testing time, the next soonest available time for this project is June. SB21-009 is not the only project the Department adjusted in the schedule. The Department has proactively adjusted, prioritized, and rearranged the CBMS system build schedule, including moving seven audit compliance projects out to the next fiscal year. This allows for the implementation of the undocumented reproductive health care program in the next available build—June 2022, in order to implement the program by July 1, 2022.

26. [Sen. Moreno] If implementation if delayed, how will the Department:
(a) Guarantee a start date of July 1, 2022 or determine a new start date;
(b) Perform provider outreach and education;
(c) Ensure patient enrollment is in order;
(d) Work with the community and providers to implement the bill; and
(e) Ensure that funding appropriated by the General Assembly for this purpose will not be repurposed?

RESPONSE

Implementation is delayed until July 1, 2022.

A) Guarantee Start Date
The Department is working to ensure that the necessary system builds for the Colorado Benefits Management System (CBMS) and interChange billing systems will be ready by July 1, 2022. The appropriate staff resources have been assigned and time allocated to support all of the requirements necessary to implement on time. In addition, this has been labeled of high importance within CBMS governance leadership to ensure timely implementation.

B-D) Communications (Provider, Member, Community)
The Department is deploying several general strategies to communicate information about this bill:

- The delay has been communicated on the Department's webpage, and the announcement has been translated into Spanish. The message includes a link to the Colorado Department of Public Health & Environment's webpage where these individuals can access Family Planning Benefits through Title X clinics.
- The Department is developing a stakeholder newsletter for this bill and other related initiatives that will be published this month.

- To support outreach to this population, the Department is hiring a benefit coordinator with experience working with populations that are undocumented, with a preference for a candidate who can speak Spanish. This position posted on Dec. 7, 2021.
- The Department held a legislative kickoff meeting for this bill and other related initiatives on Thursday, Oct. 7. At that meeting the Department solicited feedback on areas that were most important to stakeholders, and follow-up meetings are being scheduled. The next meeting will be held on Jan. 12, 2022, with a focus on defining the benefits included in these programs, as that is most pressing for the systems build. Follow-up meetings will focus on provider, member, county and community engagement.
- The Department was appropriated $699,001 per year for county administration; the fiscal note for SB 21-009 estimated that 40% of applicants would be processed by county health department employees.

Provider Education and Outreach

The Department has initiated communication planning to ensure that providers who are eligible to offer these services to members are aware of this new benefit for individuals without documentation. The Department will use its traditional provider communication pathways—such as provider bulletins, messaging in provider newsletters and outreach to provider association leaders — to share in their communications with providers, and new benefit messaging during in person stakeholder meetings, to help disseminate information to the broadest audience possible.

Patient Enrollment

The Department will also be outreaching counties to ensure they are familiar with how to enroll this new population for this program. The Department intends to engage the advocacy community. This is not a population with whom the Department has historically worked, and the Department is aware that uptake could be impacted due to lack of knowledge or mistrust of government systems. Leveraging trusted messengers in the community to overcome barriers is an important strategy.

Stakeholder Engagement with Community and Providers

The Department will continue engaging stakeholders through the winter and spring of 2022 to ensure that the work is implemented collaboratively with our partners.

E) Ensure that funding appropriated by the General Assembly for this purpose will not be repurposed?

The Department does not have the authority to repurpose the funding. Funding for these services is appropriated to a line item specific to this program, and the Department does not have any statutory or other authority that would allow it to use this funding for another purpose. Any funding remaining in the appropriation at the end of the fiscal year would revert to the General Fund. The Joint Budget Committee, and the General Assembly would need to approve any changes to repurpose the funding via a supplemental bill.

27. [Sen. Moreno] Please provide a cost estimate for providing the full family planning benefit under S.B. 21-009 (Reproductive Health Care Program). Please ensure the cost estimate includes the return on investment and cost savings that the state will achieve by offering the preventive services associated with the full family planning benefit.

RESPONSE

The Department will be able to price out the impact of expanding the services defined in SB 21-009, "Reproductive Health Care Program," based on proposed bill language defining those changes. The Department would need the changes clearly defined to release a public fiscal estimate. Once defined, a robust analysis would include an estimate of each component that bill sponsors would want included in a full family planning benefit.

Generally, preventive services in the Department's benefits are a long-term investment that supports overall population health rather than a short-term return on investment, such as future reduction in cancer rates, fertility issues associated with untreated sexually transmitted illnesses, and early detection and treatment of cancer or chronic illness. Additionally, ensuring and expanding access to preventive services has impacts on family and economic stability, educational attainment, workforce participation, and many other benefits that do not directly impact the Medicaid budget, but address total costs of care over time and are essential to the Department's mission to "improve health care equity, access and outcomes for the people we serve."

28. [Sen. Moreno] COLOR requested that the Department include in its FY 2022-23 budget and bill requests the full family planning benefit for undocumented immigrants. Please explain why this was not done.

RESPONSE

The Department routinely considers stakeholder viewpoints in its decision-making process, including its internal budget deliberation process. The Department believes that the Nov. 1 budget submission for FY 2022-23 represents a balanced approach, and the Department does not comment on the internal deliberative process.

PROVIDER RATES

29. [Sen. Hansen] Please discuss the potential for further dilution (lag) of provider rates if the common policy provider rate applied to appropriations in the Department is less than that applied to other department common policy providers.

RESPONSE

The Department's requested common policy rate increase would apply to all Medicaid providers who do not receive a targeted rate increase. Providers receiving larger increases have been identified through the work associated with the Medicaid Provider Rate Review Committee (MPRRAC), as being below benchmark rates, indicating that more significant disparities exist. Therefore, the Department believes that providing targeted rate increases to providers is more likely to close gaps in rate disparities, rather than exacerbate them.

The rate review process associated with the Medicaid Provider Rate Review Committee (MPRRAC) gives the Department line of sight to the provider rates that are lagging behind compared to other provider rates, as compared to a benchmark, like Medicare. Additionally, this process allows the Department to identify provider rates that may be too high, which is usually a result of declining costs. Targeting the money allocated for common policy rate adjustments better ensures these disparities do not continue to persist into the future.

30. [Sen. Rankin] Please provide a breakdown of rates for durable medical equipment in relation to the benchmarks for each subcategory.

RESPONSE

Durable Medical Equipment (DME) services were analyzed at the procedure code level, rather than by a subcategory breakout. The Department provided separate rate benchmarking data for DME codes that were not subject to the Upper Payment Limit (UPL), since all codes subject to UPL are set to 100% of the Medicare rate. See the 2019 Medicaid Provider Rate Review Analysis Report for a breakdown of those rate comparisons. See Appendix B (pages 30-53) in the 2019 Medicaid Provider Rate Review Analysis Report for a full list of DME codes analyzed and the rate ratio benchmarking results.

The amount being requested for the DME rebalance is a result of past budget requests and constraints. Due to the budget shortfall caused by the pandemic in FY 2020-21, the Department is seeking funding to complete these recommendations in this current budget request (FY 2021-22).

31. [Sen. Moreno] Providers indicate that non-emergent medical transport (NEMT) rates are too low to ensure provider retention and appropriate access to high value services. What is the cost of increasing NEMT rates up to the Department's recommendation of 80% of the benchmark, as opposed to the Department's proposed solution of raising rates up to at least 60.8% of the benchmark for those below that mark?

RESPONSE

The table below shows the estimated impact of increasing NEMT rates to 80% of benchmark rates compared to the Department's request to increase NEMT rates to 60.8% of benchmark rates.

Estimated Impact of Increasing NEMT Rates to 80 Percent of Benchmark Rates					
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**
FY 2022-23 Impact					
A	Increase Rates to 60.8% of Benchmark	$22,816,821	$7,393,642	$4,014,769	$11,408,410
B	Increase Rates to 80% of Benchmark	$37,260,357	$12,073,976	$6,556,204	$18,630,178
C	**Incremental Impact**	**$14,443,536**	**$4,680,334**	**$2,541,435**	**$7,221,768**
FY 2023-24 Impact					
A	Increase Rates to 60.8% of Benchmark	$25,917,365	$8,398,353	$4,560,330	$12,958,682
B	Increase Rates to 80% of Benchmark	$42,323,611	$13,714,690	$7,447,116	$21,161,805
C	**Incremental Impact**	**$16,406,246**	**$5,316,337**	**$2,886,786**	**$8,203,123**

32. [Sen. Moreno] How do Colorado's NEMT rates compare to rates paid by neighboring states for the same service?

RESPONSE

The Department has information for New Mexico, Nebraska, and Oklahoma. For these three states, Colorado ranges from 22.97% to 187.58% of the reimbursement for equivalent procedure codes that were compared in each state. It is unclear if these comparisons are indicative of rate disparities because each state has significantly different billing policies and procedures. These differences make direct comparisons difficult to interpret.

Please note that different procedure codes were compared in each state due to the billing criteria specific to each state. Additionally, the Department also uses Medicare as the primary comparator. Therefore, if a Medicare rate exists for a procedure code, then it is not compared to other states. Out of the 16 NEMT procedure codes that were reviewed, five of them were compared to Medicare rates; on average, Colorado's rates are 28% of these Medicare rates. However, this can be misleading since Medicare is much stricter with their coverage policies. These five codes account for approximately half of the Department's NEMT annual expenditure. Additional information is in Appendix B of the 2021 Medicaid Provider Rate Review Analysis Report.

State	Colorado as a Percentage of the Benchmark	Procedure Codes Included in State Benchmark Comparison
Alabama	93.93%	1 (A0422)
Alaska	88.32%	5 (A0130; A0200; A0180; A0210; A0190)
Arizona	130.71%	5 (A0090; A0130; S0209; A0080; T2005)
Arkansas	73.92%	1 (A0422)
California	112.49%	4 (A0120; A0130; A0422; T2005)
Connecticut	122.00%	1 (A0130)
Illinois	203.14%	2 (A0090; A0130)
Montana	105.78%	1 (A0422)
Nebraska	22.97%	4 (A0120; A0090; A0130; S0209)
New Mexico	187.58%	2 (A0200; A0180)

North Dakota	123.84%	5 (A0120; A0130; A0080; A0190; T2005)
Ohio	123.18%	1 (A0130)
Oklahoma	109.48%	1 (A0422)
Wisconsin	95.66%	1 (A0422)
Average	55.91%	11 (A0120; A0090; A0130; A0200; A0180; S0209; A0080; A0210; A0190; A0422; T2005)

MPRRAC

33. **[Sen. Moreno] Please describe the process for performing a benchmark comparison of rates. How are the procedural codes developed? What determines whether a service is billed through a procedural code or by the hour? How are rate increases distributed across procedural codes within a given category of reviewed rates?**

RESPONSE

The rate comparison benchmarking process involves identifying other payer sources and repricing claims data using the benchmark rates. To identify comparable rates, publicly available documentation on reimbursement policy was referenced, and the analysis employed a fee schedule specific to Colorado to produce a more valid comparison. Rates were assigned by considering the procedure code present on each claim, taking into consideration geographic components associated with paid claims. Medicare's base rate, which includes a geographic breakout for urban and rural areas defined by a zip code crosswalk furnished by the Centers for Medicare and Medicaid Services (CMS), is considered in order to compare an appropriate rate. Other states' rates are only used as benchmark comparator in cases where no Medicare rate is available.

Procedure codes are grouped into two categories. 1. CPT (current procedural terminology) codes are created and governed by the American Medical Association. 2. HCPCS (healthcare common procedure coding system) codes are created and governed by the federal Centers for Medicare and Medicaid Services (CMS). Both types of codes are created through a process which involves the

public and accepts submissions for new codes or amending current codes. The Department does not have the authority to create or amend CPT or HCPCS procedure codes. The Department determines, in accordance with state and federal law, which procedure codes are covered benefits, how much each procedure code will be reimbursed, and whether to apply amount, scope, duration limits to them.

The definition of the CPT/HCPCS procedure code determines the length of time it may be billed. Each procedure code has a definition for correct usage, and will specify what a "unit of service" is equal to for that specific code (e.g., per visit, per 15 minutes, etc.)

Rate increases, or rebalances, are distributed within a code set based on where individual codes within the code sets are currently paying in comparison to the rate benchmark, whether in Medicare or other states. Typically, rates below the 80% comparison threshold of the benchmark are identified for increases, while rates above 100% are considered for decreases.

34. [Sen. Moreno] The MPRRAC analysis identifies ranges of rates compared with benchmarks. Of what are the ranges of rates indicative? Are there regional differences in rates for the same types of services?

RESPONSE

The ranges are indicative of the percentage of the current rates in comparison to the benchmark, either Medicare or rates from other states. For example, there are 10 procedure codes under the Emergency Medical Transportation (EMT) benefit, and their rates range from 26.92%-99.51% of their respective rates benchmark.

Dependent on the service, there may be regional variations in rates based on where the service is provided, such as in rural areas or in Metro Denver for DME.

35. [Sen. Hansen] Please explain how the Department's recommendation identified in the MPPRAC report inform the Department's actual request for targeted rate increases. Will approval of the Department's request for rate increases that are below the recommendation result in or exacerbate service or access issues?

RESPONSE

The Department requested rate increases in FY 2022-23 R-9, "Office of Community Living Program Enhancements" and R-10, "Provider Rate Adjustments." The increases included in these requests were informed by the recommendations through the rate review process and determined with the goal of maximizing increases to providers within available funding. The Department prioritized funding for services that were identified as needing targeted increases, while also being able to provide an across-the-board increase for all services.

The Department is requesting increases for several services that were identified as having rates below Medicare or other states' benchmark rates through the rate review process, including non-emergent medical transportation, emergency medical transportation, non-medical transportation, the transitional living program, speech therapy, and durable medical equipment services. These items connect directly to recommendations from the last two rate review cycles. Specific to home and community-based services (HCBS) waivers, the Department is requesting funding to continue the rate increases necessary to support the $15 per hour base wage requirement that will be implemented initially using funding from the HCBS American Rescue Plan Act spending plan. This corresponds with the recommendation in this year's report to increase rates to support the lowest paid direct-care workers. The Department is also requesting funding to align rates for similar services that span multiple waivers based on the recommendations in this year's report, including massage therapy, respite, and residential services.

Some recommendations would require significant funding to fully implement, and therefore the Department often requests an incremental step towards the full recommended increase to be able to fund multiple priorities in the same year. This was the case for the requested increases for transportation services this year, which have received several targeted increases over the last several years, yet remain well below the benchmark rates. Increasing rates that are below benchmark rates, even gradually, will encourage greater provider participation and access to those services.

36. [Rep. McCluskie] Please discuss existing challenges with and potential improvements, including statutory changes, that can be made to the MPRRAC committee and rate review process.

RESPONSE

There are several existing challenges with the current statutory structure of the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The challenges are wide-ranging, and include the recommendation report, the review cycle timeline, the composition of the advisory committee, and the Department's ability to fully support the MPRRAC.

Recommendation Report

There have been concerns that the Recommendations Report does not reflect the opinions of the MPRRAC members. The current statute, section 25.5-4-401.5(2)(b) and (d), C.R.S, directs the Department to submit its recommendations in a written report by Nov. 1 to the Joint Budget Committee (JBC) and the MPRRAC, after receiving feedback from the MPRRAC and other stakeholders on the analysis report that is due May 1. The statute does not direct the MPRRAC itself to submit a report to the JBC. As a solution, this section of the statute could be amended so that the Recommendations Report includes a section that summarizes stakeholder feedback, including feedback from the MPRRAC members. However, this needs to be separate from specific Department recommendations, as stakeholder opinions may not always align with the Department's assessment.

Review Cycle Timeline

There are several concerns with the current MPRRAC review cycle timeline. The JBC and the MPRRAC both have authority to change the five-year Rate Review Schedule to include services for out-of-cycle review before Dec. 1 of each year. There are challenges with the Rate Review Schedule and JBC timelines given the need to have a robust analysis process that allows adequate time for stakeholder feedback and additional evaluation when the need is identified. The analysis for the May 1 report is started in January of the year before that report is due. Therefore, the Department needs to be notified of an out-of-cycle review much earlier than is currently in statute.

Further, the Recommendations Report is due to the JBC on Nov. 1 of each year, which is the same day the Governor's budget is due. However, current budget instructions from the Governor's Office of State Planning and Budget require the Department to submit budget proposals to the Governor in July. Therefore, it is impossible to include the current year rate review recommendations in the same year's budget requests.

Lastly, the Department has received concerns about the length of time between reviews for each service (i.e. the five-year cycle). Current resources are already fully committed to the five-year cycle and any acceleration of this timeline would require a proportional increase in resources devoted to the rate review process.

Composition of the Advisory Committee

The MPRRAC is a non-partisan 24-person advisory committee with four-year terms appointed by the President of the Senate, Minority Leader of the Senate, Speaker of the House, and Minority Leader of the House. MPRRAC appointments have been a challenge since the inception of the rate review process. Over the years, several concerns have been voiced to the Department by MPRRAC members, such as the timeliness of appointments and ensuring that expertise on the committee is representative. Further, the MPRRAC is never fully seated because of its size and the complexity of the appointments. Even when appointments are made, the duties are not always fulfilled. For example, at the November MPRRAC meeting, only 10 of the 16 members currently appointed

attended the meeting. As a solution, the committee could be replaced by a public stakeholder process. This would allow for any appropriate party to participate, which would bolster the inclusion of all relevant opinions. This could also allow the Department to outreach to the providers and members directly affected by the scheduled rate changes, which would assist in inclusion of all relevant opinions.

If the committee is maintained, the Department recommends that the committee size should be reduced. Several other committees function effectively with half of the membership (or fewer) and will pull in relevant experts when the need arises. The large membership, coupled with the significant absentee rate, remains an ongoing challenge. According to the committee Rules of Governance, committee members shall review the schedule of services being reviewed for each year, review the Departmental reports and any other meeting materials prior to the meetings, and are obligated attend 75% of the scheduled MPRRAC quarterly meetings throughout the year. In addition, the MPRRAC Chair meets with the Rate Review Stakeholder Relations Specialist prior to each public meeting. In total, the estimated number of hours the typical MPRRAC member is expected to contribute to the process is about 20 hours per year, and about 25 hours per year for the MPRRAC Chair.

Committee Staffing and Resources

The Department must review and provide recommendations for services to ensure provider retention, access to care, and quality of care. At any given time, the Department is working to implement prior year recommendations, conclude the most recent year of review, and prepare for the next year of review. The results of the analyses can be indicative of potential access issues, but are often not in-depth enough to be conclusive of whether there are access issues or determine the root cause of those access issues, both of which are critical for informing appropriate recommendations. Analyses typically generate more questions from the Department, Medicaid Provider Rate Review Advisory Committee (MPRRAC), and stakeholders, that require additional evaluation. Department staff do not have capacity to start the next year of review analyses, generate recommendations and draft the Recommendation Report, and complete multiple evaluation projects related to the current year of review. Presently, the Department only has capacity to devote resources to current year review and preparation of the selected services for the next year. In the Department's statutorily required rate review reports due to the JBC and MPRRAC, the Department is rarely able to provide the detailed analysis that is appropriate because of the resource deficiency.

The Department identified opportunities for qualitative improvements in its FY 2020-21 budget request R-8, "Accountability and Compliance Improvement Resources." This request included additional resources for evaluation and qualitative research that would have supplemented the Department's data analysis in evaluating Medicaid members' access to care. Unfortunately, as the

pandemic began, this request was unable to move forward. Future opportunity in this area may exist with ongoing evaluation of resources and priorities as circumstances change. The MPRRAC's and the Department's ability to evaluate rate disparities and make recommendations continues to be limited by available staffing and resources.

BEHAVIORAL HEALTH

37. [Rep. McCluskie] Please describe the development of capacity for the new Substance Use Disorder (SUD) benefit, including the capacity by region relative to the need by region. What is the Department doing to ensure sufficient capacity in all parts of the state?

RESPONSE

The Department requires all of the Regional Accountable Entities (RAEs) to contract with a statewide network of residential and inpatient mental health and substance use treatment facilities in order to ensure members in these areas are able to access these services. The Department, the Office of Behavioral Health, and the RAEs have been working closely for more than two years to identify current providers and develop additional capacity across the full continuum of inpatient and residential substance use disorder services.

The number of residential and inpatient substance use locations contracted with the RAEs has increased from 21 (576 beds) in January 2021, when the benefit launched, to 52 (1,326 beds) in November 2021. Contracted facilities are located in 20 counties, including two frontier counties, seven rural counties, and 11 urban counties.[3] There are similar numbers of beds per capita in each of these different areas, although access is more difficult in rural and frontier counties due to longer travel distances.

County type	Bed count	Colorado Population (2020)	Beds per 1,000 people	Total Deaths Due to any	Average Deaths per

[3] Contracted facilities in urban counties are located in Adams, Arapahoe, Boulder, Denver, Douglas, El Paso, Jefferson, Larimer, Mesa, Pueblo, and Weld counties. Contracted facilities in rural counties are located in Alamosa, La Plata, Logan, Montrose, Otero, Pitkin, and Prowers counties. Contracted facilities in frontier counties are located in Bent county and Las Animas county.

				Drug (2000-2020)[4]	1,000 People per Year
Frontier	35	129,141	0.271	360	0.133
Rural	147	582,977	0.252	1,421	0.116
Urban	1,144	5,061,596	0.226	14,206	0.134
Subtotal	1,326	5,773,714	0.230	15,987[5]	0.132

The RAEs continue to secure additional contracts for services with new providers and provide monthly status updates to the Department. Between Jan. 1, 2021, and Oct. 31, 2021, 2,363 members accessed residential services and 12,162 accessed withdrawal management services.

This growth, while welcome, exceeded the Department's expectations and initial budget projections. To support improvements in provider contracting and, therefore, access, the Department increased rates for FY 2021-22, after the first few months of the program, to secure a higher projected number of inpatient and residential SUD beds and to pay providers sufficient rates. For FY 2022-23, the Department is working to adjust risk corridor requirements to effectively incentivize RAEs to continue to build capacity throughout the continuum of inpatient and residential care to better meet member demands.

In measuring capacity, the Department evaluates the total number of beds or facilities and the different types of residential and inpatient services available. The Department has identified that there is a gap throughout the state of providers of clinically managed residential services, referred to as Level 3.5 by the American Society of Addiction Medicine (ASAM), that enables members to be transferred from the highest levels of inpatient and residential care to a more moderate level of care. While the state agencies and the RAEs are working to extend provider resources to more counties and reduce regional gaps in care, it is hard for organizations to maintain both the staffing resources and patient census to support 24-hour facilities in more rural areas of the state. As a part of the Behavioral Health Transformational Task Force, the Task Force is in the process of considering recommendations for building community capacity to provide additional services across the care continuum including some specific recommendations for SUD beds for youth and adults.

The Department worked with the RAEs to determine regional plans to expand services based on the gaps identified in the 2020 Behavioral Health Needs Assessment conducted by Health Management Associates, Inc., and funded by the Office of Behavioral Health. The Department will continue to use the 2020 assessment to inform the Department's investment of dollars moving forward, particularly provider expansion funds.

[4] Colorado Drug Overdose Dashboard, Colorado Department of Public Health & Environment

[5] Totals are slightly less than the total reported deaths by the Department of Public Health & Environment, due to counties where total deaths were below the threshold needed for reporting.

38. [Sen. Rankin] Please describe how telehealth is being used for the provision of behavioral health and how practices and utilization of behavioral health telehealth has changed through the pandemic. What are the strengths and limitations of behavioral health telehealth as a strategy to address access to care issues in parts of the state with lower population densities? What is the Department doing to support behavioral health telehealth?

RESPONSE

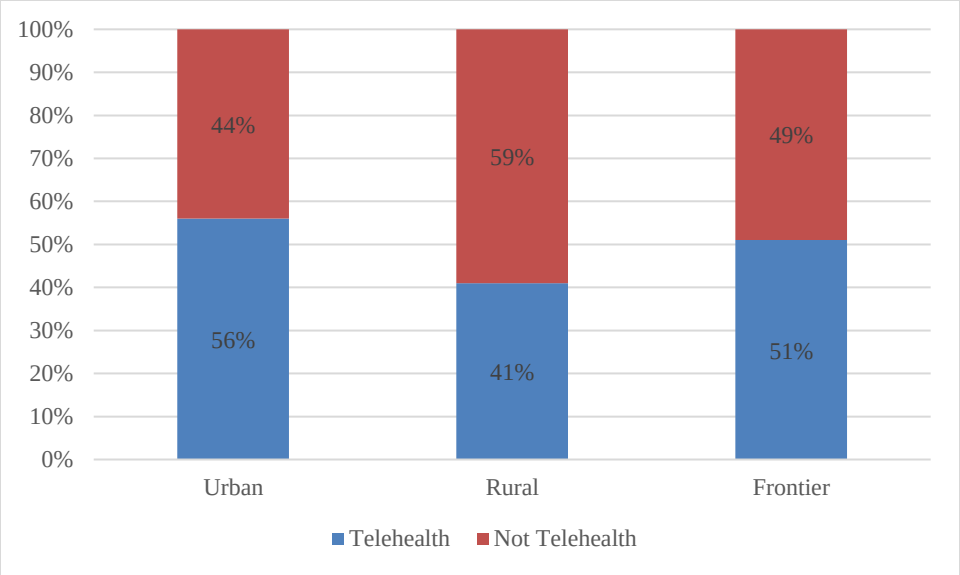
Behavioral health providers have been high adopters of telemedicine throughout the pandemic. In the first two months of 2020, prior to the pandemic, the average telemedicine utilization rate for capitated behavioral health was 0.9%. By April 2020, the average across the seven regions had grown to 50.4%. From March 2020 through March 2021, the statewide average telemedicine rate for behavioral health visits was 40.3%.

Children were the highest utilizers of behavioral health telemedicine. The most common diagnoses associated with telemedicine visits for behavioral health were similar across Regional Accountable Entities (RAEs) and included post-traumatic stress disorder, anxiety disorders, major depressive disorders, opioid dependence, and alcohol dependence.

Telemedicine reduces some of the common barriers to in-person visits experienced by members such as lack of transportation or child care. The flexibility of scheduling has also reduced no-show rates for providers, which is extremely important in areas with limited behavioral health resources. Additionally, as a managed care program, the RAEs have greater flexibility than fee-for-service to reimburse team-based care and non-traditional provider extenders, such as peer support services, that are important to addressing the comprehensive needs of members.

On the other hand, telemedicine is not appropriate for certain group programs, such as drop-in centers and clubhouses, and individual member needs. One of the weaknesses most often cited as a limitation for adoption of telemedicine services in rural areas is limited broadband access. While the table below does show differences in the percentage of total capitated behavioral health visits conducted through telemedicine by county type, the difference between urban and frontier counties is only five percentage points. Through continued investment by the Office of eHealth Innovation in expanding broadband access throughout the state, the RAEs and their providers will continue to expand utilization of telemedicine for members in rural and frontier counties.

Average of Capitated Behavioral Health Telemedicine Visits by Members Located in Urban, Rural, and Frontier Counties, March 2, 2020 to March 31, 2021



The RAEs are responsible for administering most behavioral health services for members through the behavioral health capitation. In this role, the RAEs supported the expansion of the utilization of telemedicine services in their regions by surveying providers to find out what support they needed to offer telemedicine. RAEs trained providers via webinars, offered software platforms and other resources to providers, and made phones, tablets, and internet access more readily available to members. This not only made care more available to members, it also stabilized providers struggling with reduced demand for services.

The RAEs leveraged the Department's emergency policy changes related to fee-for-service telemedicine to further increase member access to telemedicine behavioral health services. The Department has since made these changes permanent for behavioral health services delivered through the capitated benefit.

39. [Sen. Moreno] Behavioral health assessments:

- **a. Please respond to the concerns raised by advocates that the Colorado Client Assessment Record (CCAR), Drug and Alcohol Coordinating Data System (DACODS), and Interstate Compact on Mental Health are invasive, discriminatory, administratively burdensome, and duplicative of information already obtainable from the electronic health record.**
- **b. Why are these assessments required? Is every question needed to meet the requirements, or could the assessments be streamlined? How is the data used?**
- **c. How do the behavioral health assessments compare to required assessments for medical or surgical care? Are the behavioral health assessments a barrier to access?**

d. What is the Department doing to minimize the burden on clients and providers of the behavioral health assessments?

RESPONSE

a) **Please respond to the concerns raised by advocates that the Colorado Client Assessment Record (CCAR), Drug and Alcohol Coordinating Data System (DACODS), and Interstate Compact on Mental Health are invasive, discriminatory, administratively burdensome, and duplicative of information already obtainable from the electronic health record.**

The data systems, CCAR and DACODs, are managed by the Colorado Department of Human Services, Office of Behavioral Health (CDHS, OBH). The requirement for providers to use these specific systems is tied to CDHS licensing and funding requirements for licensed substance use and designated mental health providers in Colorado. HCPF does include reference to OBH data systems in RAE contracts, but does not include the names of specific systems. This is one of many places in which the Department's contracts mirror and reflect regulatory requirements in order to ensure Medicaid providers are in compliance with state and federal regulations. If the Department removed reference to these systems in its RAE contracts, they would still be required by CDHS regulations.

The Department has been working with CDHS to determine how the existing requirements can be reduced in the current CCAR and DACODS system, and OBH has made a commitment to reduce the requirements to only those required to meet federal and state standards. OBH has also been funded to retire CCAR and DACODS by summer 2023 and move to an improved system that combines substance use and mental health data collections, integrates with EHRs, and reduces duplication. One of the responsibilities of the BHA will be to coordinate data collection and analysis and set standards for providers, including addressing regulatory requirements such that they don't interfere with access to care.

b) **Why are these assessments required? Is every question needed to meet the requirements, or could the assessments be streamlined? How is the data used?**

Why the State Collects Data

OBH receives in excess of $45 million in federal block grant or other grant funding for the provision of mental health and substance use treatment. An additional $94 million dollars was added in FY 2020-21 through federal COVID-19 stimulus funds. As a recipient of these federal dollars provided by the U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (HHS, SAMHSA), OBH is required to collect and report about the services rendered and the people served by that federal funding. These systems are the primary

mechanism used to collect data to meet state and federal reporting requirements, including requirements set in statute to ensure the state is able to evaluate and monitor use of state funds. In order to ensure providers are able to report on use of public funds, provider completion of DACODS and CCAR is a requirement of agency licensure. The state is reviewing how it reports on this to make sure that we fulfill federal and state requirements with the least burden on members and providers, including pulling data from another source if possible.

How the Data is Used

OBH uses CCAR and DACODS data for a variety of purposes. A substantial portion of the data is relayed back to federal funders as a component of the block grant or other funding requirements. OBH also uses the data for required legislative reports and internal contract monitoring. The data is also used to inform a variety of one-off quality assurance/improvement activities, such as the recent Behavioral Health Needs Assessment, and the children's behavioral health financial map report.

The federal government uses this data, along with data from the Colorado Department of Public Health & Environment and other surveys, to calculate prevalence rates for substance abuse and severe mental illness and monitor state and national trends. OBH also uses the data they collect to identify behavioral health trends, understand the populations' needs, review regional trends and identify gaps across the state that need to be addressed with state and federal funding support. Their annual Drug Trends Report is a good example of how the data is used. More directly, HCPF uses this data for budget planning for services such as the SUD benefit expansion, and OBH uses this information to monitor service quality, utilization and effectiveness, monitor contracts, review regulatory compliance, and to report to the General Assembly on treatment outcomes and service needs in Colorado.

Long and Short-term Strategies to Ease Administrative Burden

While much of the data collected by the CCAR and DACODS are necessary to meet federal and state reporting obligations, OBH and HCPF have identified opportunities for reductions both in terms of the number of elements gathered and the process by which the data are collected. HCPF is working with OBH, who manages these requirements and is taking a two-pronged approach towards easing this burden.

To help OBH understand what is truly required, OBH hired a contractor to create a crosswalk of all necessary data elements by January 2022. Other short-term solutions have been implemented, or will be implemented, by the end of the calendar year. OBH set a goal to remove more than 30% of the time it takes to meet OBH data requirements as soon as possible in order to help alleviate the COVID-19 impact and until they are able to move to a new consolidated system. So far, OBH has identified the immediate removal of five reporting requirements and reduced the breadth of information reported for two additional activities. In addition, OBH is currently investigating ways

to reduce the reporting frequency for CCAR and DACODS and will make determinations by the end of December.

The Department is also working with CDHS through the MMIS and PEAK expansion project, funded through HCPF budget request R-23 in FY 2021-22, to use a single claims processing and data tracking system across both agencies. This work is aligned with the CDHS's efforts to develop a new Behavioral Health Data Collection System (BHS), scheduled to launch summer 2023. The BHS will improve administrative burden by:

- Merging the substance use and mental health data into a single platform. This will significantly reduce the number of times shared data elements are collected and entered.
- Reducing the number of required data elements to only those that are absolutely necessary.
- Changing to a modernized platform with a design that is integrated with EHRs for larger providers, provides an easier EHR-like design for smaller providers, and is compatible with provider workflows.
- Being more flexible in definitions of an episode of care rather than a rigid singular admission discharge model.

c) **How do the behavioral health assessments compare to required assessments for medical or surgical care? Are the behavioral health assessments a barrier to access?**

The behavioral health intake paperwork requires a behavioral health provider to ask the member a series of questions during the initial few sessions of their treatment and to create a treatment plan for the member. This is not a standardized assessment tool, but an effort to collect relevant demographics, patient history, family history, and understand the concerns that bring a person to seek care. HCPF supports the CDHS plan to make changes to the requirements to make this process as simple as possible to ensure that it is not a barrier to access. While this process could be streamlined, asking a new member a set of questions about their history and purpose of their visit is a common practice for most medical appointments as well.

The use of standardized clinical behavioral health inventories, often referred to as "assessments," includes validated clinical tools that measure items including risk of self-harm, where a patient should be placed for treatment, or severity of illness etc., and are not barriers to access but part of quality treatment. These tools are similar to other clinical inventories used in physical health required to determine a course of treatment. While a physician might use a blood test to measure the severity a person's illness like diabetes, the same physician would use a patient questionnaire to determine the severity of a person's depression.

d) **What is the Department doing to minimize the burden on clients and providers of the behavioral health assessments?**

In addition to the OBH efforts, HCPF has been working in collaboration with the RAEs and Medicaid providers to standardize and simplify clinical documentation requirements. As a result, all services will report the same set of standard technical documentation requirements effective Jan. 1, 2022.

HCPF and the RAEs use member enrollment and claims data as the primary data tracking mechanism. Some RAEs may collect additional information from providers as part of a pay for performance agreement or to incentivize providers to meet state goals.

40. [Rep. McCluskie] Please explain why there are such seemingly drastic variations in Medicaid reimbursement for behavioral health counseling and crisis intervention by region and by type of provider.

RESPONSE

Multiple factors influence the variation in reimbursement rates for behavioral health providers including contracts by Regional Accountable Entities (RAEs) to address regional needs, differences in services offered by providers, and cost-based pricing models for Community Mental Health Centers and Federally Qualified Health Centers.

Contracting to Address Regional Needs
Since 1995, the State has provided the majority of behavioral health services to members through a capitated payment model. Under this arrangement, the RAEs are contractually responsible for administering reimbursements to behavioral health providers for all services covered under the behavioral health capitation.

The Department sets actuarially sound capitated budgets for each individual RAE primarily based on historical utilization in the region with the trend and actuarial adjustments and other projected cost factors. The RAEs then establish individual contracts with a comprehensive network of behavioral health providers in order to meet member needs. As part of the contracting process, the RAEs negotiate service reimbursement rates with individual providers and practices that take into consideration the particular needs of the region, services offered, service complexity, the unique expertise of providers (e.g., domestic violence, transgender, children, justice-involved individuals), the number of similar services available in the region, and quality. Their provider network includes inpatient and residential facilities, Community Mental Health Centers, Federally

Qualified Health Centers, and other outpatient behavioral health clinics and providers, referred to as the Independent Provider Network.

Independent Provider Network, Community Mental Health Centers, and the Safety Net

The RAEs negotiate rates with the providers based on regional needs, the intensity of services they can provide, expertise, and quality. As a result, providers who serve specialized, high-needs populations and/or offer a robust array of coordinated services may receive higher reimbursement from the RAE.

Community Mental Health Centers (CMHCs) specifically are state-licensed safety net providers who are required to meet additional standards not required of the Independent Provider Network. Examples of additional requirements include offering an expanded set of services geared toward treating individuals with a serious mental illness, offering crisis support, and having after hours availability.

As a safety net provider, the CMHC's reimbursement from the RAEs is based on the actual costs of care, as required by state statute (section 25.5-4-403, C.R.S.). This directive requires the Department to use a different schedule for CMHC reimbursement estimates, which complicates efforts to compare rates directly across different provider types. Costs reports are used to create a price schedule which we use to set RAE rates, which is known to all parties. RAEs are required to contract with CMHCs. The RAEs are allowed to negotiate rates other than the price schedule. However, in practice, the price schedule often serves as the floor for negotiation. The state also uses this price schedule to set the RAE's capitated budgets. Some reasons for the difference in rates is that, as mentioned above, CMHCs incur costs that most other behavioral health providers do not, including the provision of complex clinical care models and whole person services, building community partnerships to help connect clients to social benefits often necessary for treatment success, the provision of services that can't be billed for directly, and additional compliance audits and oversight needed to protect vulnerable populations.

Some of the intention behind funding safety net services in a way that considers their cost is to ensure sustainable funding for essential services, to support access for Medicaid members during economic downturns or periods of low service volume, and to ensure providers with a majority of Medicaid clients served and cannot offset costs with commercial billing are still viable. Other similar and successful models of cost-plus reimbursements include Federally Qualified Health Centers which provide some capitated behavioral health services and some fee-for-service behavioral health services. Their rates also based on each health center's individual cost reports. Other safety net payments are tied to federal oversight and and/or reported outcomes. The current behavioral health model does not have enough of have either of those features, which is why the Department is making changes to the model.

Differences across Community Mental Health Centers

There are numerous factors that result in the wide range of CMHC-specific rates. Each CMHC has its own unique price schedule based on its own unique cost structure and is used for RAE contracting. This price schedule is set through independently audited cost reports. As each CMHC is different in terms of the population it serves, volume of services, type and complexity of programs offered, and geographies in which it operates, there is wide variation in CMHC price schedules. For example, there are differences in property prices and wages for staff in Denver Metro as compared to Eastern Colorado; these costs are considered in the Department's price setting efforts for each CMHC. Population and client severity differences also contribute significantly to variation in pricing between CMHCs, such as providing a high volume of drop-in services for individuals experiencing homelessness.

Addressing the Variation Going Forward

In July 2021, the Department submitted a plan to strengthen and expand the behavioral health safety net, as required by SB 19-222. This plan outlines a set of recommendations that allows a broader network of providers to join the publicly funded network and better connects payment methodologies to patient outcomes and quality care. In preparation for this plan to be implemented in 2024, the Department has been working for 12 months on ways the cost reporting model can be updated to directly tie to meeting standards and outcomes, while expanding this network to providers who are able to demonstrate their ability to provide a comprehensive set of services and serve those with complex needs.

We are also pursuing a "Universal Contract" or "Master Contract" process across the behavioral system for providers who receive monies from state agencies, like HCPF and CDHS. This Universal Contract will reduce the variation in reimbursements across providers, set expectations for providers in accepting the most difficult of patients and providing more culturally sensitive and comprehensive services, incorporate pay for performance value-based payments that reward outcomes. On the payer side, it will hold the payers more accountable for timely payments and more consistent utilization review and prior authorization policies and processes.

OTHER DISCUSSION QUESTIONS: ADULT DENTAL, OTHER BENEFITS, HOME HEALTH PRIOR AUTHORIZATION, UTILIZATION MANAGEMENT, DRUG IMPORTATION, ALL PAYER CLAIMS DATABASE (APCD), MMIS, COMPLIANCE FTE, CONTRACTOR FTE

41. [Sen. Hansen] Please provide an update on the adult dental benefit and the return on investment related to providing the benefit to members.

RESPONSE

Colorado's adult Medicaid dental benefit is essential to members so they can live healthy, productive lives. Medicaid dental coverage has played a key role in improving lives and health across the state by:

- Improving nutrition
- Supporting healthier pregnancies
- Avoiding poor medical outcomes
- Enabling people to find better jobs
- Increasing dental care for children due to whole family coverage, creating significant savings on high cost procedures for young children

Prior to Colorado's adult Medicaid dental benefit, nearly one-in-four low-income adults in Colorado had gone five years or more without a dental visit and 41% of low-income adults had untreated tooth decay. The adult Medicaid dental benefit has repeatedly demonstrated its value as a critical service to sustaining the overall health and well-being of low-income Coloradans, as well as controlling unnecessary costs elsewhere in health care.

A June 19, 2015, article published by the PEW Charitable Trust noted that "Medicaid spent $520 million in 2012 on dental-related emergency room visits, according to a research brief issued by the American Dental Association's Health Policy Institute. The researchers estimate that if these visits were diverted to private dental practices, which deliver more comprehensive and cost-effective care, that same $520 million would pay for about 1 million dental visits a year. Treating Medicaid patients in dental practices instead of emergency rooms would be a more efficient use of taxpayer dollars."

The Department implemented the Adult Dental benefit in July 2015. Since the implementation, approximately 195,397 adults have utilized the benefits each year. During FY 2020-21, 21,857 adults reached their $1,500 annual benefit maximum limit. Additionally, emergency room visits for adult dental services dropped nearly 70% since the implementation of the benefit, averaging only $588,000 since July 2015.

42. [Sen. Moreno] What has the Department done to publicize continuous coverage for glucose monitoring services to providers? Please describe any challenges related to offering the benefit in a pharmacy setting as compared with offering it through durable medical equipment providers. Include any cost analysis information between the two provider settings.

RESPONSE

The Department has worked with patient advocates, device manufacturers and other stakeholders within the diabetes community to discuss the role of continuous glucose monitors in diabetes treatment. The Department also posted information in the Provider Bulletin and the Durable Medical Equipment Billing Manual. The Department is not aware of any challenges with offering this benefit in the pharmacy setting. In fact, pharmacies appear to be the setting most favored by Medicaid members. For calendar year 2021 to date, pharmacies provided 69% of our utilizers with continuous glucose monitoring services. The reimbursement is the same regardless of the setting, so there is no cost difference depending on which provider type bills for these services.

43. **[Rep. McCluskie] The Department has recently made changes to its policy and process concerning prior authorization for home health services. Specifically, there are pending authorization requests related to documentation that is currently difficult for providers to acquire. How has the Department engaged stakeholders and providers in the decision making concerning the change in policy and process to ensure that hospitals and ordering physician offices are working with providers and making available the appropriate documentation requested by Kepro? Have the ordering entities been provided training?**

RESPONSE

The Department ensures that its third-party utilization management (UM) vendor, Keystone Peer Review Organization (Kepro), is appropriately enforcing prior authorization industry best standards across all benefit areas including, but not limited to, appropriate use of approved codes, adherence to federal and state policy, requiring supporting documentation such as signed physician orders, current provider notes, and clinical documentation and logs. All documentation submitted should support the scope, frequency, and duration and match the requested services or supplies on the Prior Authorization Request (PAR) Kepro needs to make a medical necessity determination and determine the appropriateness of the request.

The Department engaged/trained member and provider stakeholders through various means prior to the UM vendor transition, which occurred on May 1, 2021, and prior to re-starting the PAR requirement for pediatric long-term home health, including multiple live and recorded trainings and question-and-answer sessions before go-live that reinforced current policy and PAR processes. Additionally, the Department provides updates via provider bulletins, email, special bulletins, the ColoradoPAR website, and public meetings. The Department also implemented the UM email inbox, which is monitored throughout the day, dedicated to the submission of PAR-related questions and concerns, and has recently met with several stakeholder groups about their concerns in addition to participating in recurring stakeholder meetings. Providers have been asked to submit

specific case information so the Department may fully investigate individual member cases. The Department responds directly to those providers and uses the information to identify trends and to educate other providers who may have similar questions. The Department also uses provider feedback to provide guidance to Kepro and improve the UM Program. In a direct response to stakeholder feedback, the Department determined that during the phased in implementation (Nov. 1, 2021-Aug. 31, 2022) to restart the PARs for pediatric home health, the signed order, or signed Plan of Care with an order, that covers the initial 60 days of the authorization, will be accepted to authorize the PAR for the dates requested, if the request meets all other requirements for compliance, including medical necessity. The Department will evaluate the program and determine in fall 2022 through stakeholder engagement if there are needed regulatory changes. This communication was published on Nov. 30, 2021, in Operational Memo 21-081 and a notification was sent to providers via the Department's Fiscal Agent, Gainwell. During the 10-month implementation period, the Department will be conducting provider outreach and offering dedicated training about policy and PAR requirements.

44. **[Rep. McCluskie] How is the Department addressing the duplicative documentation requirements imposed by the Medicare Conditions of Participation to support the medical necessity of delivered services by Home Health agencies and the documentation requirements for the prior authorization review?**

RESPONSE

Long-term home health (LTHH) is a critical service for our members. Members with serious illnesses or disabilities rely on LTHH services to live independently in their homes and communities. In order to protect the availability of these services, the Department must track these resources and reassure federal partners that these services are provided in a safe and clinically appropriate manner, and that the services are not being overused or abused. Therefore, the Department has long maintained a prior authorization process prior to initiation of services. While the Medicare plan of care form specifies the services necessary to meet patient-specific needs, and identifies the responsible clinical discipline(s) and the amount, frequency, and duration of visits, it does not account for adherence to Medicaid rules and policy, or utilization management best practices. Kepro, the Department's utilization management vendor, has the responsibility to review clinical documentation, in addition to the federally required forms, to support the medical necessity of the home health prior authorization requests.

45. [Rep. McCluskie] In the letter to state Medicaid directors from the Centers for Medicare and Medicaid Services (CMS) concerning American Rescue Plan Act (ARPA) implementation, CMS indicates that the state cannot impose stricter eligibility standards, methodologies, or procedures for Home and Community-based Services (HCBS) programs and services than were in place on April 1, 2021. CMS has indicated Home Health services fall within the definition of HCBS services for purposes of ARPA. Please discuss how the PAR process changes are not considered stricter procedures and will not jeopardize the state's ARPA funding.

RESPONSE

The prior authorization process allows the Department to monitor certain benefits and ensure that only medically necessary services are provided and charged to the Medicaid program. The Department has put on hold the prior authorization process for pediatric long-term home health during the public health emergency through a federal 1135 waiver.

Prior authorization processes are permitted under maintenance of effort requirements in ARPA. The prior authorization process for home health benefits is not a stricter eligibility standard, methodology, or procedure, as described in greater detail below. In August 2021, CMS was consulted about the Department's plan to reinstitute the PAR process for pediatric long-term home health services and approved the reinstatement.

CMS previously provided interpretive guidelines in the State Operations Manual related to home health Conditions of Participation, at 42 CFR § 484.18(a). This guidance makes clear that state Medicaid programs should accept "physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed and dated physician's orders, in order to begin [Home Health Agency] services as soon as possible." Colorado Medicaid followed this guidance prior to the pandemic and will continue to do so with the reinstatement of the PAR process.

In addition, the Department has worked with stakeholders to determine the best way to reimplement the PAR process at the same standard regarding duration of approved services. Prior to discontinuing the PAR process, medically necessary services were approved for six (6) months for an initial long-term home health service request; and for one (1) year for continuing prior authorization requests. The policy and practice remain the same now and will be monitored and evaluated during this initial PAR restart phase, through August 2022.

CMS continues to issue guidance on a regular basis related to ARPA maintenance of effort expectations for home and community-based services and we are closely monitoring and

implementing their guidance. The Department will continue to work with CMS and will adapt policies as needed to match ARPA maintenance of effort expectations. The Department understands its ARPA responsibilities extend to 2024.

46. [Sen. Hansen] The Department has requested resources for additional utilization management resources for the prior authorization of specialty (high-cost) drugs. Please discuss the Department's current policies related to reimbursement for specialty (high cost) drugs. How does the Department's current policies concerning high-cost drugs, including the associated reimbursement for them, affect providers that cannot control or affect drug pricing established by pharmaceutical companies? What impact will the Department's proposed changes have on providers in the future?

RESPONSE

The request for additional utilization management resources would only impact about two dozen specialty drugs that are administered in a physician's office or clinic. For those clinics and physicians that administer the impacted drugs, the providers may need to submit prior authorization requests in the future. This would help ensure that the drugs are medically necessary. There would be no impact to reimbursement for these drugs and any prior authorization requirements would not be applicable if the drugs were administered in a hospital setting.

The reimbursement for specialty drugs covered under Medical varies based on the setting where the drugs are administered.

(1) Specialty drugs administered in a physician's office or clinic are generally reimbursed at Average Sales Price plus 2.5%. Average Sales Price is a pricing benchmark posted by the Centers for Medicare and Medicaid Services (CMS).

(2) Specialty drugs administered in an outpatient hospital setting are generally reimbursed at the enhanced ambulatory patient group (EAPG) rates provided by a vendor. Hospitals are assigned a hospital-specific base rate, then payment is calculated as the assigned EAPG's adjusted relative weight multiplied by the billing hospital's base rate. The reimbursement may vary depending on the hospital and their specific base rate. To more appropriately compensate for high cost specialty drugs that are not well represented by the 3M payment tool employed by the Department, six specialty drugs have been carved out of the EAPG methodology and are instead reimbursed at 72% of the net invoice cost (with an additional payment from the provider fee estimated to add about 12-14% to this payment, net 84-86% of invoice). Colorado hospitals were also provided with a process to add new specialty drugs to this carve out process earlier in 2021 in recognition of the impact of emerging high-cost, specialty drugs. Prior to the EAPG methodology, the

Department would reconcile to 72% of cost based on hospital cost reports. The Department converted to the EAPG payment methodology in a cost neutral manner, at the directive of the JBC. To continue that JBC directive, drugs carved out of the EAPG methodology are paid at 72% of invoice (cost) (plus the impact of the CHASE fee, net 84-86% of invoice). Note that this 84-86% of invoice is significantly higher than the 75-79% of costs that Medicaid pays on average to hospitals for all services.

Specialty drugs administered in an inpatient hospital setting are reimbursed under the All Payer Refined Diagnosis Related Group (APR-DRG) methodology and are not carved out and reimbursed separately. The grouper for a claim (referred to as the DRG) is determined by the diagnosis codes submitted on that claim. DRGs have a relative weight determined by using a mix of Medicaid claim data and national statistics supplied by a vendor. The weight for the DRG is then multiplied by the hospital's specific base rate in order to determine the payment for the claim. Under this model, the payment is tied to the cost of treating the condition as opposed to the specific services that are rendered. This encourages the use of lower cost alternatives if those alternatives are medically appropriate.

The reimbursement for drugs outside of hospital settings is tied to actual reported costs; therefore, reimbursement will reflect changes in drug pricing. If cost goes up, reimbursement will increase as well.

47. [Sen. Hansen] Please provide an update on the drug importation program.

RESPONSE

The Department has been working to implement the Prescription Drug Importation Program since the passage of SB 19-005. The Department submitted a draft Section 804 Importation Plan for federal consideration in March 2020 as part of a federal request for comments on HHS importation rulemaking. In November 2020, the federal government issued a final rule, setting forth the framework for state-led importation programs. With that framework, the Department embarked on a competitive procurement process in early 2021 to identify the necessary supply chain partners to make the importation program a reality for Colorado. Since April, the Department has been in negotiations with several candidates and intends to award contracts in early 2022.

The Department will announce supply chain partners in the first half of 2022 as contracts are executed and the importation drug list is finalized. Once these pieces are in place, the Department will finalize and submit an importation plan application to the federal government, targeting by mid-2022. The federal government has set forth a timeline of six months for review and approval,

so the Department estimates that a Colorado program could be operational in 2023. Throughout this process, the Department intends to hold targeted stakeholder engagements to ensure partners in Colorado are aware of progress and opportunities for engagement and participation.

48. [Sen. Rankin] For each of the past three fiscal years, please provide a list of APCD scholarship recipients and the topics for which the scholarship was awarded.

RESPONSE

Over the six years the APCD Scholarship Program has been in place, 129 projects totaling $2.9 million have been awarded through the program. The $500,000 APCD Scholarship Program budget allocation funding was cut in FY 2020-21 due to the fiscal downturn. The Department is requesting to restart the APCD Scholarship Program starting in FY 2022-23 with $200,000 General Fund through R-15 "Restore APCD Scholarship Funds." The below is a summary of projects and dollars by year.

Year	Total Projects	Project Dollars Awarded
FY 2014-15	18	$475,000
FY 2015-16	23	$475,050
FY 2016-17	23	$495,950
FY 2017-18	23	$475,344
FY 2018–19	17	$500,000
FY 2019-20	25	$500,000

As requested, a detailed breakdown of all projects for the last three years of the APCD Scholarship Program is provided as Attachment 1.

49. [Rep. McCluskie] Please discuss the Department's plan to transition away from contracted resources toward the utilization of state FTE, the timeline for

completing the transition, and the contingency plan if the state FTE cannot be hired and trained by the targeted date(s).

RESPONSE

The Department plans to convert five FTE from the System Integrator contractor budget. This allows the Department direct hiring oversight of this critical staff and builds on areas generally not possible with contractors. For example, FTE can be ingrained in the Department's culture, mission and vision leading to better, more efficient outcomes for internal and external stakeholders. Over the years, the Department has successfully hired FTE for internal business processes management, as the Department is in control of the hiring process, selecting the best candidates the first time, and managing employee training and performance to most effectively reflect the needs of the Department. If approved, the Department would post the open positions as soon as possible after the Long Bill is signed, with the goal of having staff hired and working in the summer of 2022.

If the Department cannot hire the FTE by the targeted dates, the Department would consider reorganizing or promoting current staff, and backfilling their positions. Although the contingency plan would shift staff to meet the most critical needs, the Department would need to make decisions on which projects to address and which to delay until resources can be added.

50. **[Rep. McCluskie] Please provide additional information concerning the compliance and oversight responsibilities discussed in R13. Exactly where will compliance and oversight efforts be expanded or strengthened if this request is approved?**

RESPONSE

The Department proposes to expand and strengthen compliance and/or oversight responsibilities in a variety of program areas. As part of the Department's focus on continual improvement to provide sound stewardship of financial resources, the Department has identified administrative opportunities to expand and strengthen operational compliance and program oversight and accountability. Failure to address these program areas may result in low quality services for members and potentially the clawback of federal funding as the result of eligibility error rates above minimum requirements.

Quality Reporting
The FTE would strengthen and develop quality programs with a focus on the Centers for Medicare & Medicaid Services' Child and Adult Core Sets of health care quality measures. Specifically, the Department would focus on several core measures; including Hospital Quality Improvement Payments, the Hospital Transformation Program, and Substance Use Disorder Waiver areas. Beginning in FY 2024-25, the Department is required by CMS to publicly report on these core set of quality measures.

Financial Compliance
The FTE would be the subject matter expert over audit findings pertaining to the Department's financial systems, with responsibilities associated with researching Office of the State Auditor (OSA) audit requests, which includes querying and reconciling data from the Department's data analytics system or Business Intelligence & Data Management (BIDM) system and the Colorado Operations Resource Engine (CORE); and interpreting and responding to auditor questions related to federal and state reporting. Additionally, the requested FTE related to the Recovery Audit Contract (RAC) program would expand program integrity review and fraud capture efforts by working with vendors to identify and recoup overpayments to providers. The vendor requires state staff to assist with identifying and recovering payments and the additional state staff would allow the vendor to expand the number of audits.

Benefit Compliance
The requested FTE would address the increase in workload related to changing state and federal rules and regulations. The position would specialize in tracking and implementing rules, federal mandates, and rate changes for the Department's programs. Delay in implementation of rules, federal mandates, and rate changes through CMS may result in non-conformance of federal policy and potential reduction in federal funding.

Olmstead Compliance
The FTE would manage and oversee the implementation of the Colorado Community Living Plan[6], which is Colorado's Olmstead Plan. Strategies outlined in the Colorado Community Living Plan include work by several state agencies to fulfill the commitment of community living across the state, and coordination of these efforts is critical. This coordination has proven to be a massive lift and can no longer be managed within existing resources. Failure to meet these requirements may be met with legal action.

PACE Oversight
The requested FTE would develop, implement, and oversee a Program of All-inclusive Care for the Elderly (PACE) pay-for-performance framework that includes identifying and developing key performance metrics and revamping the PACE capitation rates through extensive stakeholder

[6] Colorado's Community Living Plan (July 30, 2014), Colorado Department of Health Care Policy & Financing, Colorado Department of Human Services, Colorado Department of Local Affairs, Office of the Governor Joint Endorsement.

engagement. Secondly, the position would be responsible for enhanced oversight and development of inspection and review structures to ensure the health, safety, and welfare of PACE members.

Eligibility Compliance
The requested FTE would ensure eligibility appeals are processed consistently in a timely manner per HB 16-1277 "Concerning the Appeal Process for Medical Assistance Benefits," to address the OSA audit findings[7] and implement fixes to address error rates and issues related to the eligibility appeals process.

Nursing Facility Compliance
The first FTE would implement and administer the new supplemental payment program for nursing facilities introduced by HB 19-1210, "Prohibitions on Local Government Establishing Minimum Wage Laws within its Jurisdiction," and ensure compliance with the act's requirements. In addition, the Department requested resources to enhance compliance with the Civil Monetary Penalty (CMP) program by addressing CMS survey findings and reinvesting penalty funds into nursing home projects. This second FTE would represent the Department's priorities in the management of the CMP program, including in the determination of how the funds will be used, participation in the Nursing Home Innovations Grant Board established in SB 14-151, monitoring and measuring awarded grants for outcomes, and evaluation and analysis of concluded grants to determine viability for replication.

51. [Sen. Rankin] What tasks do the current contractors perform? Please describe the responsibilities of the newly created FTE.

RESPONSE

In R-12 "Convert Contractor Resources to FTE," the Department requests to convert contractor resources to FTE for eight different functions, listed below. For each function, the tasks currently performed by contractors would become the responsibilities of the newly created FTE. The Department seeks to improve all areas of operations associated with the administrative functions included in this request. The Department anticipates this request will enhance administrative functions by using state FTE who can be more responsive to Department priorities and more integrated into the Department's passionate and expert culture and quest for operational excellence.

[7] State of Colorado, Office of the State Auditor, June 2021, Statewide Single Audit Fiscal Year Ended June 30, 2020, pages I-10, II-5

- **Long-Term Care Utilization Management:** A contractor currently evaluates the administration of the home- and community-based services (HCBS) 1915(c) waivers by case management agencies to ensure waiver compliance and continuous quality improvement. The Department requests four FTE to perform these tasks in place of contractor resources. This change allows the Department to target and adjust the quality oversight of case management agencies based on complaints or identified performance concerns without the requirement for contract amendments or a delay in the analysis. In addition, bringing this work internally allows the Department to pair performance concerns with robust training to improve agency performance to the benefit of our members.
- **HCBS Waiver Claims Post-Payment Review:** A contractor currently conducts post-payment reviews of HCBS waiver claims, recoups overpayments, and identifies potential fraud, waste and abuse. The Department requests two FTE to perform these tasks in place of contractor resources.
- **Primary Care Fund (PCF) and Colorado Indigent Care Program (CICP) Review:** A contractor currently reviews PCF and CICP applicant agencies to ensure regulatory compliance and expects additional reviews under HB 21-1198. The Department requests four FTE to perform these tasks in place of contractor resources.
- **Alternative Pay Model (APM) Rate Setting:** A contractor currently provides rate-setting services for value-based programs including the maternity bundled value-based payment and APM 2. The Department requests one FTE to partially replace contractor tasks that do not require actuarial expertise.
- **Program Eligibility and Application Kit (PEAK) Outreach and Colorado Benefits Management System (CBMS):** A contractor currently enhances PEAK through user research-driven improvements, and contractor resources are used to provide broad oversight of PEAK and CBMS. The Department requests six FTE to perform these tasks in place of contractor resources.
- **Independent Verification and Validation (IV&V):** A contractor currently performs IV&V for Medicaid Enterprise systems. New CMS standards require less IV&V and more Outcome-Based Certification (OBC) work, focusing more on business outcomes than technical requirements. The Department requests two FTE to partially replace contractor resources and perform OBC work.
- **Medicaid Management Information System (MMIS) Training:** A contractor currently provides regular MMIS training sessions to providers and Department staff and maintains written training materials. The Department requests two FTE to perform these tasks in place of contractor resources.
- **University of Colorado School of Medicine Physician (CUSOM) Physician Supplemental Payments:** A contractor currently calculates the upper-payment limit for CUSOM supplemental payments and the Department requests one FTE to perform this

task instead. Additionally, the Department requests two FTE for payment oversight, based on approval in the 2021 legislative session.[8]

COMMON QUESTIONS FOR DISCUSSION

1. **Please provide an update on how remote work policies implemented in response to the COVID-19 pandemic have changed the Department's long-term planning for vehicle and leased space needs. Please describe any challenges or efficiencies the Department has realized, as well as to what extent the Department expects remote work to continue.**

RESPONSE

The Department is operating in accordance with the universal Flexible Work policy issued by the Department of Personnel and Administration (DPA) on June 11, 2021. The Department is in the process of finalizing its own internal flexible work policies within the guardrails of the universal policy. The Department anticipates that remote work will continue to be a significant component of operations long term and has incorporated this assumption into its space planning.

Preliminary employee surveys and discussions with managers and leaders have indicated that between one-third and one-half of employees will be working primarily remotely long term, with the remaining employees utilizing a hybrid model. The Department used this data and contracted with a space planner to determine the impact on the Department's square footage needs. As a result of this analysis, the Department was able to determine that its space needs could be consolidated into one building, with a cushion built in for future additional staff (or could be subleased to another state agency in the event of excess space).

The Department, with agreement from DPA and the State Architect, plans to vacate 1570 Grant St. and consolidate into its commercial leased space. 1570 Grant St. will be repurposed in accordance with the Reimagine State Government Plan. Lease negotiations are ongoing, and the Department can provide further information when the negotiations are completed.

The Department does not have any state vehicles, but would note the importance of increasing daily and shared parking spaces in the downtown area in anticipation of the hybrid workforce model.

2. **Please describe the most significant one-time federal funds from stimulus bills (e.g., CARES Act and ARPA) and other major new federal legislation (e.g., Federal Infrastructure Investment and Jobs Act) that the Department has received or expects**

[8] leg.colorado.gov/sites/default/files/cb6-03-24-21.pdf

to receive. For amounts in new federal legislation that have not yet been distributed, please discuss how much flexibility the state is expected to have in use of the funds.

RESPONSE

The most significant one-time federal funds the Department received are from the temporary 6.2 percentage point increase on the federal medical assistance percentage (FMAP) through the Families First Coronavirus Relief Act (FFCRA) and a temporary 10 percentage point increase on the FMAP for home and community-based services (HCBS) through the American Rescue Plan Act (ARPA). See the response to common question #13 for a detailed list of all stimulus funds the Department received. In addition, the Department anticipates there will be significant provisions impacting Medicaid in the Build Back Better Act, if Congress passes it.

FFCRA Enhanced Federal Medical Assistance Percentage (FMAP)

The Families First Coronavirus Response Act provided a temporary 6.2 percentage point increase to the standard FMAP for Medicaid services. The federal match rate increased from 50% to 56.2% for most Medicaid services, but not for members eligible through the Affordable Care Act Medicaid expansion. The enhanced bump will continue until the end of the public health emergency based on current law. The Department is required to comply with several requirements to be eligible for the increase, including maintaining coverage for members throughout the public health emergency, even if they no longer qualify for the program. The Department has received $948.5 million through the FFCRA FMAP bump through September 2021, which has helped the state balance its budget during the pandemic. The majority of these funds reduced the amount of General Fund needed to pay claims, with a portion reducing the amount of cash funds needed.

ARPA HCBS Enhanced Federal Match

Section 9817 increased the federal medical assistance percentage (FMAP) for Medicaid home and community-based services (HCBS) spending by 10 percentage points from April 1, 2021, through March 31, 2022. The bill specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The Department submitted a spending plan to implement this provision and received approval from the Centers for Medicare and Medicaid Services (CMS) and the JBC in September 2021. The Department projects saving $304 million in state funds from the enhanced federal match and spending $512 million through the spending plan, which includes the $304 million in freed-up state funds and matching federal funds for eligible projects. The Department is implementing the spending plan and posts regular updates on its external website.[9]

The Department's spending plan includes eight priority categories. Each category represents a critical area of need for members, their families, and the provider network. Within each category

[9] hcpf.colorado.gov/arpa

there are specific projects, totaling 66 overall. The projects encompass a range of work activities, from current efforts that can be strengthened and supercharged with these funds, to large, transformative work that will ensure Colorado's HCBS system is a national model for excellence in health outcomes, access, member satisfaction, and affordability. At the heart of each is the Department's guiding principle: to ensure access to high-quality services in the community of choice for all members.

One of the key components of the spending plan is to increase rates for direct care workers providing services to members with disabilities with a requirement that providers pay a base wage of $15 per hour. This makes up about 40% of the spending plan. The spending plan includes funding for this through April 15, 2023. The Department is requesting to continue the $15 per hour base wage increases through the regular budget in FY 2022-23 R-10, "Provider Rate Adjustments."

Build Back Better Act

The Department is closely watching progress of the Build Back Better Act in Congress. The current draft of the bill includes several key Medicaid provisions. These include: ramping down the enhanced FMAP authorized under FFCRA through September 2022; outlining a state option to begin redetermining members currently locked into Medicaid under the continuous coverage requirement for April 2022 through September 2022, with requirements around how that can be done; an increase to the FMAP for members eligible through the Affordable Care Act (ACA) expansion from 90% to 93% for three years; and an enhanced FMAP bump for HCBS services with a similar provision stating the funds must be reinvested, as described in ARPA Section 9817.

The level of flexibility for any potential federal funds the state may receive through future federal legislation will be dependent on the legislation itself, as well as the U.S. Treasury guidance that would be issued subsequent to the passage of the legislation, which will establish the allowable flexibility for how the funds are used. For some stimulus funding, this federal guidance is established soon after passage of the relevant legislation, but in many other cases this guidance has taken several months to be finalized. For state and local fiscal recovery funds, the Department continues to evaluate the FAQs and additional guidance provided by the U.S. Treasury.

COMMON QUESTIONS

1. **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. 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 2008-2021: 337

Not Fully Implemented Bills with a HCPF Fiscal Impact 2008-2021: 6

The Department has records of the status of implementation for legislation dating back to 2008. Over the last 12 years, the Department has successfully implemented over 286 bills. Since Medicaid is governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that require federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval which was denied. Without federal financial participation, the Department was unable to implement these bills.

Legislation	**Legislation Summary**	**Barriers to Implementation**
SB 21-009	The bill directs the Department to administer a reproductive health care program to certain individuals who are not eligible for coverage under Medicaid only because of their citizenship or immigration status.	The legislation requires changes, a project, to our Colorado Benefits Management System (CBMS). Many of the Department's resources, as well as the CBMS vendor's resources, have been committed to the COVID-19 PHE unwind project, which goes into CBMS in the February build. Because of the magnitude of the COVID-19 unwind project, other projects had to be pushed to the April build, which is now full. This means the next available build is June. This project will go into the June CBMS build in order to meet the July 1 date. The Department has been proactive in adjusting the CBMS build schedule and delayed the implementation of several other existing projects in order to implement this legislation by July.
HB 21-1166 Cross-System Behavioral Health Crisis Response as it Relates to Persons with Intellectual and Developmental Disabilities	This bill makes an appropriation for the Department to obtain a vendor for the training of twenty (20) service providers, case managers, and mental health counselors state-wide in a comprehensive care	The Department issued a solicitation for a Documented Quote (DQ) to secure a vendor to conduct the training as outlined in the bill. The DQ was issued from Sept. 27, 2021, through Oct. 6, 2021. This was six (6) days longer than the typical three (3)-day response request period. The Department did not receive any responses to the DQ solicitation.

	coordination and treatment model.	Due to the specificity written in the bill for the requirements of a vendor, there are limited vendors in the nation who meet the criteria to provide the type of training solicited. The vendor the Department anticipated would respond to the DQ solicitation was not able to respond in the time frame due to a contract they are engaged on with a project for the City and County of Denver. The potential vendor indicated that they would not be able to perform the work required in the bill in accordance with the time frames required in the bill. The Department will repost the DQ and attempt to secure a vendor.
SB 19-005 Import Prescription Drugs from Canada (Rodriquez, Ginal/Jaquez Lewis)	This bill creates a new program in the Department called the Canadian Prescription Drug Importation Program. Under the bill, the Department must submit a federal waiver application to legally import prescription drugs from Canada. Once approved, the Department will work to design a safe and affordable system to import quality medications at a lower cost for all Coloradans.	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 will be identified in early 2022, after which the Department intends to submit a formal application to the federal government by mid-2022. After the federal review and approval process, importation can begin, likely in 2023.
SB 16-120 Review by Medicaid Client for Billing Fraud	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, legislative bills, and audits that need to be implemented next year in the eligibility system. The Department has this project on its list

(Roberts/Coram)	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.	and can tentatively schedule for early 2023.
HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.	The Department has not yet implemented HB 15-1318, "a fully consolidated Intellectual and Developmental Disabilities (IDD) waiver." The Department's actuarial findings from this work reveal a significant fiscal impact of a redesigned consolidated waiver for which there was no appropriation. Because of this fiscal impact and the lack of ongoing direct service funding associated with HB 15-1318 to implement this mandate, the Department is taking steps to move the work forward with smaller, incremental changes that will provide a better and more thoughtful experience for members receiving services. The first step will be to build upon the significant amount of completed work and begin to align services (for example, service definitions and provider qualifications) across waivers. In simplifying and aligning services, the Department will make accessing services more straightforward and will

		strengthen provider capacity, creating a more stable workforce for the future. The second step will be to focus efforts and analyses on service units and overall authorization limits in the Home and Community-Based Services (HCBS) Supported Living Services (SLS) and Developmental Disabilities (DD) waivers. This would allow for a more individualized approach that would meet each member's needs, moving the Department towards aligned services and a consolidated waiver. Lastly, the new Assessment Tool and Person-Centered Support Plan and Person-Centered Budget Algorithm must be fully implemented for the Department to fully redesign the SLS and DD waivers in an efficient, coordinated, and thoughtful manner. The Department is currently working and making progress on all three of these incremental approaches and related initiatives necessary for moving us closer to CMS approval and implementation of a consolidated Adult IDD waiver.
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	The Department cannot implement this bill as written because it is contingent upon federal financial participation. In order for the state to receive federal financial participation, hospice providers must bill for all services and 'passthrough' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through State Plan or waiver to reimburse Class I nursing facilities directly for room and board, or to pay a provider licensed as a hospice as if they were a licensed Class I nursing facility. Although licensed inpatient hospice facilities are a hospice

		provider type recognized by the Colorado Department of Public Health & Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.

2. **Does the Department have any HIGH PRIORITY OUTSTANDING recommendations with a fiscal impact identified in the Office of the State Auditor's "Annual Report: Status of Outstanding Audit Recommendations"? What is the Department doing to resolve these HIGH PRIORITY OUTSTANDING recommendations? Please indicate where in the Department's budget request actions taken towards resolving HIGH PRIORITY OUTSTANDING recommendations can be found.**

The 2021 report will be published on Dec. 6, 2021, and can be found at this link: http://leg.colorado.gov/content/audits. JBC staff will send out an updated link once the report is published.

RESPONSE

In reference to the outstanding audit recommendations identified in the Office of the State Auditor's "Annual Report of Audit Recommendations Not Fully Implemented," the Department has 10 recommendations that are considered "high priority." This is a decrease from 14 recommendations in the prior year.

The Department's budget requests R-8 "County Administration, Oversight, and Accountability" and R-13 "Compliance FTE" include resources requested to address ongoing improvements to eligibility systems and procedures.

High Priority Recommendations

1. Recommendation 2020-014 relates to the Department improving internal controls over financial reporting by developing, documenting, implementing, and communicating a process for conducting annual reviews of the Colorado interChange System and Organization Controls (SOC) 1, Type II reports to determine if any issues have been noted and whether actions are necessary to remediate these issues.

Implementation Status Update

Implemented. Completion date: July 7, 2021.

The Department completed a final version of the Contracts and Compliance Management Desk Manual in June 2021. This manual describes the process and identifies the roles accountable at HCPF for conducting annual reviews of the Colorado interChange SOC 1, Type II reports and remediating issues noted from those reviews. Further, the Department informed all Health Information Office staff about the Contracts and Compliance Management Desk Manual and its contents in July 2021.

2. Recommendation 2020-034a relates to the Department strengthening its internal controls over Medicaid eligibility to ensure compliance with state and federal regulations by educating caseworkers by incorporating the issues identified through the audit in training and support for the local counties and Medical Assistance (MA) sites to ensure that caseworkers are maintaining the required documentation to support eligibility, correctly calculating resources and resource thresholds, entering information correctly into the Colorado Benefits Management System (CBMS), verifying income to the supporting documentation, terminating benefits appropriately, and enrolling beneficiaries in the correct Medicaid program. The training should focus on and target local counties and MA sites with issues identified in the audit.

Implementation Status Update
Partially Implemented. Estimated completion date: July 31, 2022.

The Department revised its training model which is on track and will be fully rolled out to all counties by July 2022.

3. Recommendation 2020-034b relates to the Department strengthening its internal controls over Medicaid Eligibility to ensure compliance with state and federal regulations by establishing an interim monitoring process over local counties and MA sites until the new oversight monitoring process is implemented as well as to ensure that Medicaid eligibility is processed in accordance with federal regulations and federal grant requirements.

Implementation Status Update
Partially Implemented. Estimated Completion Date: July 31, 2023.

The Eligibility Site Oversight and Accountability Program was implemented in February 2021. The Monitoring Dashboard Phase 2 is pushed back until July 2023 due to completing priorities with legislative mandates.

4. Recommendation 2020-034c relates to the Department strengthening its internal controls over Medicaid eligibility to ensure compliance with state and federal regulations by researching and resolving CBMS system issues to ensure that it is using the correct income information and income thresholds in determining eligibility, eligibility is reconciled between CBMS and the Colorado interChange system, buy-in

premiums are assessed, and any issues related to the transfer of inaccurate information from the Social Security Administration are resolved.

Implementation Status Update

Partially Implemented. Estimated Completion Date: Conditional on the expiration of the COVID-19 public health emergency.

The research and system updates for this recommendation were resolved in May 2019, February 2020, March 2020, and June 2021. The Department will resume the reconciliation process, which will allow the Department to terminate ineligible beneficiaries in the reconciliation report, between CBMS and Colorado interChange when authorized by CMS, once the public health emergency has been lifted.

5. Recommendation 2020-036d relates to the Department improving its internal controls over Children's Basic Health Plan (CBHP) payments by researching and resolving the CBMS and Colorado interChange system interface issues to ensure that the Colorado interChange system only pays providers capitation payments on behalf of eligible beneficiaries.

Implementation Status Update

Partially Implemented. Estimated Completion Date: Conditional on the expiration of the COVID-19 public health emergency.

The Department implemented a reconciliation report in March 2020. This report is reviewed monthly and reveals beneficiaries who are showing up as eligible in the Colorado interChange but not showing eligible in the Colorado Benefits Management System (CBMS). The Department started working on a reconciliation process prior to the COVID-19 public health emergency which would allow the Department to terminate ineligible beneficiaries identified in the reconciliation report. The Department is unable to complete the reconciliation process between CBMS and Colorado interChange due to the public health emergency but will resume the process once authorized by CMS and once the public health emergency has been lifted.

6. Recommendation 2020-039a relates to the Department improving its internal controls over the Medicaid and Children's Basic Health Plan provider eligibility determination. This will ensure compliance with federal and state requirements by improving the Department's review process of provider licenses to ensure the license information in the Department of Regulatory Agencies (DORA) license database matches the license information in the Colorado interChange system. This will also ensure timely termination and restrictions for providers whose licenses are suspended or expired.

Implementation Status Update

Not Implemented. Estimated Completion Date: July 31, 2022

The Department is on schedule to document the following standard policies and procedures:

1. Reviewing license actions to ensure that they are properly documented and required actions are completed in a timely manner.

2. Implementing system changes that will make the data feed from DORA functional including installing a front-end claims edit that will prevent claims from providers with an expired license from paying.

7. Recommendation 2020-039c relates to the Department improving its internal controls over the Medicaid and Children's Basic Health Plan provider eligibility determination to ensure that it complies with federal and state requirements by effectively training and monitoring its fiscal agent to ensure that copies of active licenses are maintained and provider license information in the Colorado interChange system matches the information in DORA's license database.

Implementation Status Update
Partially Implemented. Completion Date: July 31, 2022

Since January 2019, the Department continues to monitor the Fiscal Agent through ongoing audits, meetings and reports. The Department and the Fiscal Agent will continue to collaborate to maintain and ensure accuracy.

8. Recommendation 2020-041c relates to the Department improving its internal controls over Medicaid eligibility by effectively training and monitoring local counties and Medical Assistance sites to ensure that caseworkers are obtaining and documenting the Office of Information Technology Service Desk's approval for changes to beneficiaries' Social Security Numbers and that beneficiaries are enrolled in the correct Medicaid program.

Implementation Status Update
Partially Implemented. Estimated completion Date: July 31, 2023

The Department implemented several projects to assist in partially implementing this recommendation. For example, the Monitoring Dashboard Phase project was implemented in June 2020. This project identifies members who are active with no social security number and monitors eligibility errors, interfaces, data entry, and eligibility results to reduce invalid data changes from interfacing from the State Identification Module (a module that assigns a unique identifier to the member). Another project, implemented in December 2020, reduces incorrect data entry errors from interfacing from the State Identification Module. The Monitoring Dashboard Phase 2 project has been pushed back until July 2023 due to competing priorities with legislative mandates.

9. Recommendation 2020-042a is related to the Department improving its internal controls over Medicaid claims payments by researching and resolving the Colorado Benefits Management System, TRAILS, and Colorado interChange interface issues to

ensure that Colorado interChange only pays provider claims on behalf of eligible beneficiaries.

Implementation Status Update

Partially Implemented. Estimated completion Date: Conditional on the expiration of the COVID-19 public health emergency.

The Department implemented a reconciliation report in March 2020. This report is reviewed monthly and reveals beneficiaries who are showing up as eligible in the Colorado interChange but not showing eligible in the Colorado Benefits Management System (CBMS). The Department started working on a reconciliation process prior to the PHE which would allow the Department to terminate ineligible beneficiaries identified in the reconciliation report. The Department is unable to complete the reconciliation process between CBMS and Colorado interChange due to the public health emergency but will resume the process once authorized by CMS and once the public health emergency has been lifted.

10. Recommendation 2020-044a is related to the Department improving its controls over Medicaid and Children's Basic Health Plan program provider eligibility determination and enrollment to ensure that it complies with federal and state requirements by working with its fiscal agent to ensure that Colorado interChange performs all required database matches and properly displays results of Social Security Number and Federal Employer Identification Number verifications for all providers.

Implementation Status Update

Partially Implemented. Estimated completion Date: July 31, 2022

The interChange is accurately displaying Social Security Number and Federal Employer Identification Number verifications for all providers as of May 26, 2021. The Department continues to work with its Fiscal Agent to ensure that the manual database checks are being completed until the automated process is completed July 2022.

3. **Is the Department spending money on public awareness campaigns? If so, please describe these campaigns, the goal of the messaging, the cost of the campaign, and distinguish between paid media and earned media. Further, please describe any metrics regarding effectiveness and whether the Department is working with other state or federal departments to coordinate the campaign?**

RESPONSE

The Department was not appropriated money for public awareness campaigns last year. The Department used existing staff resources thus far to communicate Health First Colorado benefits and covered services to members during the COVID-19 public health emergency. The Department

anticipates needs for significant communications in partnership with the Colorado Department of Public Health & Environment (CDPHE) next year to ensure public health messaging on vaccines reaches members and providers.

The Department has leveraged existing channels other than paid media to communicate with its audiences. Examples include sharing CDPHE guidance and resources with numerous stakeholders representing members and providers, Connect for Health Colorado, advocates, counties, and other partners. Message examples included, but were not limited to, safety measures during the pandemic such as wearing masks, social distancing, washing hands, vaccine efficacy and availability, and celebrating holidays with household members. The Department utilized these messages and channels to increase awareness of its programs to help Coloradans stay covered during this economic downturn. None of these Department efforts generated additional costs for the state.

4. **Please identify how many rules you have promulgated in the past year (FY 2020-21). With respect to these rules, have you done any cost-benefit analyses pursuant to Section 24-4-103 (2.5), C.R.S., regulatory analyses pursuant to Section 24-4-103 (4.5), C.R.S., or any other similar analysis? Have you conducted a cost-benefit analysis of the Department's rules as a whole? If so, please provide an overview of each analysis.**

RESPONSE

From October 2020 to October 2021, the Department promulgated 78 rules. The Department does cost-benefit and regulatory analyses for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analyses are included in the rule-making document packet that accompanies each rule proposed by the Department. The cost-benefit analysis includes the following components:

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

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

With respect to these rules, a separate cost-benefit analysis was requested for three of the rules. Section 24-4-103(2.5), C.R.S., states that anyone may request a cost-benefit analysis within five days of the publication of notice of proposed rulemaking in the Colorado Register. The response to the cost-benefit analysis request was structured like the analysis performed on every rule described above. The request comes with information and the Department responded to that request.

The Department performed a regulatory analysis of all 78 rules pursuant to section 24-4-103(4.5), C.R.S. The regulatory analysis performed on each rule is compliant with statute and is available to the public for review five days prior to the rule-making hearing on the Department's public website. The Department has not conducted a cost-benefit analysis of the rules as a whole.

Each year, the Department is required to submit a regulatory report to the General Assembly and the Secretary of State. This report documents all rules promulgated by the Department and is on the Department's website. The Department's cost-benefit and regulatory analyses are also available on the Department's website for the Medical Services Board at https://hcpf.colorado.gov/medical-services-board.

5. **What are the major cost drivers impacting the Department? Is there a difference between the price inflation the Department is experiencing compared to the general CPI? Please describe any specific cost escalations, as well as cost impacts driven by COVID-19 and supply chain interruptions.**

RESPONSE

The primary cost driver impacting the Department's FY 2022-23 General Fund request is the anticipated end to the enhanced federal match permitted by the Families First Coronavirus Relief Act during the public health emergency (PHE). During the PHE, states are eligible to receive a 6.2 percentage point increase in the base federal medical assistance percentage (FMAP). The current forecast anticipates the enhanced FMAP will end Dec. 31, 2021, therefore leading to a significant General Fund increase in the FY 2022-23 budget. The Department is projecting that it will need an increase of $306.6 million General Fund in FY 2022-23 compared to its appropriation to fund Medicaid and CHP+ services. About three quarters of that amount, around $224 million, is due to the projected end of the enhanced FMAP.

In the opposite direction, the Department's request projects a year-over-year decrease for overall Medicaid caseload in FY 2022-23. Medicaid caseload grew significantly from FY 2019-20 through FY 2021-22, primarily for children and adult populations, due to the downturn in the economy, the related increase in Medicaid enrollees, and the moratorium on disenrolling Medicaid members during the PHE. In this forecast, the Department is projecting a decrease in overall caseload as the PHE is expected to end Dec. 31, 2021, as of the publishing of this forecast. The Department is projecting overall growth of 9.31% in FY 2021-22 and a decrease of 9.30% in FY 2022-23. Growth is driven primarily by income-sensitive groups which are projected to grow by 10.19% in FY 2021-22 and a decline of 9.92% in FY 2022-23. This impact is dampened by a projected increase in acute care per capita costs. Per capita costs have been lower than normal throughout the PHE as the members who are locked into Medicaid are less expensive than members who are not locked into the program. After the PHE ends, the Department will redetermine all members who are currently locked into the program and will disenroll those who no longer qualify. The Department anticipates that per capita costs will rebound back to pre-pandemic levels. In addition, there are underlying increasing trends in inpatient hospital and pharmacy costs, as well as higher costs due to the continued growth of available specialty drugs.

For populations in which eligibility is not driven by economic conditions, such as adults 65 and older and people with disabilities, the Department is projecting growth of 4.12% in FY 2021-22 and a decrease of 5.51% in FY 2022-23. The biggest cost driver for these populations continues to be the growth in utilization of Medicaid long-term services and supports, including home and community-based services (HCBS), the Program of All-Inclusive Care for the Elderly (PACE), and long-term home health. Over the long term, the Department expects that this General Fund growth will be driven in large part by the aging of Colorado's population. Services incurred by people 65 and older, and people with disabilities who qualify for Medicaid, are paid for using General Fund and will receive a 50% federal match rate once the PHE ends.

Members with one or more chronic condition are also a major cost driver for the Department. Members with a chronic condition in FY 2018-19 accounted for approximately 83% of the total medical spending. As the population ages it is expected that more of the Department's budget will be attributed to expenditure related to chronic conditions. The Department's R-6 "Value Based Payments" request will empower primary care medical providers in the Accountable Care Collaborative to innovate in the way they deliver care to patients with chronic conditions. This will help control costs related to spending for chronic conditions and help members to live healthier lives.

For most services, the Department does not experience "price inflation," as the Department does not automatically adjust rates for inflation. Instead, the Department adjusts most rates only when additional funding is appropriated by the General Assembly. As providers experience rising costs due to factors such as wage growth or the increasing cost of their employee benefits, they generally must absorb those cost increases until the General Assembly appropriates funding to increase

Medicaid rates. The Department's Nov. 1 Budget request R-10 includes a number of provider rate increases, including funding to permanently continue higher rates for HCBS as implemented through the Department's HCBS spending plan to support the direct care work force. The Department will continue to require a wage passthrough to ensure workers receive at least $15 per hour base wage. The Department's request also includes funding to address recommendations from the Department's annual rate review process on transportation (EMT, NEMT, NMT), durable medical equipment, and speech therapy; and, funding for a 0.5% across-the-board rate increase to other fee-for-service providers.

Although most services do not see inflationary rate changes without additional appropriations, some service categories do receive automatic rate increases when required by statutory formulas. Key examples include nursing facilities (required by state statute), federally qualified health centers (required by federal law), pharmacy (required by federal regulation), managed care rates (required by federal regulation), and Medicare premiums.

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

RESPONSE

The Department is projecting strong, positive growth in overall caseload as the ongoing economic uncertainty is expected to continue. The Department is projecting overall growth of 9.31% in FY 2021-22 due to the continuation of the public health emergency (PHE) and the corresponding continuous coverage requirement to receive the emergency enhanced FMAP. The Department is forecasting an overall decrease of 9.30% in FY 2022-23 due to the projected end of the PHE, after which members who are locked into Medicaid are expected to be redetermined and potentially disenrolled. Growth in FY 2021-22 is driven primarily by income-sensitive groups which are projected to grow by 10.19%. The income-sensitive groups are also expected to drive most of the decreases in FY 2022-23 where they are projected to decrease by 9.92%.

For populations in which eligibility is not driven by economic conditions, such as adults 65 and older and people with disabilities, the Department is projecting growth of 4.12% in FY 2021-22 and a decrease of 5.51% in FY 2022-23. The projected growth is informed by projections of the aging population and historical growth of people with disabilities. The State Demographer indicated that the 65 and older adult population in Colorado increased by 43% from 2010-2017, compared to 14% for the rest of the state's population, and is projected to increase by nearly 70% by 2030. The biggest long-term cost drivers for these populations continues to be the growth in

utilization of Medicaid long-term services and supports, including home and community-based services (HCBS), the Program of All-Inclusive Care for the Elderly (PACE), and long-term home health. Over the long term, the Department expects this General Fund growth will be driven in large part by the aging of Colorado's population. Services incurred by people age 65 and older and people with disabilities who qualify for Medicaid are paid for with General Fund and generally receive the standard federal match rate. Federal contributions for this population are currently receiving an additional 6.2 percentage points from the Families First Coronavirus Response Act (FFCRA) during the PHE; additionally, federal contributions for certain services related to HCBS received an increase of 10 percentage points from the American Rescue Plan Act. The Department expects these enhanced federal fund rates to expire by the end of FY 2021-22, upon which the state would need to resume paying the full General Fund share at 50%.

7. **In some cases, the roles and duties of existing FTE may have changed over time. Please list any positions that have been created in the Department since FY 2019-20 that were not the result of legislation or a decision item.**

   For all FY 2022-23 budget requests that include an increase in FTE:

   a. Specify whether existing staff will be trained to assume these roles or these duties, and if not, why;

   b. Specify why additional FTE are necessary; and

   c. Describe the evaluation process you used to determine the number of FTE requested.

RESPONSE

The Department has created 18.0 FTE positions since FY 2019-20 as identified in table 1 below. Of the positions created below, eight are grant funded and have no General Fund impact and three are temporary positions related to short-term workload increases. Additionally, over that time the Department has abolished one permanent position due to being no longer needed. Further, the Department has repurposed 26 positions to address priorities of the Department, thereby avoiding a request for additional general funds. No replacement positions are posted in the Department until the Executive Director agrees that filling that vacant position is a priority over other Department needs.

Table 1 - Non-Legislative positions created since FY 2019-20

Position Title	Reason Position Created	Number of Positions
FY 2019-20		
Project Coordinator	Maternal Opioid Misuse Model (MOM) Grant	1.0
Program Management II	PEAK Manager - funded by multiple agencies	1.0
FY 2020-21		
Administrator III	Maternal Opioid Misuse Model (MOM) Grant	2.0
Program Management I	CBMS positions for workload increases	2.0
Analyst IV	Health Information Exchange (HIE) Advanced Planning Document (APD) assistance	1.0
FY 2021-22		
Administrator III	Prescriber Tool Advanced Planning Document (APD) assistance	1.0
Training Specialist III	Staff Development Center (SDC) Regional Training Rep	1.0
Analyst III	Joint Agency Interoperability (JAI) Project Manager - term-limited ends June 30, 2024	1.0
Administrators	Money Follows the Person (MFP) Grant	5.0
Compliance Specialist II	Provider Audits – term-limited ends June 30, 2022	2.0
Human Resource Spec III	HR position due to workload increases	1.0
Total		**18.0**

For FY 2022-23 budget requests that include an increase in FTE:

a. The Department is requesting resources across several budget requests to better align the workforce with the significant increases in workload the Department is experiencing and will continue to experience. Existing staff would not be trained to assume these roles because the Department is already over capacity at managing the current needs/requirements. For all FTE requests, existing staff who apply and are qualified are trained for those roles and duties. If the Department hires existing staff into these new positions, it would then be tasked with back-filling that person's old role.

b. Additional FTE are necessary because the Department is already at workload capacity within existing resources. With increased federal and state regulations, the Department requires additional FTE to more effectively oversee compliance with the Department's existing programs and vendors.

c. The Department uses a variety of processes to evaluate the number of FTE needed. For example, the Department uses prior experience on staffing levels for projects of a similar magnitude. The Department also uses current vendor contracts to estimate the FTE needed. Some

contracts offer a one to one relationship related to the number of FTE the vendor has performing the duties and the number the Department would need. Additionally, the Department uses current workload statistics in determining the number of FTE required. For example, the Department determines the amount of additional work the program would be driving and extrapolates the number of FTE required based on the amount of work the current resources can perform in a given year.

8. **Please describe any ongoing or newly identified programmatic impacts for the Department resulting from cash fund transfers as part of the FY 2019-20 and FY 2020-21 balancing process.**

RESPONSE

The Department's budget includes the following cash fund transfers resulting from the final FY 2019-20 and FY 2020-21 balancing process and projected in FY 2021-22 and FY 2022-23:

- **Use of Increased Medicaid Match**: HB 20-1385, "Use of Increased Medicaid Match," required the Department to use a temporary increase in federal financial participation (FFP) available through the Families First Coronavirus Response Act for certain financing payments to reduce General Fund. This includes supplemental payments for hospitals, nursing facilities, and University School of Medicine, as well as payments made with certified public expenditure. The payments to each program remained net neutral resulting in no programmatic impacts. SB 21-213, "Use of Increased Medicaid Match," similarly directs the Department to use the temporary increase in FFP in FY 2021-22 and FY 2022-23 to reduce General Fund.
- **Healthcare Affordability and Sustainability Fee Cash Fund Offset**: HB 20-1386, "Use Fees for Medical Assistance Program General Fund Offset," authorized the use of $161 million in revenue from the Healthcare Affordability and Sustainability Fee Cash Fund as General Fund offset in FY 2020-21. This resulted in higher overall fees charged to the hospitals.
- **Intellectual and Developmental Disabilities Services (IDD Services) Cash Fund Offset**: The JBC approved an action in the FY 2020-21 Long Bill to offset General Fund expenditure with $6.7 million from the Intellectual and Developmental Disabilities Services (IDD Services) cash fund. This reduced the reserves in the cash fund by more than the amount needed to fund previously approved commitments through FY 2021-22. These commitments include the Supported Employment Pilot Program, eliminating the waitlist for the state-only Supported Living Services program, and reducing the waitlist for the Family Support Services program. Because of the projected insufficient balance of the IDD Services cash fund to fund these commitments, the JBC approved an action in the FY 2021-22 Long Bill to partially fund these programs using General Fund through FY 2021-22.

However, there was an unanticipated influx of revenue into the cash fund from General Fund reversions following FY 2020-21. The balance of the IDD Services cash fund is now more than sufficient to fund existing commitments through the statutory expiration of the IDD Services Cash Fund in FY 2021-22. The Department has requested General Fund for FY 2022-23 to allow for the continuation of the programs.

9. **Please describe the Department's FY 2020-21 vacancy savings, as well as projected vacancy savings for FY 2021-22 and FY 2022-23. How has the Department utilized vacancy savings in recent years?**

RESPONSE

The Department actively monitors under-expenditure in its personal services budget each year and reverts any unused funding. In FY 2021-22 and FY 2022-23, the Department is not projecting any vacancy savings. Although hiring new positions has been challenging, the Department has seen increases in temporary employees, and increases in salary offers due to the tight labor market and the requirements of SB 19-085, the Equal Pay for Equal Work Act. These factors will continue to put upward pressure on salary increases to ensure equity across the Department and the Department anticipates this will continue. In recent years, some vacancy savings have been used to provide temporary discretionary pay adjustments to staff who are performing more than one job while the vacancy is being filled or to maintain current staff with critical skills, acting pay for special assignments, and adding positions within the Department due to workload demands.

10. **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. Please:**

    a. List each source of non-tax revenue (e.g., fees, fines, parking revenue, etc.) collected by your department that is subject to TABOR and that exceeds $100,000 annually. Describe the nature of the revenue, what drives the amount collected each year, and the associated fund where these revenues are deposited.

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

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

NOTE: An example template for providing data for this question will be provided by the JBC Staff.

RESPONSE

a. The following table lists the Department's cash funds that have non-tax revenue subject to TABOR and provides a description of the revenue source.

Table 1: Non-Tax Revenue Sources Subject to TABOR		
Source of Non-Tax Revenue	**Description of Revenue**	**HCPF Funds with Revenue**
Motor Vehicle Registrations	Per 42-3-217.5 (3)(c), C.R.S., a $25 surcharge on breast cancer awareness special license plates is to be deposited in the Eligibility Expansion Account. Because the eligibility expansion has been authorized, ongoing revenue collections are deposited in the main fund.	Breast and Cervical Cancer Prevention and Treatment Program (Fund 15D0)
Children's Basic Health Plan Premiums	Premiums are collected from families of Child Health Plan *Plus* enrollees who enter the program. Premiums are $25 for families with one child enrolled and $35 for families with two or more children enrolled. Any families that are below 150% of the federal poverty level (FPL) do not pay a premium. Revenue is driven by the number of families enrolled in the program and the household size and federal poverty level of each family.	Children's Basic Health Plan Trust (Fund 11G0)
Health Care Service and Provider Fees	Service fees are collected from private and public intermediate care facilities who provide care for individuals with intellectual disabilities. The fee level is set by the Medical Services Board, not to exceed 5% of the total costs incurred by all intermediate care facilities. Revenue is driven by the number of private and state operated intermediate care facilities that the Department collects fees from. Provider fees are collected pursuant to section 25.5-6-203, C.R.S. The Department is required to collect a Quality Assurance Fee from nursing facilities, including facilities that do not serve Medicaid members. Each year, the fee is increased by inflation based on the national skilled nursing facility market basket index determined by the Secretary of Health and Human Services for future years. In FY 2020-21, the provider fee could not exceed $15.66 and, in FY 2021-22, the provider fee shall not exceed $16.06.	Service Fee Fund (Fund 16Y0) and Medicaid Nursing Facility Cash Fund (Fund 22X0)

Medicaid Premiums	Premiums are paid by members eligible for and participating in the Medicaid Buy-In Program based on a sliding-fee scale. Revenue is driven by the number of members who participate in the program.	Medicaid Buy-In Cash Fund (Fund 15B0)
Medicaid Provider Enrollment Fees	Fee revenue currently consists of provider screening fee revenue which, pursuant to federal regulations under 42 CFR § 455.460, must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government. Revenue is driven by the number of Medicaid providers that need recertification and the number of new providers undergoing background checks to become a Medicaid provider.	Department of Health Care Policy & Financing Cash Fund (Fund 23G0)
Other Intergovernmental Revenue	The Department receives an annual intergovernmental transfer from Denver Health to assist with payments to eligible nursing facilities to expand access for patients who require special long-term services and supports because of physical, behavioral, and/or social complexities. The intergovernmental agreement of the transfer is expected to continue around $700,000.	General Fund (Fund 1000)
Operating Transfer from TABOR Enterprise	There is an annual transfer from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Cash Fund to the Department to offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums. The expected annual transfer amount is $15,700,000 in subsequent years.	General Fund (Fund 1000)
Operating Transfer from CUSOM	The Department receives an intergovernmental transfer from the clinical revenues of the University of Colorado School of Medicine (CUSOM). The funding provides the state-share necessary for federally-matched supplemental payments paid back to CUSOM. The funding will help develop the recently formed Aurora Community Health Commons, which is a federally qualified health center, in partnership with Salud Family Health Centers.	General Fund (Fund 1000)

Interest	Non-exempt interest income is received from various cash fund balances. The amount of interest income is based on the balance of each cash fund. The Department has two cash funds that received non-exempt interest income above $100,000 in FY 2020-21. Beginning in FY 2021-22, the Nursing Penalty Cash Fund will be managed by the Department of Public Health & Environment. At the end of FY 2021-22, the Intellectual and Developmental Disabilities Services Cash Fund will repeal.	Intellectual and Developmental Disabilities Services Cash Fund (Fund 27U0) and Nursing Penalty Cash Fund (Fund 2840)

b. The following table lists the Department's cash fund actual revenues collected in FY 2020-21 and projected revenues to be collected in FY 2021-22 and FY 2022-23.

Table 2: Non-Tax Source Revenues

Source of Non-Tax Revenue	FY 2020-21 Revenue	FY 2021-22 Revenue Estimate	FY 2022-23 Revenue Estimate
Motor Vehicle Registrations	$793,013	$793,013	$793,013
Children's Basic Health Plan Premiums	$13,195	$518,018	$1,209,463
Health Care Service and Provider Fees	$59,709,859	$56,626,537	$61,181,688
Medicaid Premiums	$104,804	$3,391,977	$6,896,418
Medicaid Provider Enrollment Fees	$326,144	$326,144	$326,144
Other Intergovernmental Revenue	$613,200	$700,000	$700,000
Operating Transfers from TABOR Revenue	$15,870,388	$15,700,000	$15,700,000
Operating Transfer from CUSOM	$46,189,025	$11,668,599	$11,668,599
Interest (Fund 27U0 Only)	$163,366	$276,973	$0
Total	**$123,782,994**	**$90,001,260**	**$98,475,324**

c. The Department did not submit any FY 2022-23 decision items that would increase revenues subject to TABOR.

11. **Please describe one-time federal stimulus funds (such as the CARES Act, ARPA, and the Federal Infrastructure Investment and Jobs Act) that the Department has received or expects to receive**

RESPONSE

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

- **Telehealth Services:** The Department received $5,068,381 in FY 2020-21 from the CARES subfund through SB 20-212, "Reimbursement for Telehealth Services." This bill expanded Medicaid reimbursement for telehealth services, which was necessary to protect the safety of both members and providers while still providing access to services during the pandemic. The Department fully spent the funding in the first half of FY 2020-21.
- **Senior Strike Force Staffing:** The Department spent $45,820 in FY 2020-21 for FTE to support the Governor's cross-agency taskforce. This taskforce was created to develop and implement strategies to mitigate the spread of the illness and save lives in residential congregate settings that serve adults 65 and older and people with disabilities. The Department used the funding to staff a project manager and workforce lead for the taskforce.
- **Vaccine Outreach:** The Department received $14,337,696 to implement targeted vaccine outreach for two high-priority population groups: 1) homebound members and 2) populations impacted by health disparities. The Department made funds available to the Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and case management agencies to ensure resources were available to vaccinate these populations. These efforts led to 100% of homebound members who wanted to receive a vaccine, receiving their vaccine and minimized the health disparity gap between racial groups within the Medicaid population. These activities are eligible for reimbursement by the Federal Emergency Management Agency (FEMA) Disaster Relief Fund, and the Department is working with the Department of Public Safety to move expenditures to that fund.

Families First Coronavirus Relief Act (FFCRA)

- **Enhanced Federal Medical Assistance Percentage (FMAP):** FFCRA provided a 6.2 percentage point increase to the standard FMAP for Medicaid services. The federal match rate increased from 50% to 56.2% for most Medicaid services. The enhanced federal match will continue until the end of the public health emergency based on current law.

The Department is required to comply with several requirements to be eligible for the 6.2 percentage point increase, including maintaining coverage for members throughout the public health emergency, even if they no longer qualify for the program. The Department has received $948.5 million through the FFCRA FMAP bump through September 2021, annualizing to over $1 billion through December 2021. This has helped the state balance its budget during the pandemic. Most of that amount reduced the amount of General Fund needed to pay claims, with a portion reducing the amount of cash funds needed.

American Rescue Plan Act (ARPA)

- **Home and Community-Based Services (HCBS) Enhanced Federal Match:** Section 9817 increased the federal medical assistance percentage (FMAP) for Medicaid HCBS spending by 10 percentage points from April 1, 2021, through March 31, 2022. The bill specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The Department submitted a spending plan to implement this provision and received approval from the Centers for Medicare and Medicaid Services (CMS) and the JBC in September 2021. The Department projects saving $304 million in state funds from the enhanced federal match and spending $512 million through the spending plan, which includes the $304 million in freed-up state funds and matching federal funds for eligible projects. The Department is implementing the spending plan and posts regular updates on its external website.[10]
- **100% FMAP to Urban Indian Health Organizations:** Section 9815 provides a 100% federal match for services provided in an Urban Indian Health Organization for eight quarters. The Department anticipates receiving a projected $118,850 in additional federal funds through this provision and a corresponding reduction of that amount to General Fund. The enhanced federal match is accounted for in the Department's R-1, "Medical Services Premiums." In addition, the Department submitted R-16, "Urban Indian Health Organizations State-Only Payments," to request to use the freed up General Fund to make state-only payments to Denver Indian Health and Family Services, which is the only Urban Indian Health Organization in the state.
- **100% FMAP for COVID-19 Vaccine Administration:** Section 9811 provides a 100% federal match for expenditure billed for COVID-19 vaccine administration for Medicaid and CHP+. The Department anticipated receiving a projected $10 million in additional federal funds through this provision and a corresponding reduction of that amount to state funds. The enhanced federal match is accounted for in the Department's R-1, "Medical Services Premiums."
- **Increased Allotment for Disproportionate Share Hospital Payments:** Section 9814 increases the federal allotment for payments to hospitals that serve a disproportionate share of low-income patients to account for the 6.2 percentage point FMAP increase authorized under the Families First Coronavirus Relief Act. The Department projects that it will draw

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

down an additional $27.1 million through the increased allotment. This will be used to offset General Fund per SB 21-213, "Use of Increased Medicaid Match."

- **Behavioral Health Recovery Act (SB 21-137):** SB 21-137, "Behavioral Health Recovery Act," appropriated $250,000 in state and local fiscal recovery fund dollars to support training health care & behavioral health care professionals in substance use screening, brief intervention, & referral to treatment (SBIRT). SBIRT is a comprehensive, integrated best practice for early identification, intervention and treatment for people with or at risk of substance use disorder. These funds are anticipated to be expended by the end of FY 2021-22.
- **Planning Grant to Provide Community-Based Mobile Crisis Services:** The Department received $818,278 in a direct grant from CMS under Section 9813 to plan how to expand the Department's crisis response services. This planning grant will help determine how to implement the state option to provide qualifying community-based mobile crisis intervention services, which would qualify for an enhanced 85% federal match if implemented.
- **Sunset Limit on Maximum Rebate Amount for Single Source Drugs and Innovator Multiple Source Drugs:** Section 9816 eliminates the current cap on rebates that manufacturers pay to the state for certain prescription drugs. This provision goes into effect Dec. 31, 2023. This would likely result in higher rebates overall to the state, which would offset overall cost of care for Medicaid members.
- **12-Month Postpartum Coverage for Medicaid and CHP+:** SB 21-194, "Maternal Health Providers," expands eligibility for members who were eligible for pregnancy-related and postpartum services from 60 days postpartum to twelve months postpartum. Section 9812 of ARPA provides a state option to expand coverage in this way through the Department's state plan agreement with CMS. There is no additional or enhanced funding through ARPA to implement the provision.
- **Funding for Administrative Staff for the ARPA-Related Work:** The Department was allocated $80,000 from the Public Health/Administrative fund allocated to the Governor's Office to begin work on standing up the administrative infrastructure for ARPA-related projects. The funding is specifically for the costs to hire 5.0 FTE for two months in human resources, accounting, and procurement to ensure the Department can implement the various ARPA projects as soon as possible.

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
FY 2019-2020			
Employers/Purchasing Alliances			
Peak Health Alliance			
Custom Outmigration Reports	$20,608	80%	20%
Summit and Grand County Cost Comparison	$23,744	80%	20%
Local First			
Southwest Health Alliance Cost Analysis	$23,744	80%	20%
Mesa County Public Health			
Mesa County Cost Savings Analysis	$23,744	80%	20%
Garfield County			
Garfield County Cost Analysis	$23,744	80%	20%
Chaffee Community Foundation			
Lake and Chaffee County Cost Comparison	$23,744	80%	20%
Northern Colorado Consortium: Systems of Care Initiative			
Advanced Care Directives Code Evaluation	$3,610	80%	20%
Northern Colorado Consortium: CBGH			
Northern Colorado Low Value Care Tool	$1,900	80%	20%
Northern Colorado Consortium: Larimer County			
Knee Replacement and Revision Episodes of Care, Knee Surgery Referral Patterns	$21,280	80%	20%
	$166,118	80%	20%
Academic Researchers			
University of Colorado			
Division of Health Care Policy and Research			

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
HIE Participation and Post-Acute Care Patient Outcomes	$48,832	80%	20%
Colorado Clinical and Translational Sciences Institute			
Lung Cancer Screening and Proximity Report	$27,664	80%	20%
Department of Neurology			
Neurology Adolescent Stroke Risk Factors	$58,392	57%	43%
Surgical Outcomes and Applied Research Program (SOAR)			
Utilization of Emergency Care Following Bariatric Surgery	$51,744	80%	20%
Division of Geriatric Medicine			
Impact of Respite Care for Persons Affects by Alzheimer's	$25,872	80%	20%
Division of Pulmonary Sciences and Critical Care Medicine			
Determining Healthcare Trajectories for Patients Experiencing Critical Illness in the State of Colorado	$37,184	80%	20%
Burden of Steroid-Related Pneumocystis Pneumonia in Colorado	$25,984	80%	20%
Department of Orthopedics			
Exploring Socioeconomic Bias in Choice of Elective Treatments for Multiple Orthopedic Injuries	$34,832	80%	20%
Department of Pediatrics- pCNA Program			
Parents as their Child's Certified Nursing Aid (pCNA) Program	$50,736	80%	20%
University of Denver			
Incidence of Cancer Diagnosis in the Rocky Flats Region	$4,000	80%	20%
	$365,240	76%	24%
State Agencies and Governmental Entities			
Colorado Department of Human Services			
Children's Behavioral Health Financial Mapping	$21,504	100%	0%
Colorado Department of Labor & Employment			
Evaluation of Trauma Activation Fees	$1,000	80%	20%

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
Colorado Department of Public Health and Environment			
Extract Enhancement	$15,811	75%	25%
	$38,315	89%	11%
Nonprofits/Associations			
Colorado Cancer Coalition			
Lung Cancer Screening Analysis	$13,440	80%	20%
Colorado Consortium for Prescription Drug Abuse Prevention			
CO Opioid Use and Abuse Prevention Evaluation	$41,888	80%	20%
9Health Fair			
Economic Value of 9Health Screenings	$12,320	80%	20%
	$67,648	80%	20%
FY 2019-2020 Totals	$637,321	78%	22%

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
FY 2018-2019			
Academic Researchers			
University of Colorado			
Department of Pediatrics			
Predicting Asthma Outcomes Through Analysis of Early Respiratory Hospitalizations in Children	$43,904	77%	23%
Cancer Center			
HPV Vaccination HSR Project, Evaluating the Impact of Distance and Vaccination	$46,256	78%	22%
School of Medicine			
Apoyo con Carino (Support through Caring): Improving Palliative Care Outcomes for Latinos with Advanced Medical Illness	$45,472	85%	15%
Division of Cardiology			
Cardiac Stress Tests and Evaluating Low-Value Tests and Their Potential Harm	$42,560	77%	23%
Colorado School of Public Health			
Evaluating and Modeling REMS Drug Diffusion, Prescription & Utilization Patterns	$47,712	79%	21%
University of California Los Angeles			
UCLA Youth Psychotropic Medication Use	$59,696	75%	25%
	$285,600	78%	22%
State Agencies and Governmental Entities			
Colorado Division of Insurance			
Potential Savings with Costs Associated with Reinsurance Program Repricing Claims Using Medicare Reference Based Methodology	$35,884	100%	0%
Colorado State Legislature			
Understanding the Variance of Paid/Allowed Amount Among the Top 25 CPT Codes Across the State	$9,184	100%	0%
	$45,068	100%	0%

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
Nonprofits/Associations			
CIVHC Analytics			
Milliman/VBID Low Value Waster Calculator Extract	$51,296	74%	26%
Palliative Care - The Costs Associated with the Care at End of Life	$20,500	100%	0%
Colorado Children's Access Program			
Emergency Department Utilization Project- Evaluating the Cost Savings of Establishing Medical Homes	$41,776	85%	15%
Colorado Community Managed Care Network (CCMCN)			
CCMCN Subscription- Integrating Claims Data to FQHC Clinical Data for Care Management	$80,640	56%	44%
Colorado Consumer Health Initiative			
Analysis of Prescription Drug Costs, Top 20 High Volume/ High Cost Prescriptions	$26,656	92%	8%
Colorado Dental Association (CDA)			
Evaluating ED Usage for Dental Pain Since the Inclusion of Dental Benefits in HFC Medicaid Plans	$10,080	84%	16%
Colorado Medical Society			
Charging Patterns for Professional Services in Colorado Relating to Out-of-Network and Variations Pricing	$33,824	82%	18%
Northwest Colorado Community Health Partnerships			
ED Utilization and Potentially Avoidable Costs in NW CO	$21,504	81%	19%
Lanig Family Fund - A Donor Advised Fund of Rose Community Foundation			
Spinal Cord Injury Prevalence and Costs in Colorado	$16,875	80%	20%
	$303,151	76%	24%
FY 2018-2019	$633,819	79%	21%

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

FY 2017-2018 to FY 2019-2020

Organization	Total Cost	Scholarship Support	Requestor Portion
Fiscal Year 2017-2018			
Employers/Purchasing Alliances			
Colorado Business Group on Health (CBGH)			
CBGH Provider Report	$24,400	75%	25%
	$24,400	75%	25%
Academic Researchers			
Dartmouth College			
Pediatric Variations Between Rural and Urban Communities	$42,112	76%	24%
University of California at San Francisco			
Health Care Utilization, Access to Care and Outcomes Among Adults with Complex Chronic Childhood Conditions	$27,668	64%	36%
	$69,780	71%	29%
State Agencies and Governmental Entities			
Colorado Department of Public Health & Environment			
CDPHE Improving Access to LARC's	$18,592	73%	27%
CDPHE Provider Report	$8,750	94%	6%
US Attorney's Office, District of Colorado			
DOJ Opioid Working Group	$9,000	67%	33%
Colorado State Legislature			
Opiate and Physical Therapy Analysis	$11,648	100%	0%
Evaluation of top CPT codes by volume	$8,288	100%	0%
New Hampshire Insurance Department			
Annual Report on Cost Drivers in New Hampshire	$14,388	97%	3%
	$70,666	87%	13%
Nonprofits/Associations			
Colorado African Organization			
Colorado Refugee ER Cost Analysis	$8,960	67%	33%
Colorado Cancer Coalition			
Lung Cancer Screening Task Force	$30,464	93%	7%

COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP RECIPIENTS

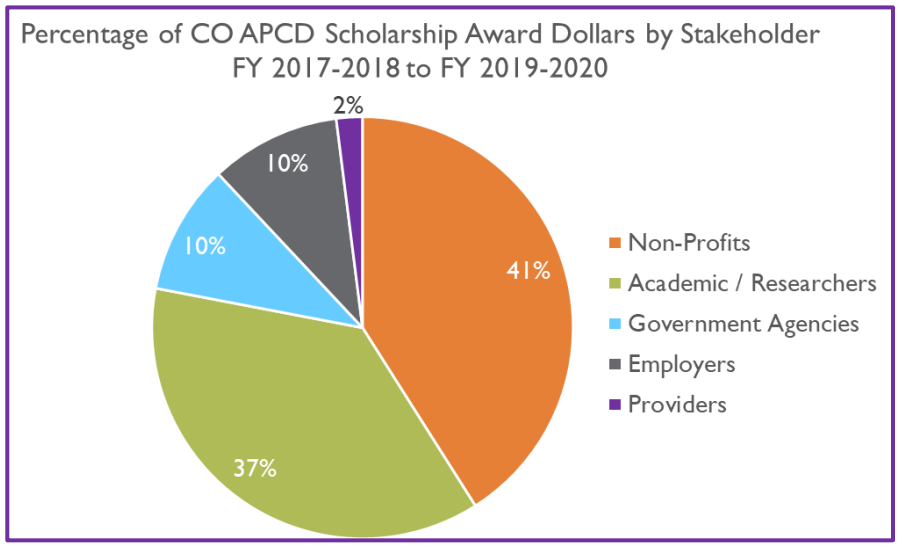
FY 2017-2018 to FY 2019-2020

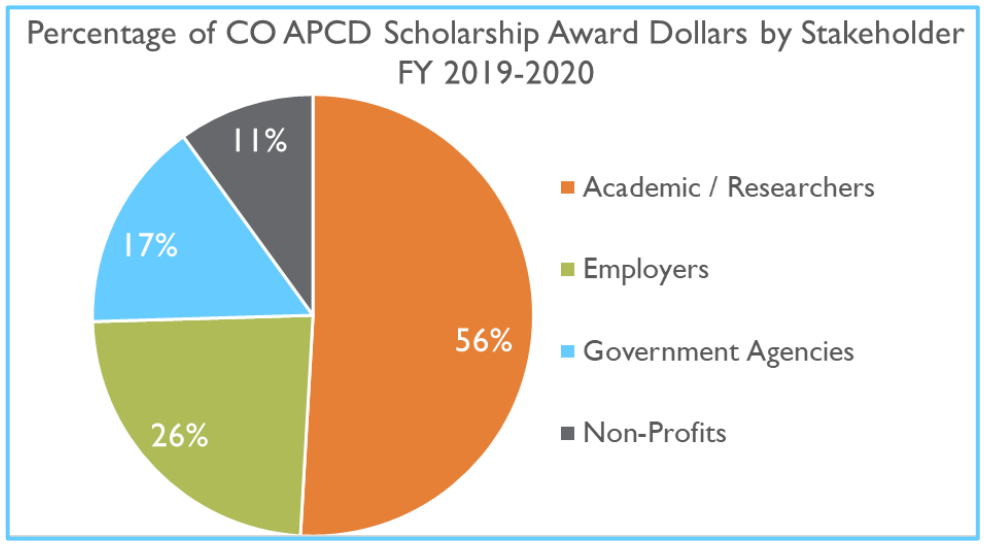
Organization	Total Cost	Scholarship Support	Requestor Portion
Colorado Health Institute			
Hepatitis C Study Collaboration with CDPHE	$27,552	89%	11%
Colorado Community Managed Care Network (CCMCN)			
Integrating Claims Data to FQHC Clinical Data for Care Management	$54,536	82%	18%
Trailhead Institute			
County Health Rankings State Profile	$38,966	92%	8%
Northwest Colorado Community Health Partnership			
Pre/Post NWCCHP Intervention Analysis	$56,448	81%	19%
Doctors Care			
Doctors Care Premium Evaluation	$43,312	77%	23%
San Luis Valley Public Health Partnership			
Outpatient Migration Dashboards	$15,000	80%	20%
Center for Health Progress			
CHP Public Reports	$10,976	95%	5%
Colorado Association of Family Physicians			
HCPF-CAFP Primary Care Medicaid Project	$15,000	87%	13%
Bell Policy Institute			
HMA Respite Care Impact Study	$49,504	70%	30%
Family and Intercultural Resource			
Summit County Cost Analysis	$20,720	76%	24%
Catalyst for Payment Reform			
CPR Scorecard Macro-Indicators	$14,560	79%	21%
	$385,998	82%	18%
Physician Practices			
Boulder Valley IPA			
BVIPA Physician Drill Down	$35,000	86%	14%
	$35,000	86%	14%
FY 2017-2018	$583,844	81%	19%

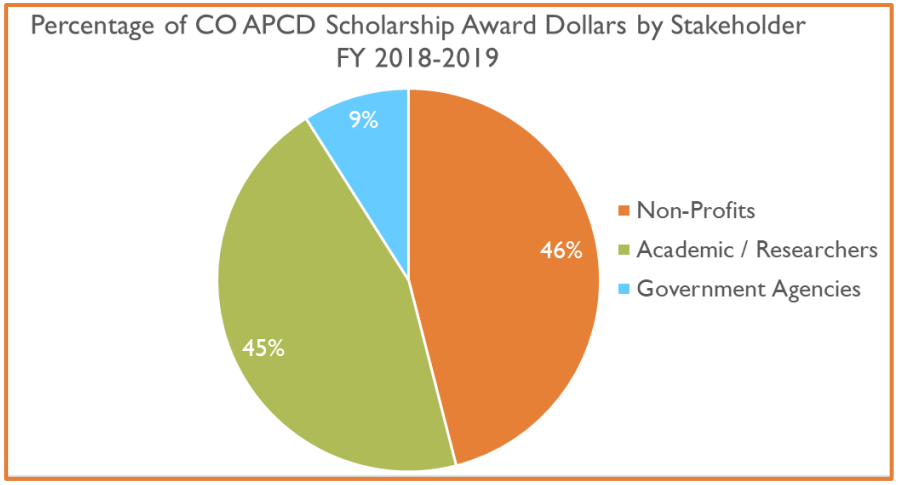
COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP BREAKOUTS BY STAKEHOLDER

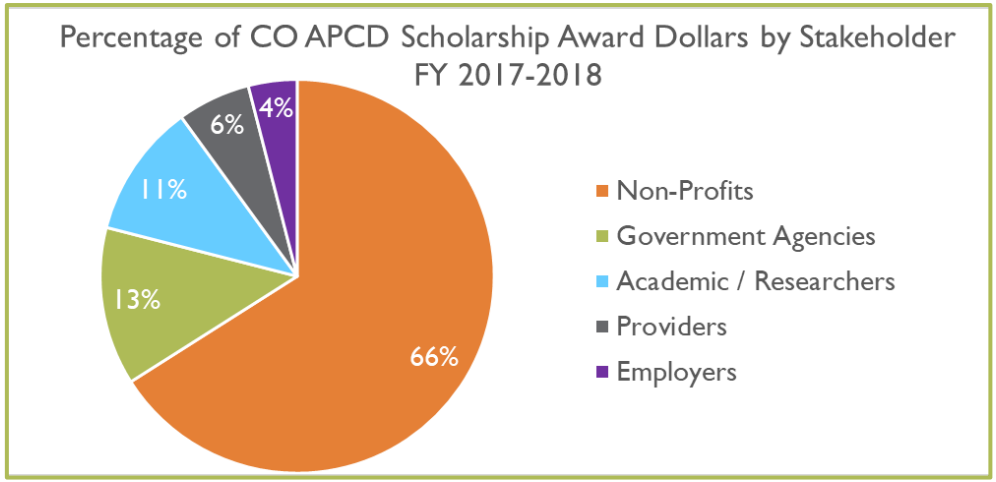
FY 2017-2018 to FY 2019-2020

By Award Dollars





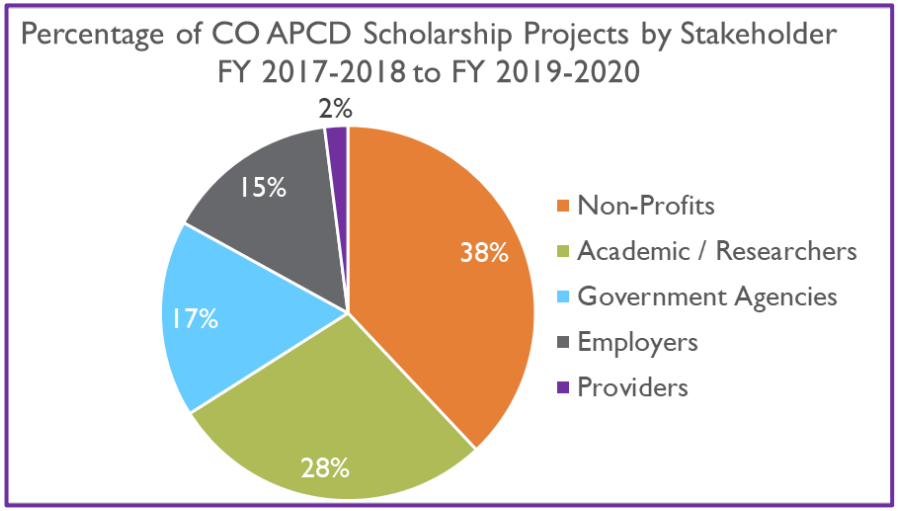


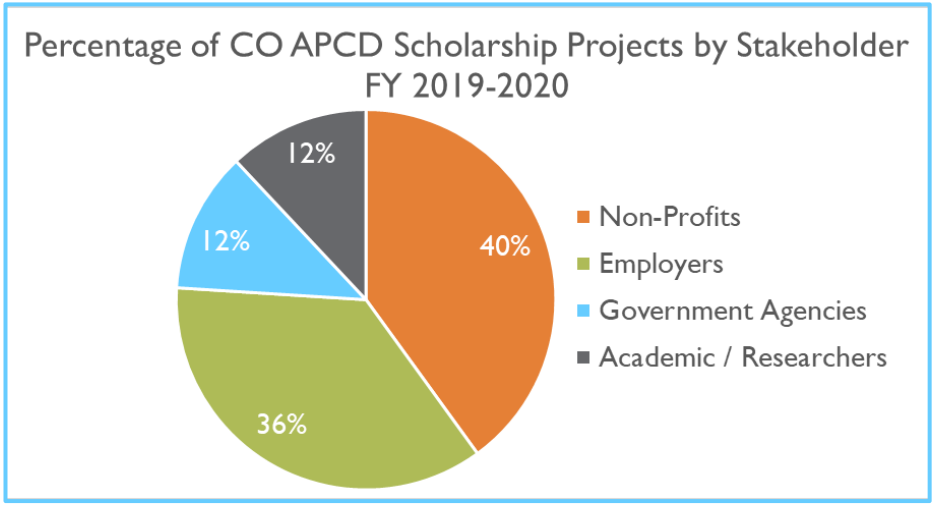


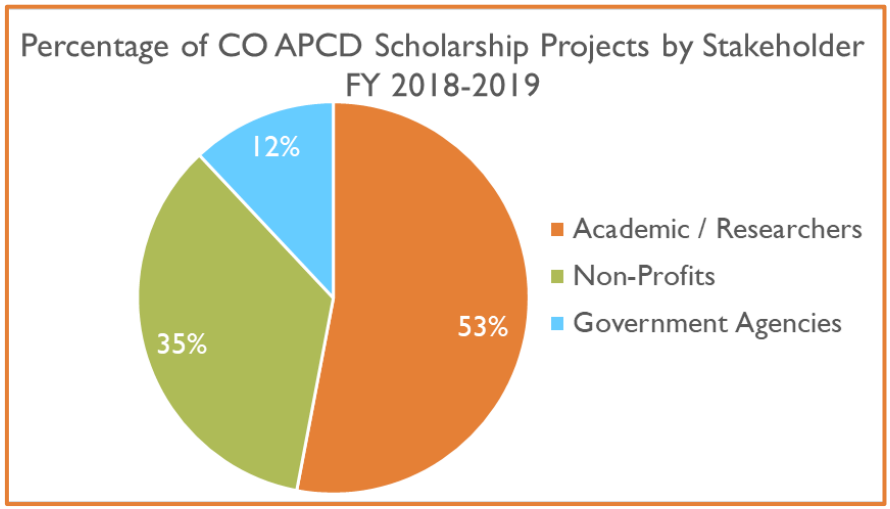
COLORADO ALL PAYER CLAIMS DATABASE SCHOLARSHIP BREAKOUTS BY STAKEHOLDER

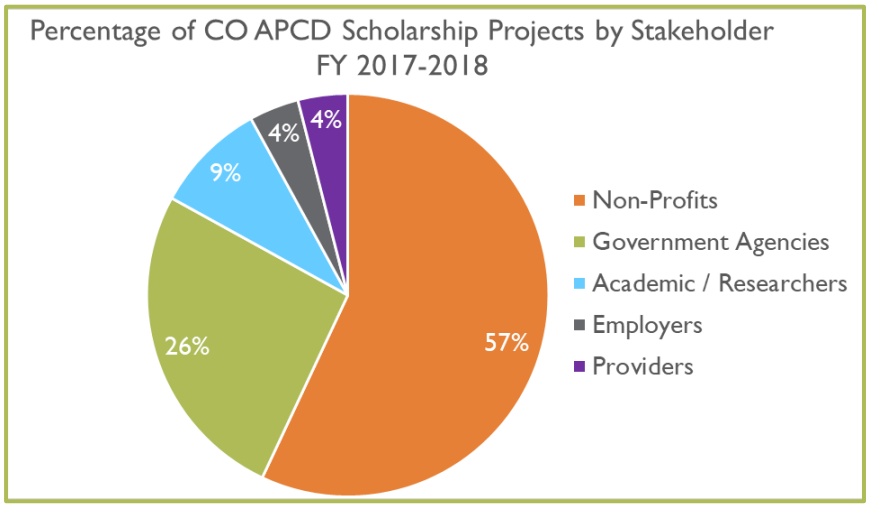
FY 2017-2018 to FY 2019-2020

By Project









One-time Funds Received/Anticipated to be Received (amounts)								
State Department	Federal Bill (e.g., CARES, ARPA, Infrastructure Investment and Jobs Act)	Total Amount by Bill (Program Details Should Sum to These Figures)	Major Program Name	Brief Program Description	Funds originating as Coronavirus State Fiscal Recovery Funds (appropriated/transferred in 2021 legislative session)	Funds Provided Direct to the State Department for Administration or Other Specific Functions. (Exclude funds passed through to other other governments or beneficiaries.)	For amounts other than Fiscal Recovery Funds, How does State Access the Funds (e.g., formula allocation, grant application)	When are the funds available? (e.g., Mar 2020-Dec 2022)
HCPF	CARES	19,451,897	Telehealth Services	SB 20-212 "Reimbursement for Telehealth Services" expanded Medicaid reimbursement for telehealth services.		5,068,381	Appropriated through SB 20-212	July 2020 - December 2020
HCPF	CARES	19,451,897	Senior Strike Force Staffing	FTE to support the Governor's cross-agency taskforce created to develop and implement strategies to mitigate the spread of the illness and save lives in residential congregate settings that serve older adults and people with disabilities		45,820	Allocated by Governor's Office	July 2020 - December 2020
HCPF	CARES	19,451,897	Vaccine Outreach	Funding to implement targeted vaccine outreach for two high-priority population groups: 1) homebound members and 2) populations impacted by health disparities.		14,337,696	Pass through from DEF funding from CDPHE	April 2021 - December 2021
HCPF	FFCRA	1,084,000,000	Enhanced Federal Medical Assistance Percentage	Provided a 6.2 percentage point increase to the standard FMAP for Medicaid services until the end of the public health emergency.		1,084,000,000	FMAP rate increase	January 2020 - Quarter of PHE End
HCPF	ARPA	342,409,864	Home and Community Based Services (HCBS) Enhanced Federal Match	Section 9817 increased the federal medical assistance percentage (FMAP) for Medicaid HCBS spending by 10 percentage points from April 1, 2021 through March 31, 2022. The bill specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The Department submitted a spending plan to implement this provision and received approval from the Centers for Medicare and Medicaid Services (CMS) and the JBC in September 2021.		304,372,736	FMAP rate increase	FMAP Increase: April 2021 - March 2022 Spending Plan: April 2021 - March 2024
HCPF	ARPA	342,409,864	100% FMAP to Urban Indian Health Organizations	Section 9815 provides a 100% federal match for services provided in an Urban Indian Health Organization for eight quarters.		118,850	FMAP rate increase	April 2021 - March 2023
HCPF	ARPA	342,409,864	100% FMAP for COVID Vaccine Administration	Section 9811 provides a 100% federal match for expenditure billed for COVID vaccine administration.		10,000,000	FMAP rate increase	April 2021 - One year after the PHE ends
HCPF	ARPA	342,409,864	Increased Allotment for Disproportionate Share Hospital Payments	Section 9814 increases the federal allotment for payments to hospitals that serve a disproportionate share of low-income patients to account for the 6.2 percentage point increase to the standard FMAP authorized under the Families First Coronavirus Relief Act.		27,100,000	Federal allotment increase	January 2020 - Quarter of PHE End
HCPF	ARPA	342,409,864	Behavioral Health Recovery Act (SB 21-137)	SB 21-137, "Behavioral Health Recovery Act," appropriated $250,000 in State and Local Fiscal Recovery Fund funding to support training health care & behavioral healthcare professionals in substance use screening, brief intervention, & referral to treatment (SBIRT).	250,000			July 2021 - June 2022
HCPF	ARPA	342,409,864	Planning Grant to Provide Community-Based Mobile Crisis Services	The Department received $818,278 in a direct grant from CMS under Section 9813 to plan how to expand the Department's crisis response services.		818,278	Grant Application	September 30, 2021 - September 29, 2022
HCPF	ARPA	342,409,864	Sunset Limit on Maximum Rebate Amount for Single Source Drugs and Innovator Multiple Source Drugs	Section 9816 eliminates the current cap on rebates that manufacturers pay to the State for certain prescription drugs.		-		December 31, 2023 and ongoing
HCPF	ARPA	342,409,864	12-Month Postpartum Coverage for Medicaid and CHP+	SB 21-194, "Maternal Health Providers," expands eligibility for members who were eligible for pregnancy-related and postpartum services from 60 days postpartum to twelve months postpartum. Section 9812 of ARPA provides a state option to expand coverage in this way through the Department's state plan agreement with CMS. There is no additional or enhanced funding through ARPA to implement the provision.		-		July 2022 and ongoing
HCPF	ARPA	342,409,864	Funding for Administrative Staff for the ARPA-Related Work	The Department was allocated $80,000 from the Public Health/Administrative fund allocated to the Governor's Office to begin work on standing up the administrative infrastructure for ARPA-related projects.	80,000			August 2021 - September 2021

Introduction

Kim Bimestefer, Executive Director

Critical Work Set Us Up to Be Successful

Thank you, JBC – you made all this possible

- Enrolled >310k members since pandemic started, +25%
- Protected member benefits & provider reimbursements
- Stabilized system with $246M relief payments & regulatory flexibilities
- Expanded access to care – added 16,558k providers (18% increase), 30 pharmacies & 882 pharmacists (44% increase) to Medicaid network, 1,716 (20% increase) in behavioral health
- Exceeded customer service standards for claims paid (<6 days), calls answered (<150 seconds)
- Implemented 99 internal IT (MMIS) projects with ZERO Defects (claim system since 9/1/19)
- HCPF Admin is <4% of spend (carriers = 13.5%+) FTE <0.5% of spend
- Controlled Medicaid cost growth (PMPM –4%)
- Increased vendor accountability to increase savings & performance

"Great options of locations and doctors. Staff really cares about my health and makes healthcare affordable for me." Member

"The member hotline is great and easy to get through to lately. The mobile app is easy. I've gotten ample notification of documents I need to submit which is fantastic." Member

We now cover more than **1.56 million** (**1** in **4**) Coloradans

Health First Colorado

Child Health Plan *Plus*

Buy-In Programs

The Colorado Indigent Care Program

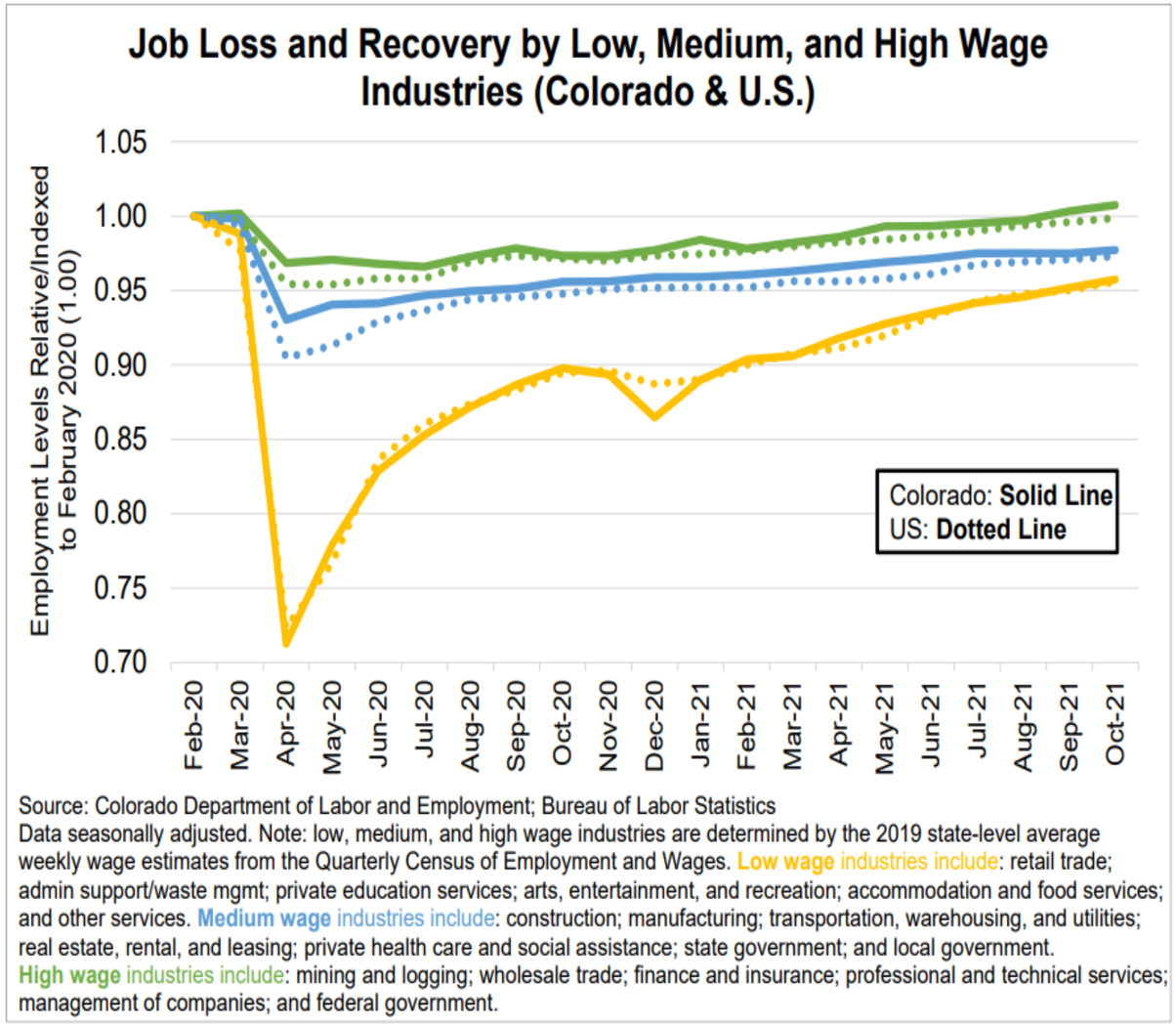
Long-Term Services and Supports

Dental Program

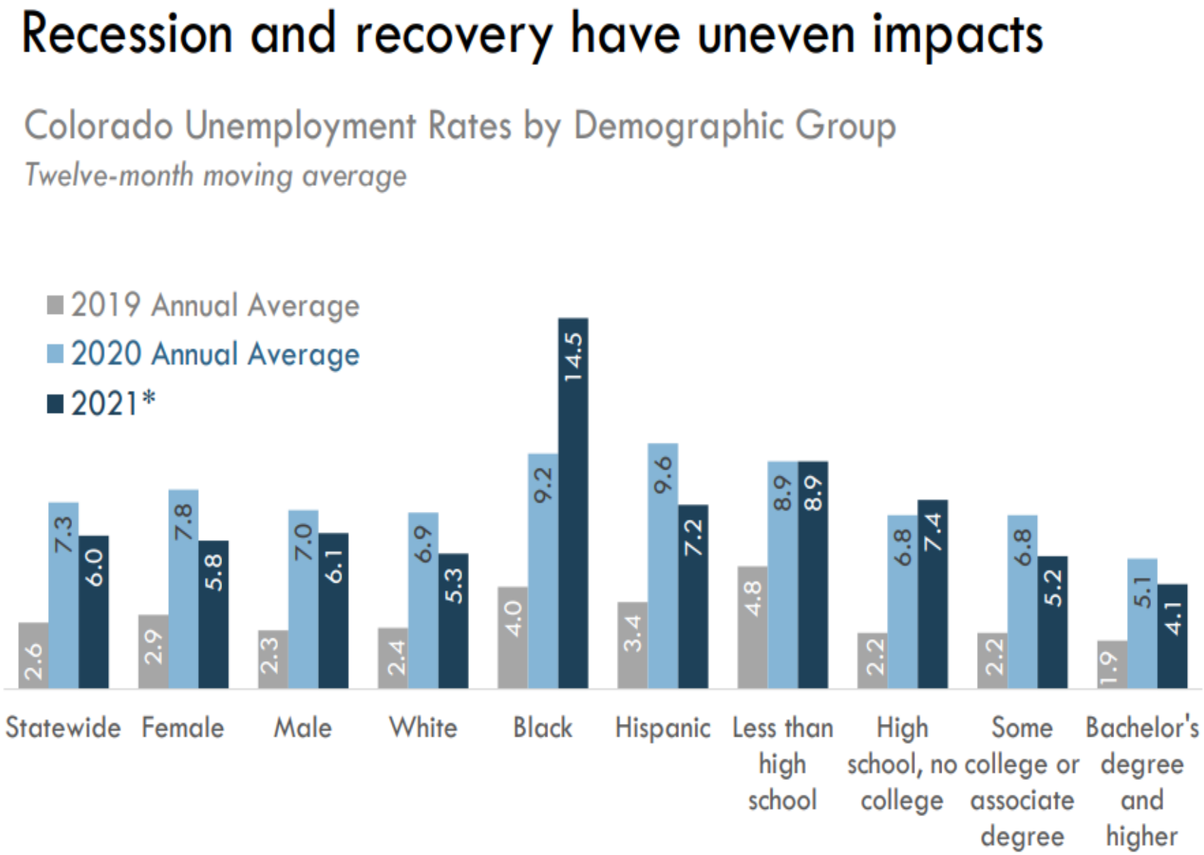
- Medicaid Expansion Adults +67%, ~50% of overall growth
- Medicaid Children +31%, ~30% of growth
- Medicaid Parents +35%, ~15% of growth
- Colorado Uninsured Rate Steady: 6.6% (steady), through Pandemic by keeping Coloradans covered

"I am so [grateful [for] the coverage Medicaid has offered during these turbulent times. I had a colonoscopy performed at no charge to me, and I couldn't be more thankful. The website & technical aspects of the app & communications have been great." Member

CO: Longer Recovery for Low Income & Uneven Impacting Medicaid, CHP+



Source: Colorado Department of Labor and Employment; Bureau of Labor Statistics
Data seasonally adjusted. Note: low, medium, and high wage industries are determined by the 2019 state-level average weekly wage estimates from the Quarterly Census of Employment and Wages. Low wage industries include: retail trade; admin support/waste mgmt; private education services; arts, entertainment, and recreation; accommodation and food services; and other services. Medium wage industries include: construction; manufacturing; transportation, warehousing, and utilities; real estate, rental, and leasing; private health care and social assistance; state government; and local government. High wage industries include: mining and logging; wholesale trade; finance and insurance; professional and technical services; management of companies; and federal government.



Source: U.S. Bureau of Labor Statistics, Current Population Survey. Data are not seasonally adjusted. Unemployment rates by gender, race, and ethnicity for individuals 16 and over. Unemployment rates by educational attainment for individuals 25 and over. Twelve-month moving averages are calculated differently than the official estimates of unemployment and should not be compared directly.
* 2021 twelve-month average, September 2020 to August 2021.

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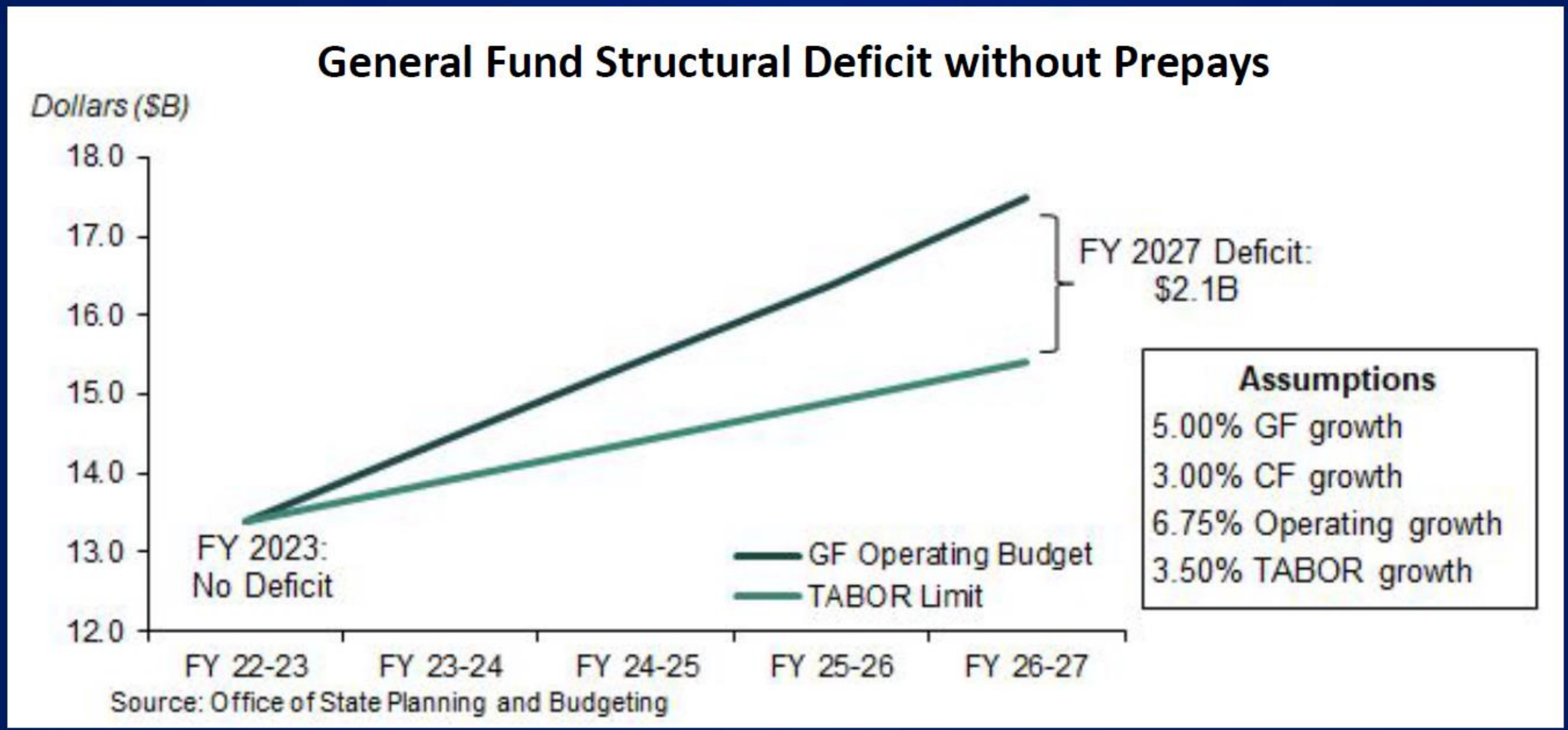
Sources: Colorado Legislative Council Staff, Economic & Revenue Forecast, September 2021: leg.colorado.gov/EconomicForecasts

ONE-TIME FUNDS AVAILABLE BUT LONG-TERM PRESSURES REMAIN



Source: FY 2022-23 BUDGET REQUEST Governor Jared Polis November 1, 2021

Medicaid population is morphing/shifting, impacting trend

PWC Report

U.S. Medical Trends

2022: 6.5%

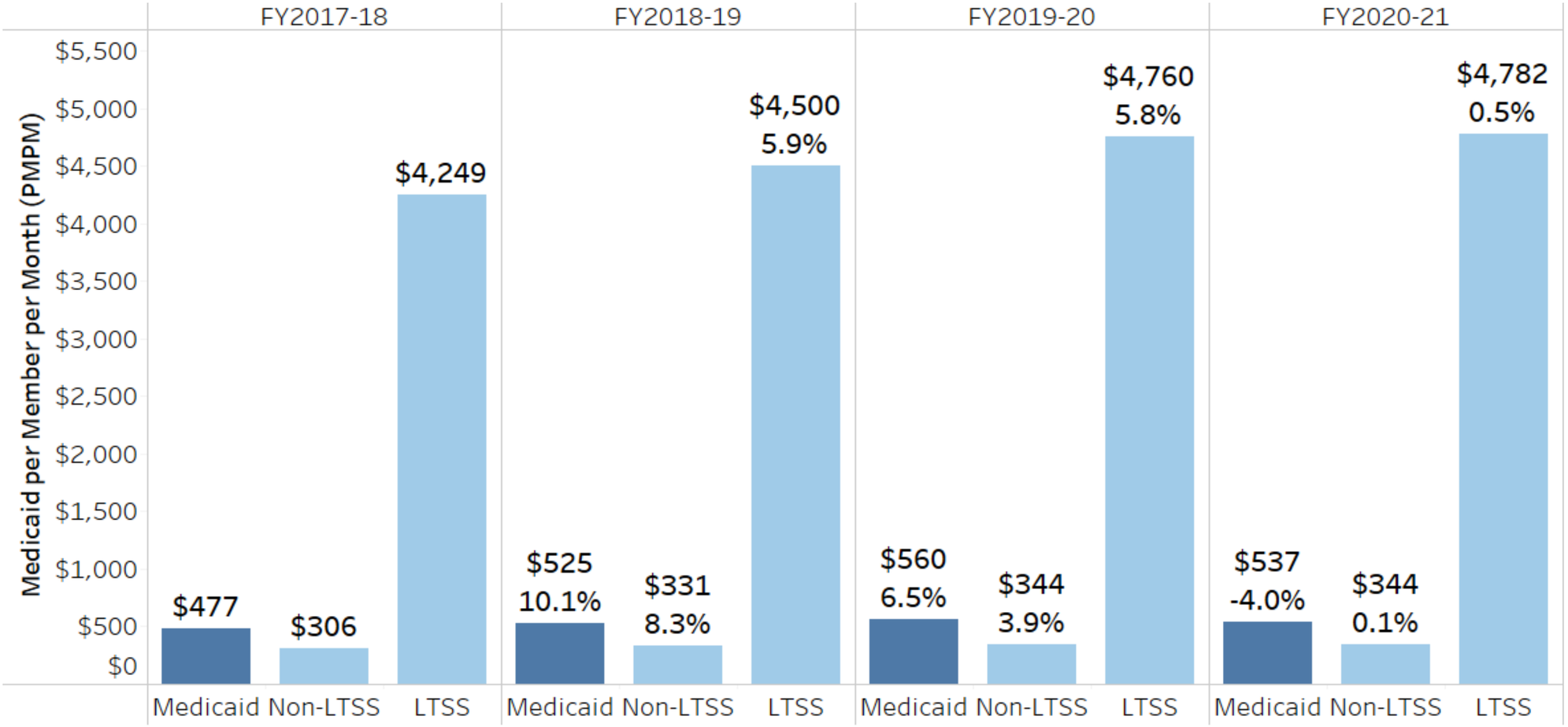
2021: 7%

2020: 6%

2019: 5.7%

2018: 5.7%

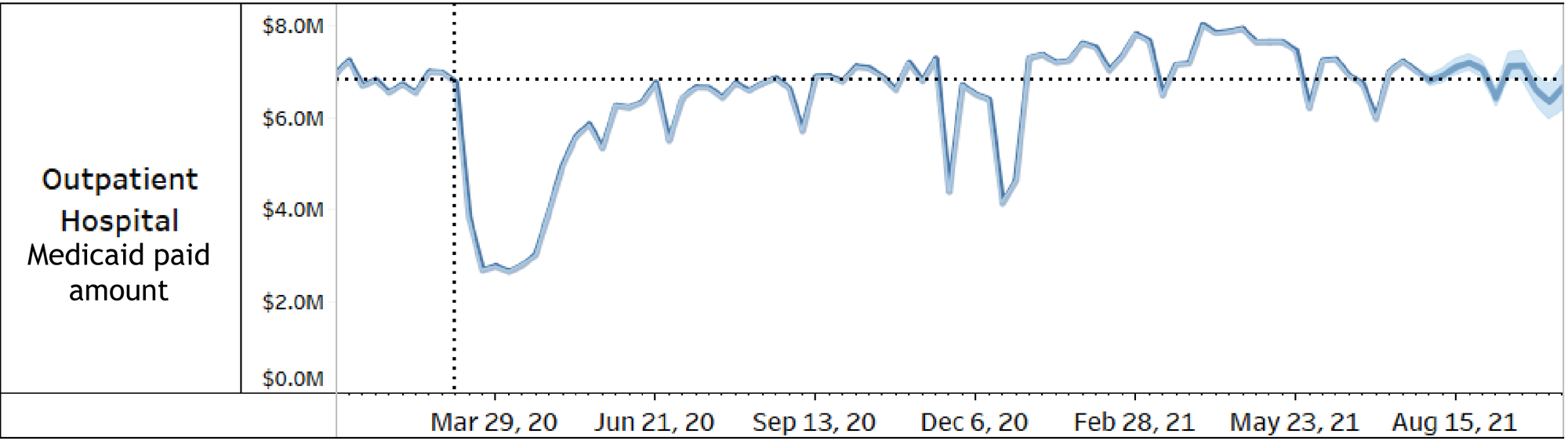
Accounting for pandemic-rooted cost inflators/deflators, PwC's Health Research Institute is projecting 6.5% medical cost trend in CY 2022 (CY 2021 was 7%)

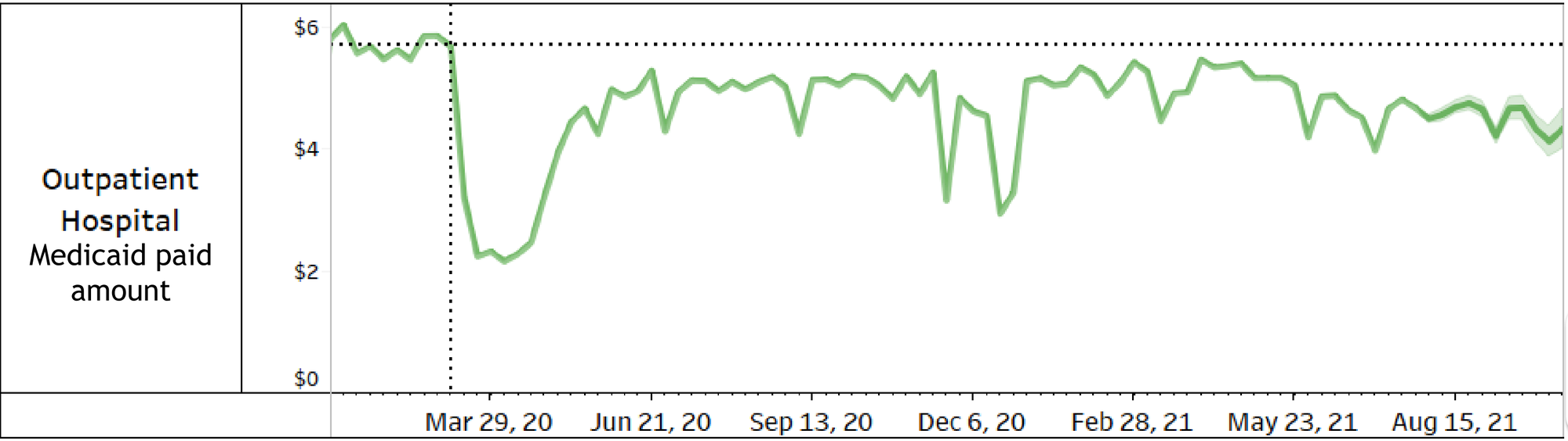


CO Medicaid Per Member Per Month Claims

Source: PwC Health Research Institute, "Medical cost trend: Behind the numbers 2022"

COVID Impact on Medicaid Spend & PMPM





Blue is the total IBNR adjusted Paid per Week

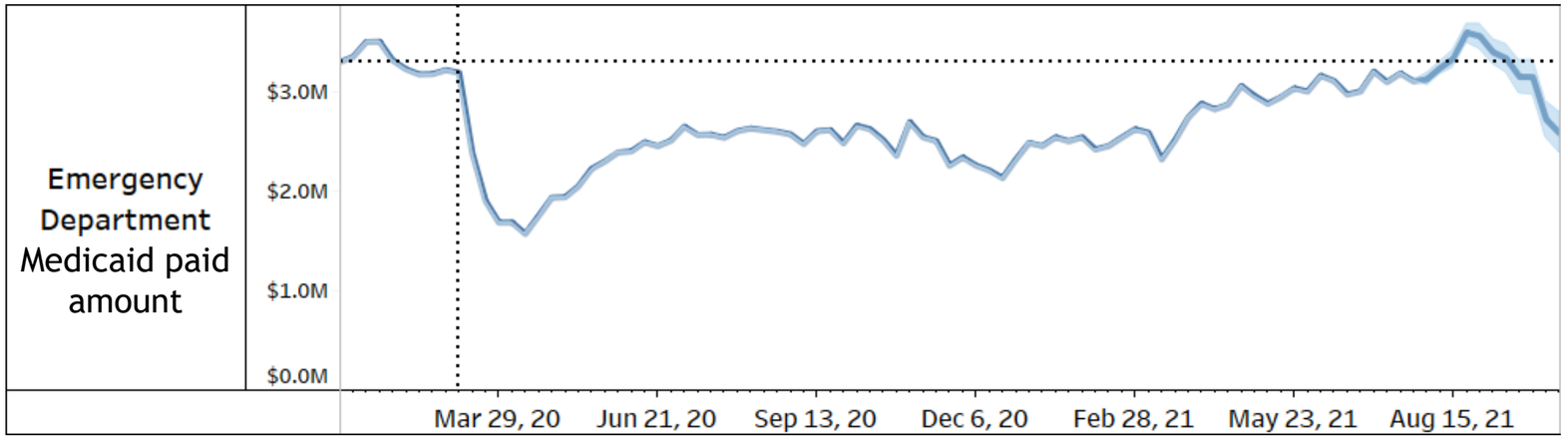
Light blue shading is the range of uncertainty with a 95% confidence interval associated with the IBNR estimate

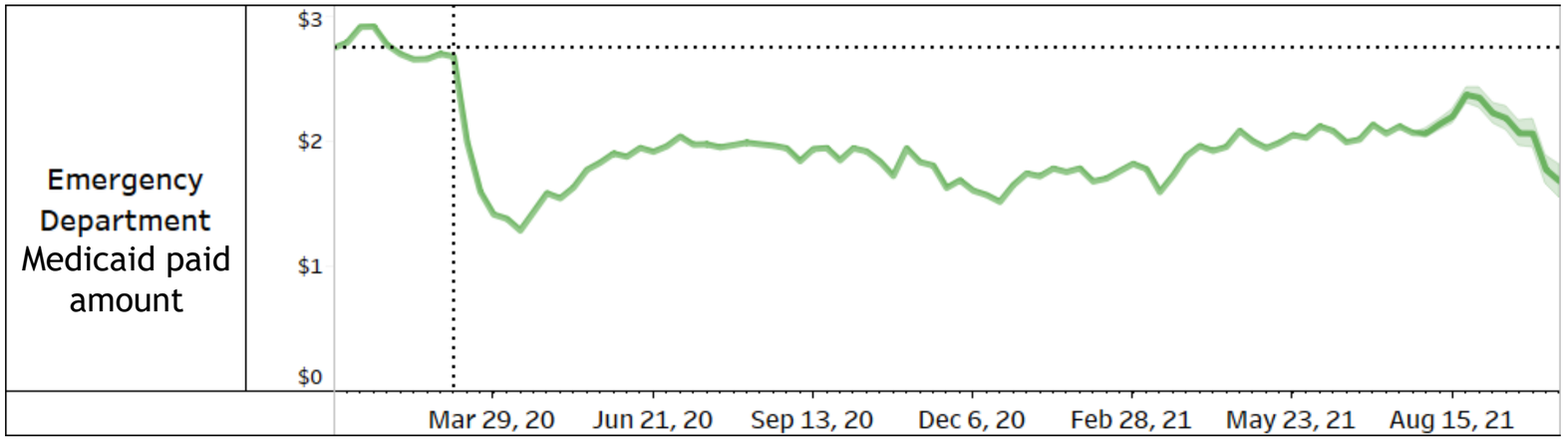
Green is the IBNR adjusted Paid per Eligible Member per Week (PMPW)

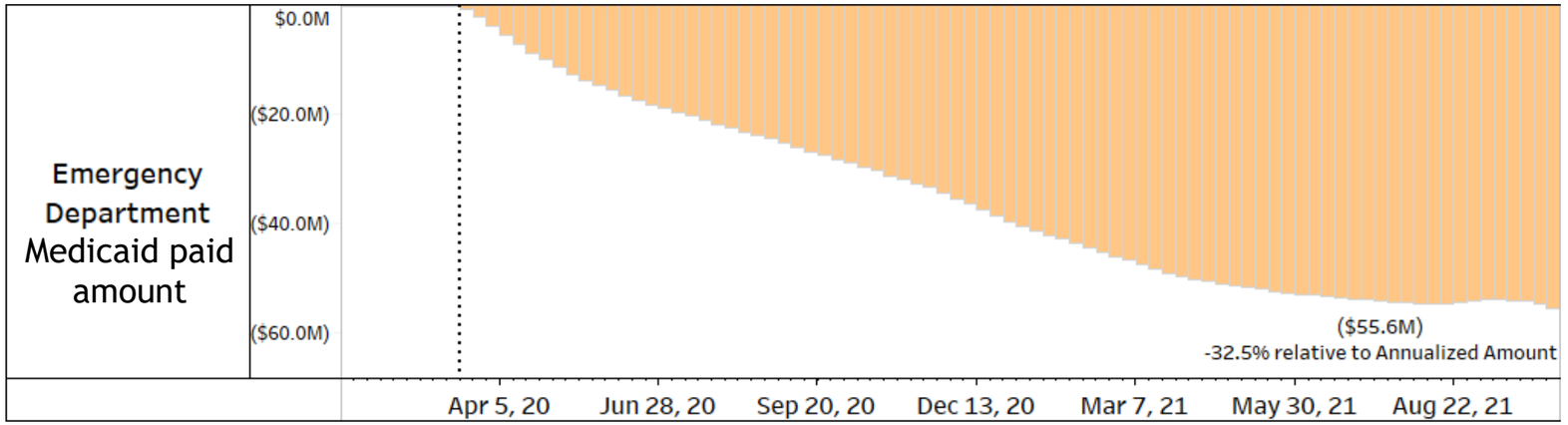
Light green is the range of uncertainty with a 95% confidence interval associated with the IBNR estimate

Vertical line is the last week prior to social distancing. Horizontal line is the weekly average paid before social distancing.

During this time, hospitals are down $30.5m on outpatient services







COVID Impact on Medicaid Spend & PMPM

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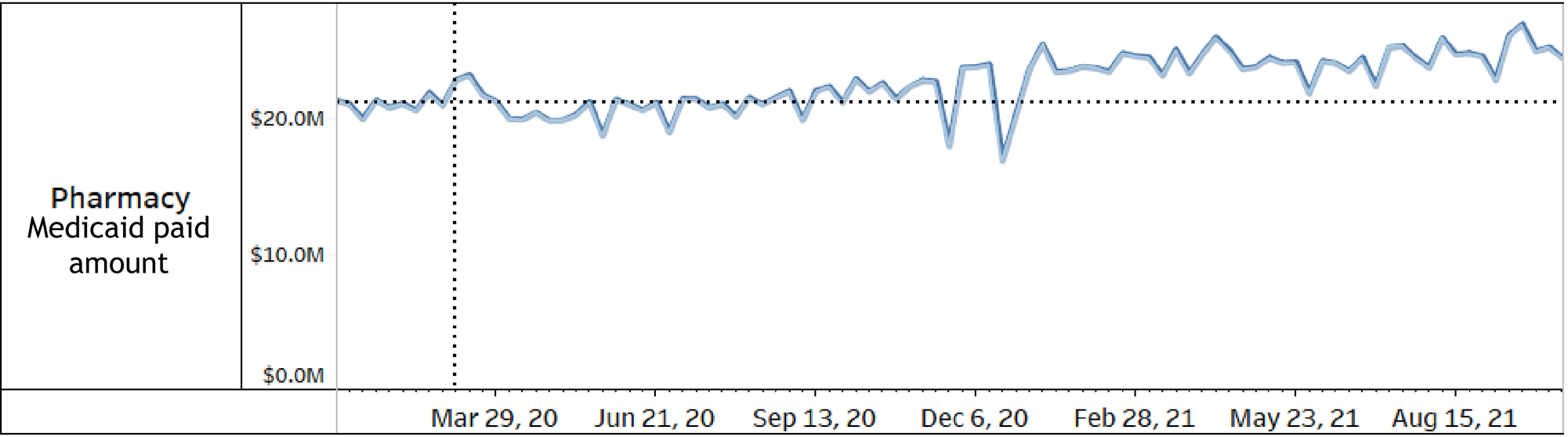
Green is the IBNR adjusted Paid per Eligible Member per Week (PMPW)

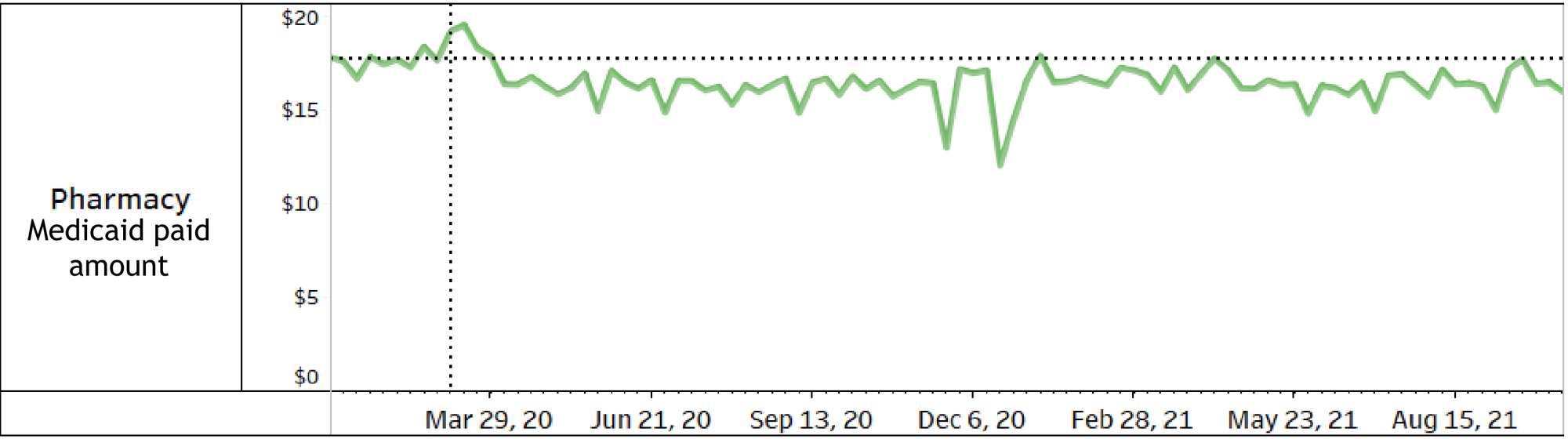
Light green is the range of uncertainty with a 95% confidence interval associated with the IBNR estimate

Orange is the Weekly Cumulative Gain/Loss post social distancing start

Vertical line is the last week prior to social distancing. Horizontal line is the weekly average paid before social distancing.

During this time, emergency department services are down $55.6m (includes both facility and professional ED expenditures)





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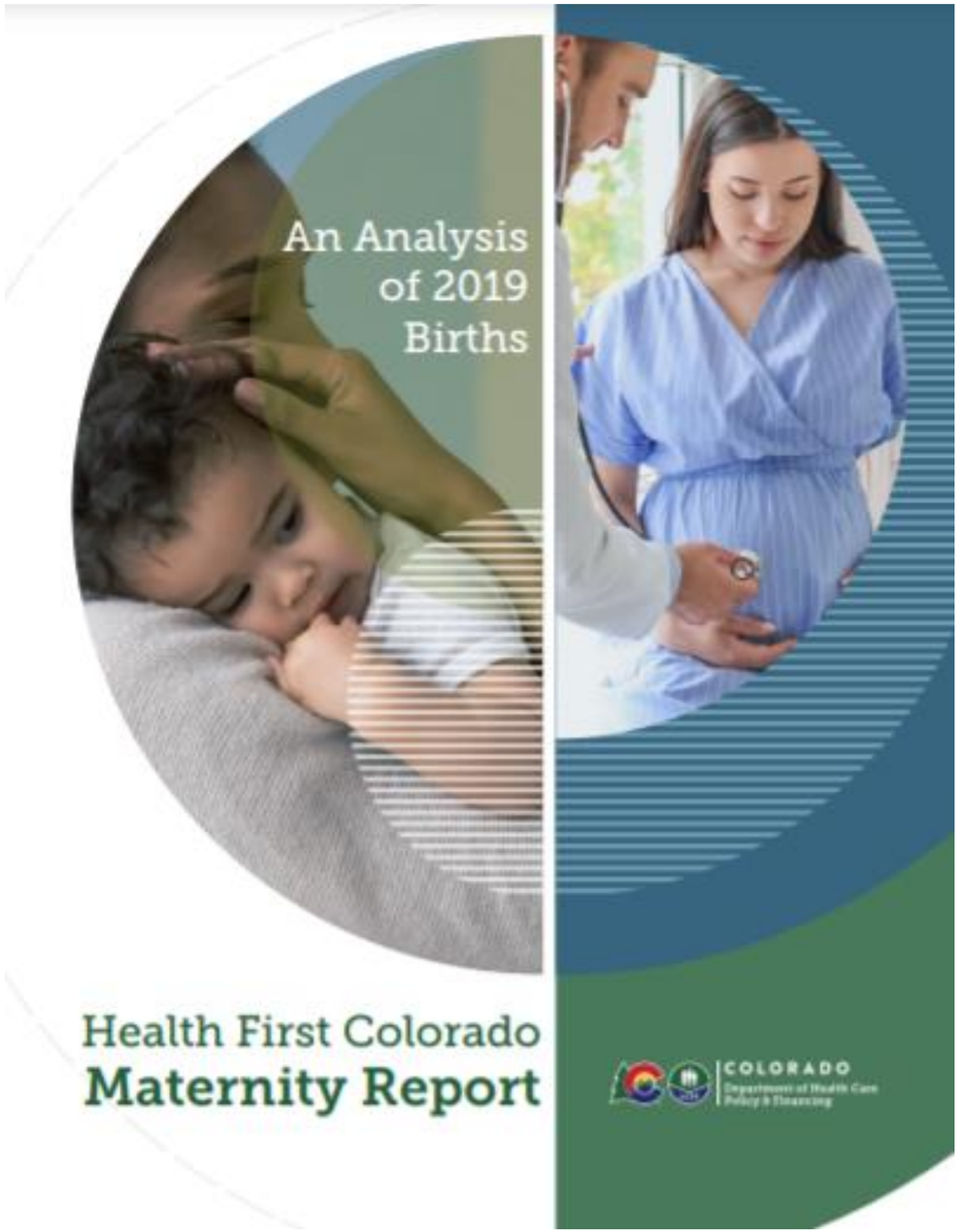
Green is the IBNR adjusted Paid per Eligible Member per Week (PMPW)

Light green is the range of uncertainty with a 95% confidence interval associated with the IBNR estimate

Vertical line is the last week prior to social distancing. Horizontal line is the weekly average paid before social distancing.

Health Disparities Focus

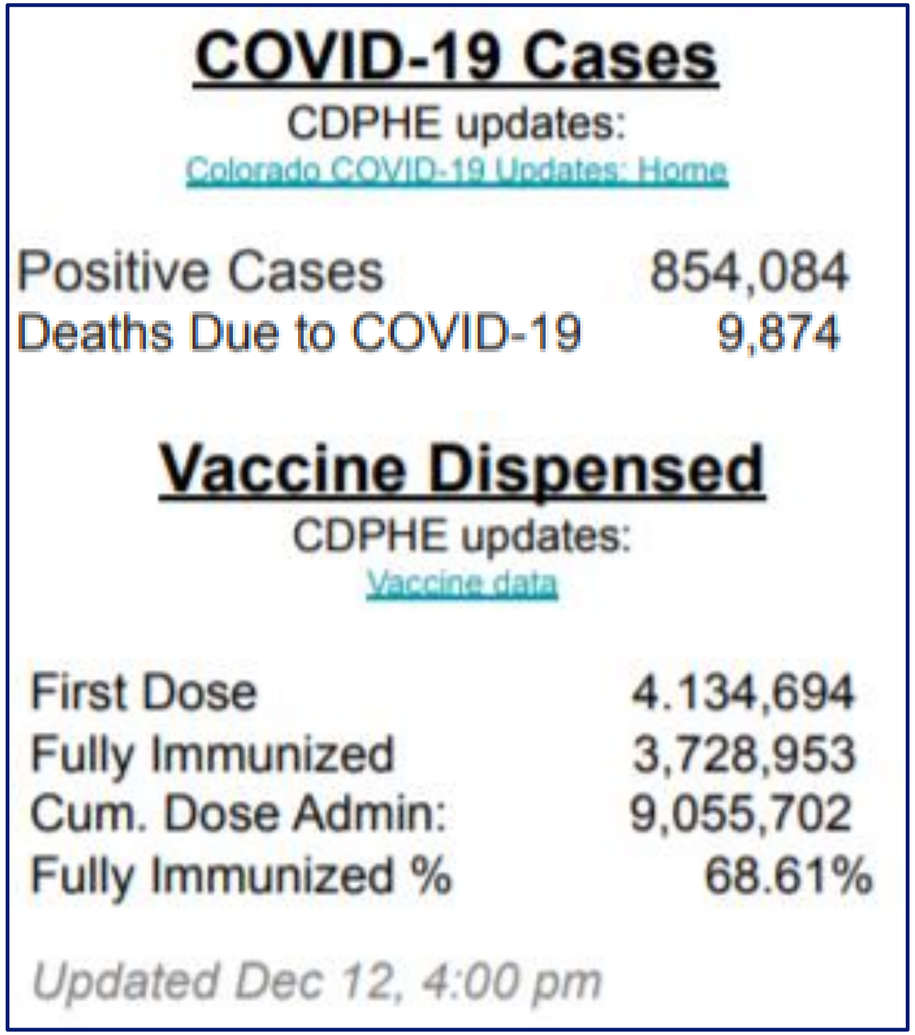
- Vaccine Uptake
- Maternity
- Behavioral Health
- Prevention



Source: CDPHE Community Health Equity Map (2013-2017 Data)

COVID-19 Vaccination Uptake Disparity

18-26-Point+ Gap Btw Low Income and All Coloradans



COVID-19 Cases

CDPHE updates:

Colorado COVID-19 Updates: Home

Positive Cases	854,084
Deaths Due to COVID-19	9,874

Vaccine Dispensed

CDPHE updates:

Vaccine data

First Dose	4.134,694
Fully Immunized	3,728,953
Cum. Dose Admin:	9,055,702
Fully Immunized %	68.61%

Updated Dec 12, 4:00 pm

Ages 5-19	Ages 20+
44.7% Colorado population fully or partially vaccinated (as of 12/2/21) All Coloradans	79.4% Colorado population fully or partially vaccinated (as of 12/2/21) All Coloradans
26.5% Medicaid members fully or partially vaccinated (as of 11/29/21)	52.8% Medicaid members fully or partially vaccinated (as of 11/29/21)

Sources: Governor's Emergency Management Dashboard (12/13/21) & HCPF Vaccination Rates Dashboard accessed 12/13/21

Medicaid Affordability Solutions must address not just costs but disparities & health as well

Utilization Management: Right care, right place, right time, right price

Complex Case Management: High cost and high need members

Population Health: Maternity Program Management, Diabetes Program

Innovations: Prescriber Tool (P1&P2), eConsults, Providers of Distinction

Value Based Payments: HTP, Primary Care, Maternity, Prescriber Tool, Providers of Distinction

Without innovation & collaboration, future state budget deficits will increase pressure on the Medicaid budget, threatening benefits, provider reimbursements, network access

Demand is up while the workforce is shrinking

The Great Resignation

- Health care workers are exhausted and are part of the "great resignation"
- Staffing is a serious challenge across hospitals, NHs, ALFs, personal/home care & BH, impacting Medicaid, CDHS, and access to care for Colorado
- Transforming home and community-based services → raising caregiving workforce base wages to $15/hour to ensure Medicaid access to services will help
- Our providers can't always raise wages

Women 70% of HC Workforce

- Mothers in 2020's pandemic have reduced their work hours 4 to 5 times more than fathers to care for children
- In 2020, female unemployment reached double digits for 1st time since 1948, when the Bureau of Labor Statistics started tracking women's joblessness
- White women haven't been such a small share of the job pop since the 1970s
- Women of color are suffering acutely, with Latina and Black women hit by unemployment the hardest

HEALTH CARE RELATED OCCUPATION	% WOMEN (16 yrs+)
Medical records specialists	95.9%
Speech-language pathologists	94.4%
Dental hygienists	93.9%
Dental assistants	93.7%
Medical secretaries and administrative assistants	93.3%
Dietitians and nutritionists	91.4%
Home health aides	90.3%
Medical assistants	90.2%
Licensed practical and licensed vocational nurses	90.0%
Child, family, and school social workers	89.8%
Nursing assistants	89.3%
Nurse practitioners	88.0%
Registered nurses	87.4%
Healthcare social workers	87.0%
Occupational therapists	86.3%
Healthcare support occupations	85.3%
Phlebotomists	84.8%
Therapists, all other	84.4%
Diagnostic medical sonographers	84.0%
Psychiatric technicians	82.2%
Personal care aides	81.5%
Substance abuse and behavioral disorder counselors	81.3%

Increasing Accountability, Efficiency

- **Implemented new vendor contract process** to increase savings, accountability & performance across 350+ vendors
- **Fraud Waste and Abuse** nets monetary savings
- **Implemented County oversight & accountability projects**
- **Federal compliance** to reduce disallowance, clawbacks
- **Moving state administration of BH related benefits** (i.e., OBH first) onto HCPF platform
- **HCPF's Administration is <4%**, while commercial carriers are >13.5%
- **Right sizing** & bringing strategic functions **in-house**
- **Retain** current passionate, expert HCPF staff

R-08 & R-11 support continued work on oversight & accountability

Our budget requests support transformation, stabilizing HCPF foundation & responsibilities

Major Transformative Projects:

- **Transform Medicaid/Delivery System:** control Medicaid trends, improve access, outcomes, equity - Value-Based Payments, Prescriber Tool, Providers of Distinction, Telehealth, eConsults, PDAB, Importation. Unique collaboration with DOI.
- **Transform Home & Community Based Services:** HCBS $513M
- **Behavioral Health Transformation:** BHTF 19 priorities, BHA, Transformation $450M
- **Health Disparities:** Vaccines, Maternity, BH, Prevention
- **Rural Sustainability**
- **Healthcare Workforce**

Our budget requests support transformation, stabilizing HCPF foundation & responsibilities

Other Administration Huge Lifts:

- **PHE Unwind:** nearly 530,000 members must be redetermined (“locked-in” population)
- **County Administration Fixes:** CBMS overhaul; 12-Accuracy innovations goal to reduce 26% eligibility error rate (OSA) last 2 years & reduce federal clawback risk
- **CMS requirements:** bidding of our MMIS system (Medical claims, Rx PBM, BIDM data repository)
- **Retain** passionate, expert HCPF staff; diversity workforce; right size workplace model
- **80 Critical Projects** being implemented (non-ARPA HCBS)

Our Mission:

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

FY 2022-23 Budget Overview

The proposed budget is $13.5B total funds, $3.99B General Fund

- An increase of $343.4M General Fund over the baseline
- The vast majority is to account for the expiration of the 6.2%-pt FMAP bump
- Accounts for year-over-year utilization increases for long-term care services
- $41M General Fund for provider rates

All other discretionary requests are budget negative by $4.8M

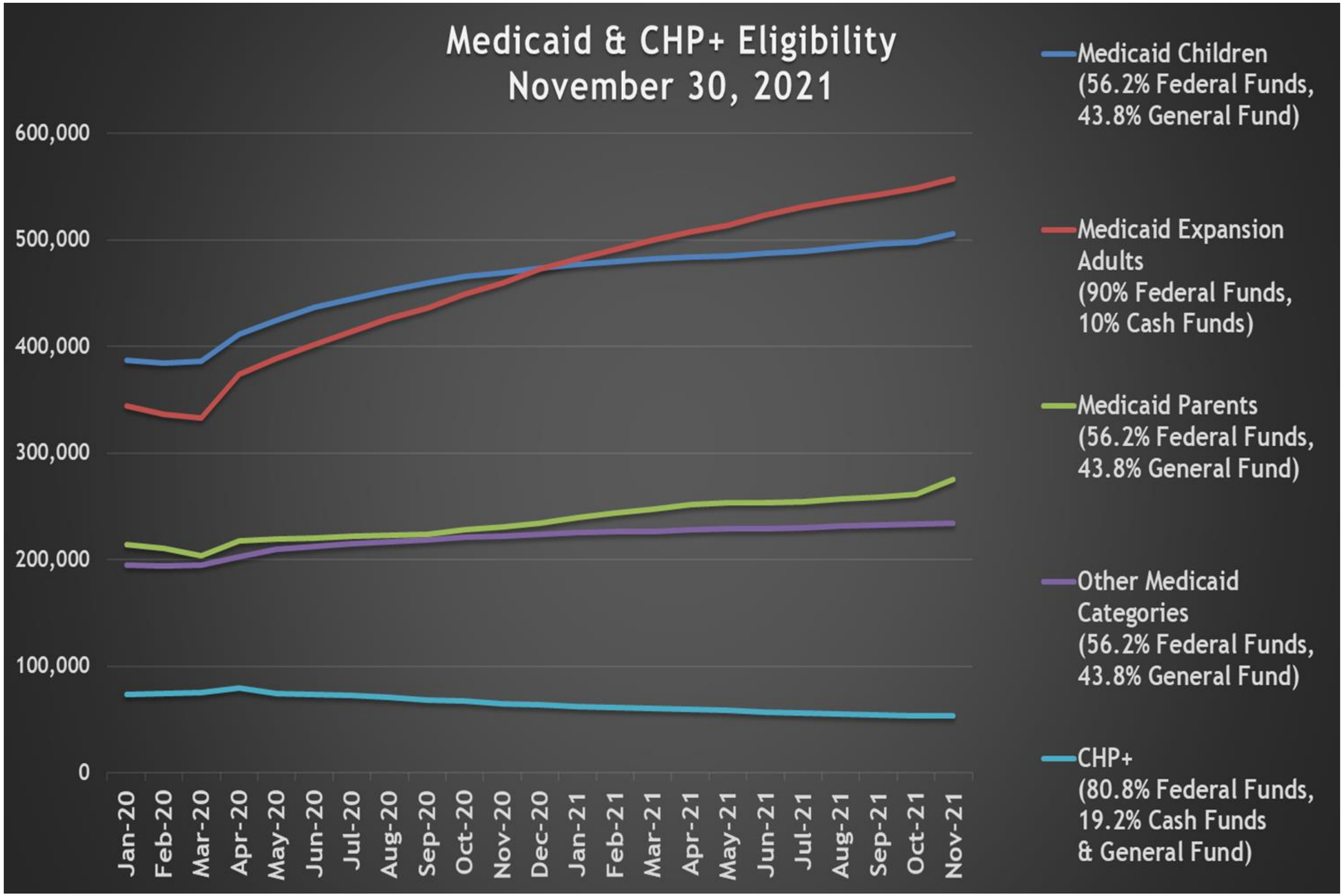
FY 2022-23 Annual HCPF Budget Request		
	Total Funds	General Fund
FY 2021-22 Budget	$13,279,388,573	$3,346,625,179
FY 2022-23 Budget Baseline	$13,396,015,183	$3,652,090,038
Percent Change	0.9%	9.1%
Caseload / Per Capita/FMAP	$85,349,586	$306,626,915
Discretionary Decision Items	$63,989,003	$36,552,387
Other Agency Impacts	$745,468	$261,551
Total FY 2022-23 Budget Ask	$150,084,057	$343,440,853
Proposed FY 2022-23 Budget	$13,546,099,240	$3,995,530,891
Percent Change from FY 2021-22	2.0%	19.4%
Percent Change from FY 2022-23	1.1%	9.4%

Questions 1-2
Public Health Emergency

Kim Bimestefer, Executive Director
Bettina Schneider, CFO

Of the 25% overall increase since pandemic started:

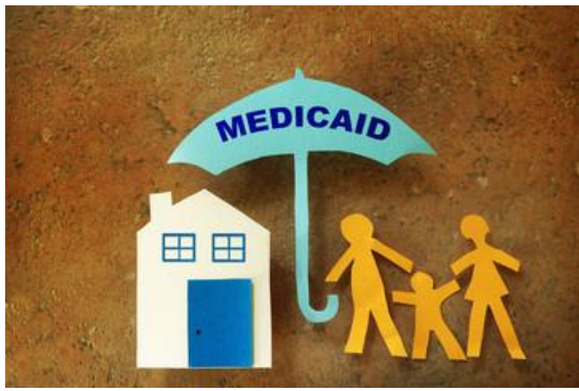
- Medicaid Expansion Adults +67%, ~50% of overall growth
- Medicaid Children +31%, ~30% of growth
- Medicaid Parents +35%, ~15% of growth



Count of Clients enrolled by aid code. Chart shows total enrollments by time periods and the changes in its composition over time.

Medicaid Continuous Coverage During Public Health Emergency

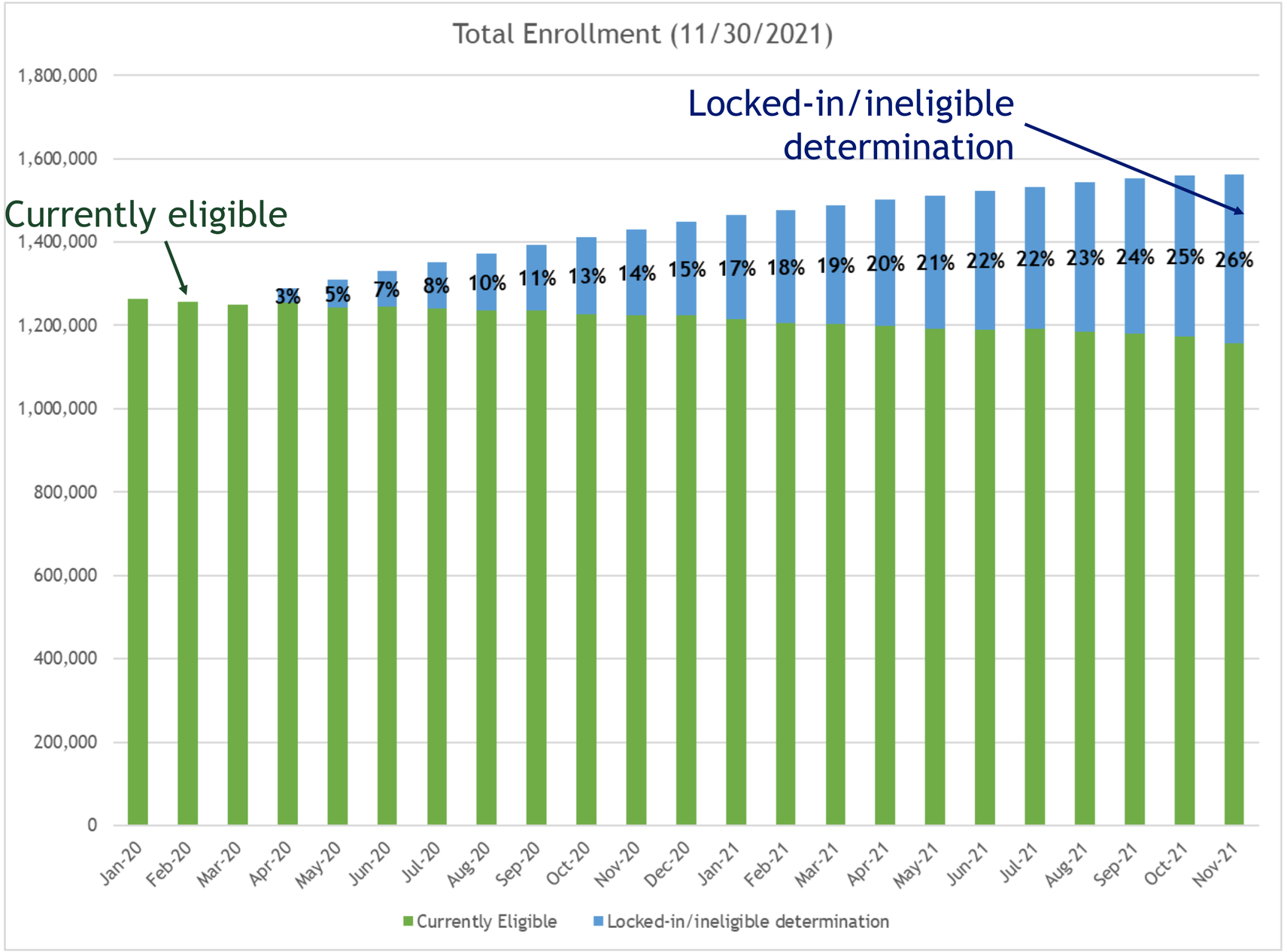
- In order to receive the enhanced 6.2% increase to the Medicaid Federal Medical Assistance Percentage (FMAP), during the Public Health Emergency:
  - Prohibited from making eligibility more restrictive
  - Cannot disenroll any member even if they no longer financially qualify for Medicaid, unless the individual voluntarily terminates eligibility, is no longer a resident of the state, or in the instance of death
- Under current law, once the PHE ends, the Department will begin a renewal process to verify that all members enrolled qualify to remain on Medicaid
- HCPF commitment to coverage, including transitioning people to CHP+ and/or Exchange



Source: Families First Coronavirus Response Act (FFCRA)

It is imperative we keep Coloradans Covered Thru This Transition

- Nearly 420,000 (26%) individuals are “locked-in” to continuous coverage.
- Another ~100,000 are locked-in to a higher Medicaid benefit class (some will be redetermined into CHP+)
- Totaling **520,744 (33%)** locked-in due to the public health emergency



Question 3
County Administration (R-08)

Kim Bimestefer, Executive Director

County Incentives Program
Measures Driving Performance

The County Administration pay-for-performance program (County Incentives) has driven improved county outcomes for several years:

- **Reducing Backlogs** - 32% decrease in application backlog, 41% decrease redetermination backlog from FY 2014-15 to FY 2017-18
- **Timely LTSS processing Improvements** - from 67% in FY 2016-17 to 88% in FY 2019-20
- **Increasing Training** - 41% increase in training hours since FY 2017-18
- **Improving Cybersecurity** - Implemented cyber and information security standards to safeguard applicant and member information. In FY 2019-20, 81% of counties submitted their Remediation Plans.

Yes, FY 2021-22 County Incentives Program contracts align with oversight & accountability focus – for the first time, **new contract measures on accuracy of county eligibility determinations** added

Office of Community Living

Bonnie Silva, Office of Community Living Director

Thank you

for approving our ARPA Home and Community Based Services (HCBS) Spending Plan –

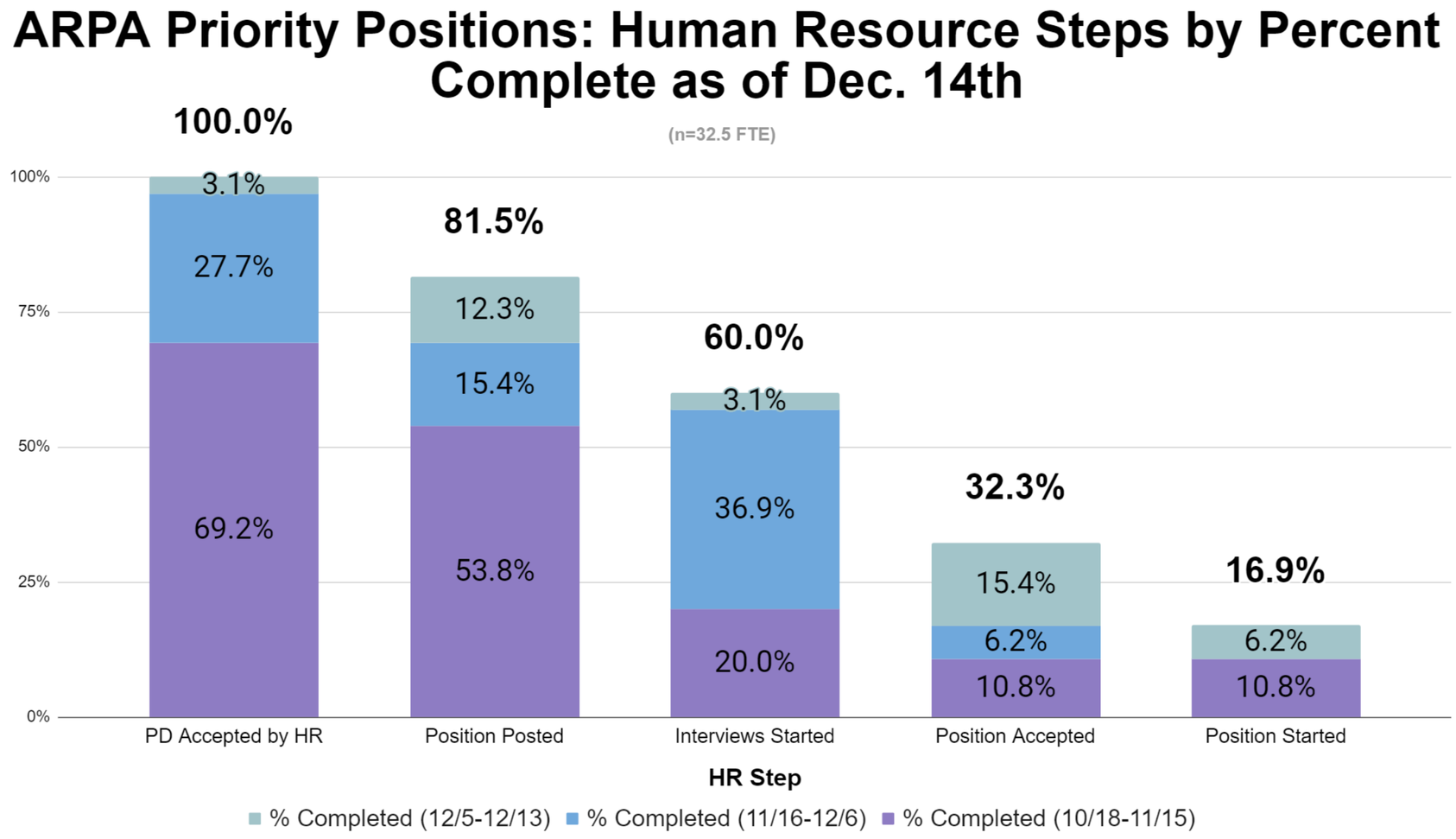
A once-in-a-generation opportunity for transformation

HCBS provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental health diagnoses.

ARPA Project Progress

Hiring:

We are on track to get the positions hired - 32.5 of 58.5 FTEs are priority hires – **HCPF is successfully hiring.**



Long-Term Services & Supports Programs

Home & Community Based Services (HCBS) Waivers

Children with Life Limiting Illness Waiver **192**	Children's Habilitation Residential Program Waiver **177**	Children's Extensive Support Waiver **2,409**	Children's Home- and Community-Based Services Waiver **2,115**	Brain Injury Waiver **615**
Community Mental Health Support Waiver **3,792**	Elderly, Blind, and Disabled Waiver **28,285**	Persons with Developmental Disabilities Waiver* **7,241**	Spinal Cord Injury Waiver **210**	Supported Living Services Waiver **5,169**

50,205

State-Funded Only Programs

Supported Living Services (SLS) **777**	Family Support Services Program (FSSP) **5,885**	**6,662**

Facility-based Programs

Nursing Facilities **12,837**	Intermediate Care Facilities **149**	**12,986**
Program of All-Inclusive Care for the Elderly (PACE) **5,875**		**5,875**

Total Served in LTSS

75,638

Program Serving Indiv. with IDD

SOURCE: FY 2020-21; based on claims in MMIS. * There is a waiting list for the HCBS-DD waiver. As of June 30, 2021, there were 2,819 people waiting for enrollment into the HCBS-DD waiver "As Soon As Available."

Who Receives Long-Term Services & Supports?

8%

Children & Adolescents
ages 20 & younger
& qualifying former
foster care youth

45%

Adults
ages 21-64

47%

Older Adults
ages 65 or
older

Cross Disability

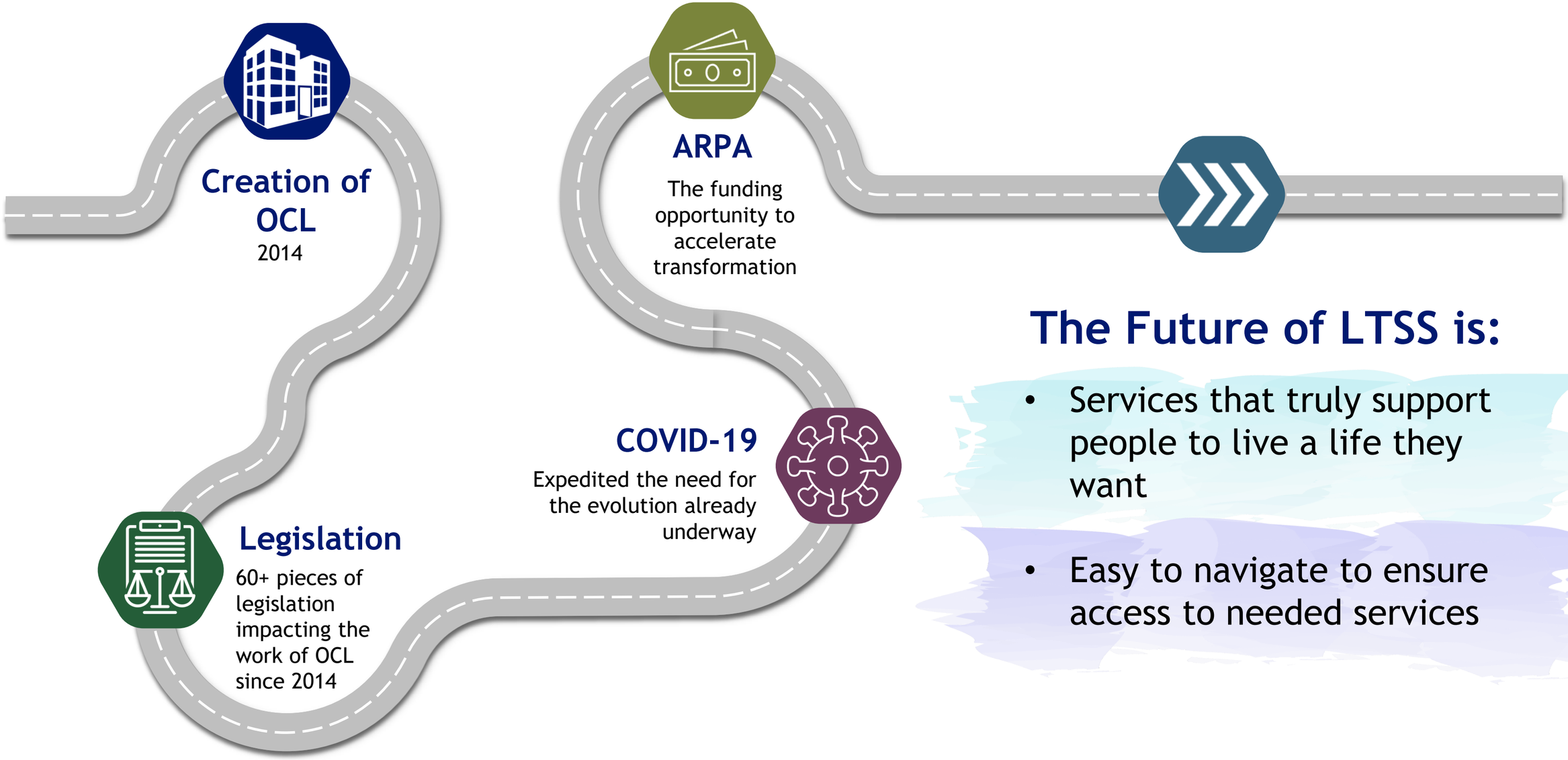
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

84% have a **chronic condition** (compared to the 40% of the rest of the Medicaid)

30% have 5 or more of chronic conditions

FY2020-21; Data represent percentage of people receiving Medicaid LTSS in various age groups.

An Evolution of LTSS in Colorado



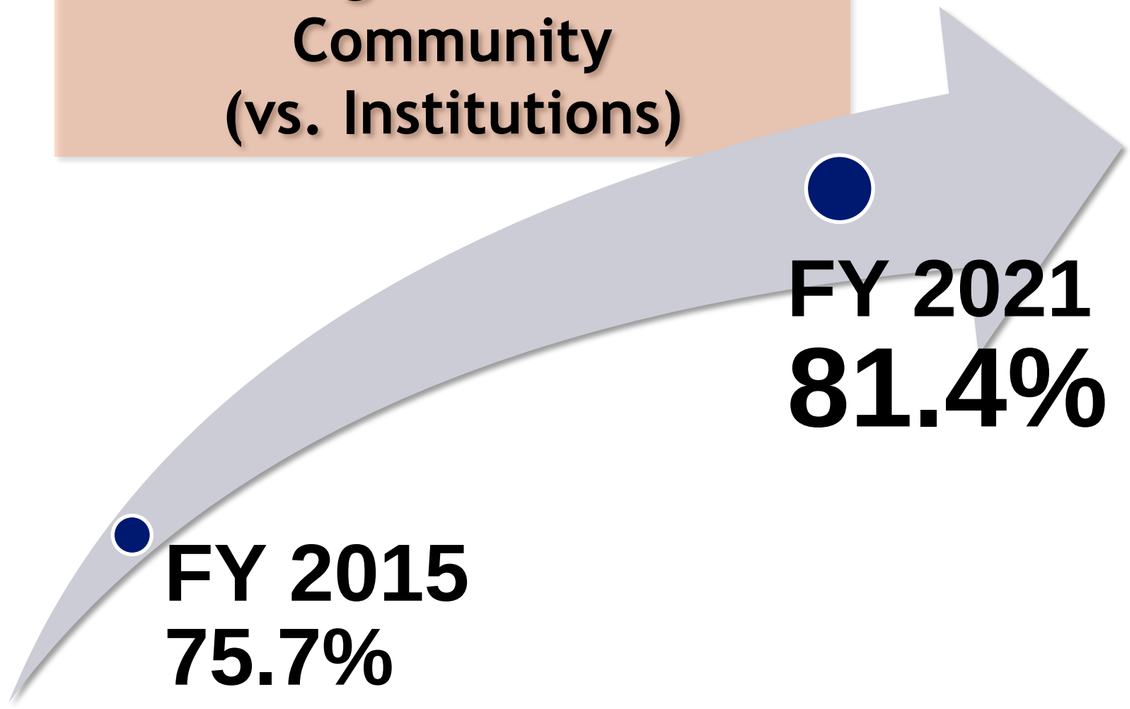
The Future of LTSS is:

- Services that truly support people to live a life they want
- Easy to navigate to ensure access to needed services

Community-Based Program Growth

Program Growth by HCBS Waiver From FY 2015 - FY 2021				
Brain Injury	Children With Life Limiting Illness	Children's Extensive Supports	Children's Habilitation Residential Program	Children's HCBS
+73%	+44%	**+111%**	**+247%**	+78%
Community Mental Heath Supports	Developmental Disabilities	Elderly, Blind, & Disabled	Spinal Cord Injury	Supported Living Services
+14%	+44%	+17%	**+304%**	+25%

% of LTSS Population Receiving Services in the Community (vs. Institutions)



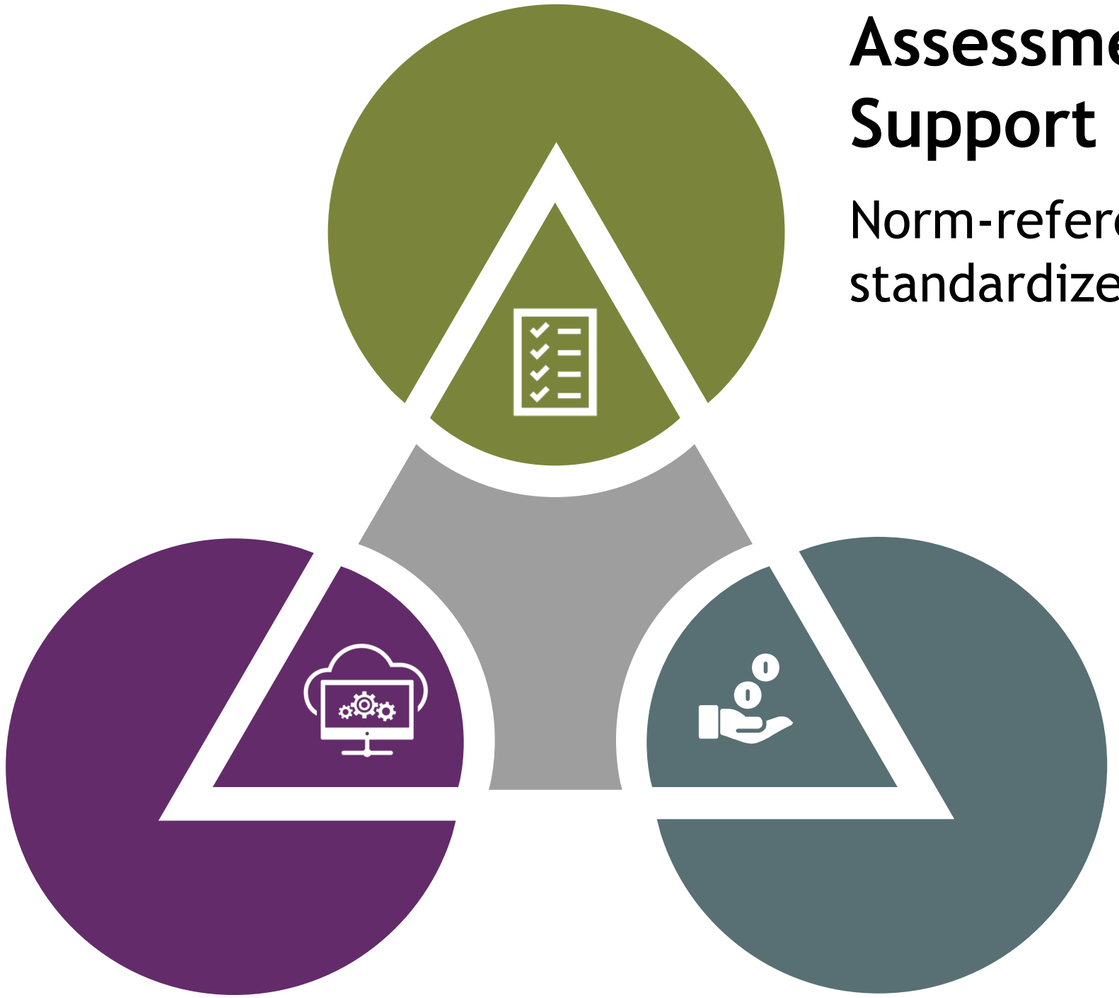
Question 4
SB 16-192 Implementation Update

Bonnie Silva, Office of Community Living Director

SB 16-192 Components

Assessment & Support Plan Tool

Norm-referenced and standardized for all LTSS Members



New IT System

Supporting all of the interdependencies of this work

Person Centered Budget Algorithm

Individualized budget for Members based on needs

Milestones & Complexity

Assessment & Support Plan Tool

Milestones

- ✓ Piloted new Assessment & Support Plan
- ✓ Finalized Assessment and Support Plan

Complexity

- Case Management Agency Readiness

New IT System

Milestones

- ✓ Procured new IT Vendor capable of achieving needed functionality
- ✓ Conducted IT system Data mapping of legacy systems

Complexity

- Sub-contractor Capability
- Interdependencies of System Changes
- Data Migration

Person Centered Budget Algorithm

Milestones

- ✓ Began meeting with a technical advisory group of stakeholders
- ✓ Started mapping system requirements for implementation

Complexity

- Lack of data to inform & develop the PCBA

Health Care Policy & Financing Discussion Questions

Kim Bimestefer, Executive Director
Bettina Schneider, Chief Financial Officer
Pete Walsh, MD, Chief Medical Officer
Tracy Johnson, PhD, Medicaid Director

Value-Based Payments (R-06)
Questions 5-9

Kim Bimestefer, Executive Director
Pete Walsh, MD, Chief Medical Officer

R-6 is critical to meeting CMS goals for Medicaid agencies

- Feds expect state Medicaid agencies to adopt value-based payments:
  - 25% of payments be made through advanced APMs by 2022
  - 50% of payments be made through advanced APMs by 2025
- This policy has spanned federal administrations.

Source: CMS State Medicaid Director Letter 20-004, 9/15/20

Colorado Medicaid Shift from Volume- to Value-Based Care

R-06 supports this important work to improve quality, reduce disparities & lower cost

Medical Care Delivery Model

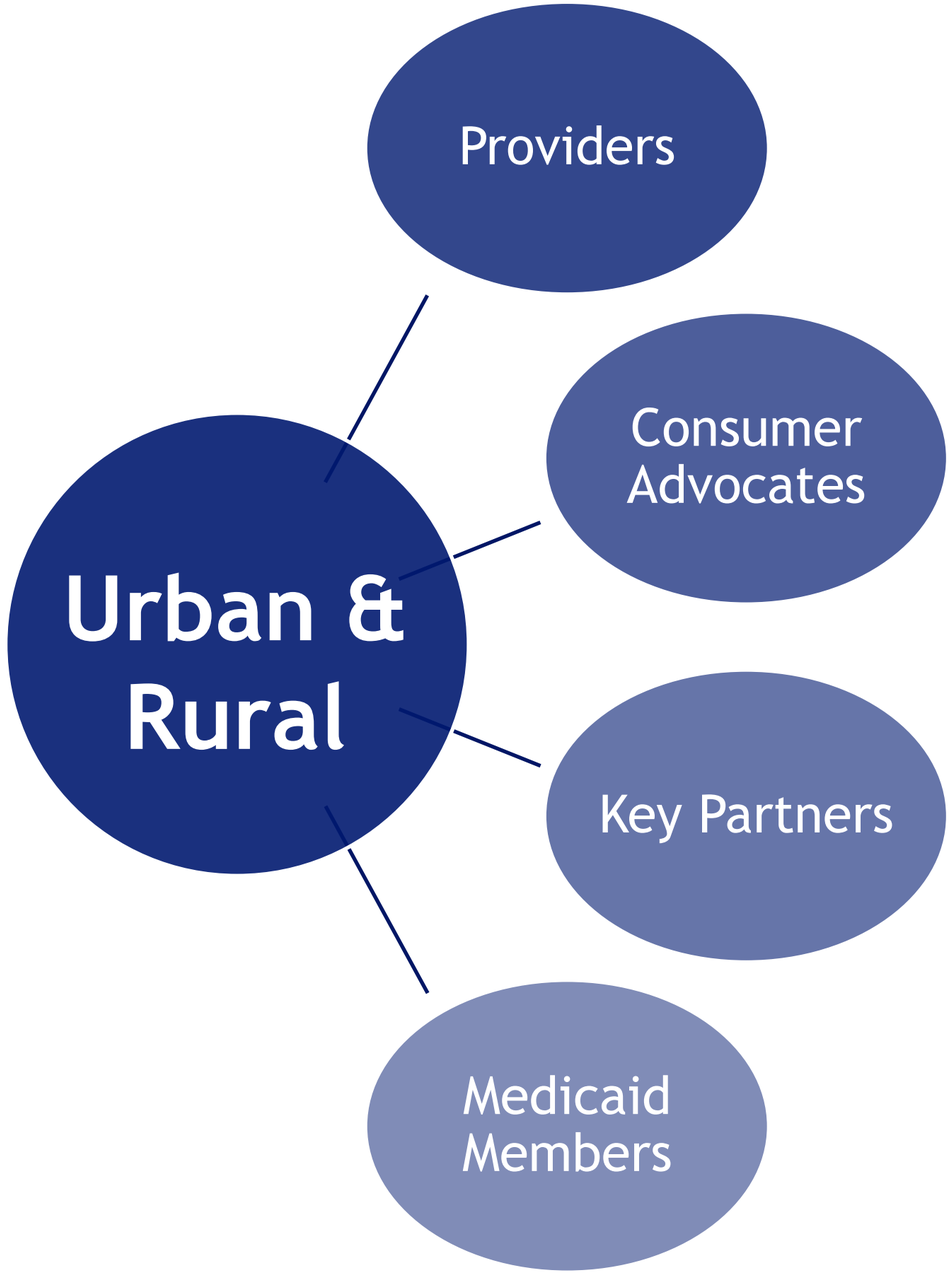
- **Align incentives** to address disparities, improve access & health outcomes & drive affordability without reducing provider reimbursements or benefits
- **Transform Medicaid Delivery System:**
  - eConsults support PCPs, reduce inappropriate specialist referrals & help direct care to higher performing providers, called Providers of Distinction
  - Value-Based Payments, Prescriber Tool, Providers of Distinction, Telemedicine, eConsults, PDAB, Importation. Unique collaboration with DOI & DPA

Evidenced-Based Approach

- Studying Other States- Arkansas, Ohio, Tennessee
- Studying 50+ Value-Based Payments CMS Reviewed
- Following CMS Guidance Towards Mandatory APMs
- Leveraging Commercial Strengths, With Focus On Members

HISTORIC: Colorado is 1 of 4 states where Medicare is collaborating with Medicaid & DOI on primary care VBP models

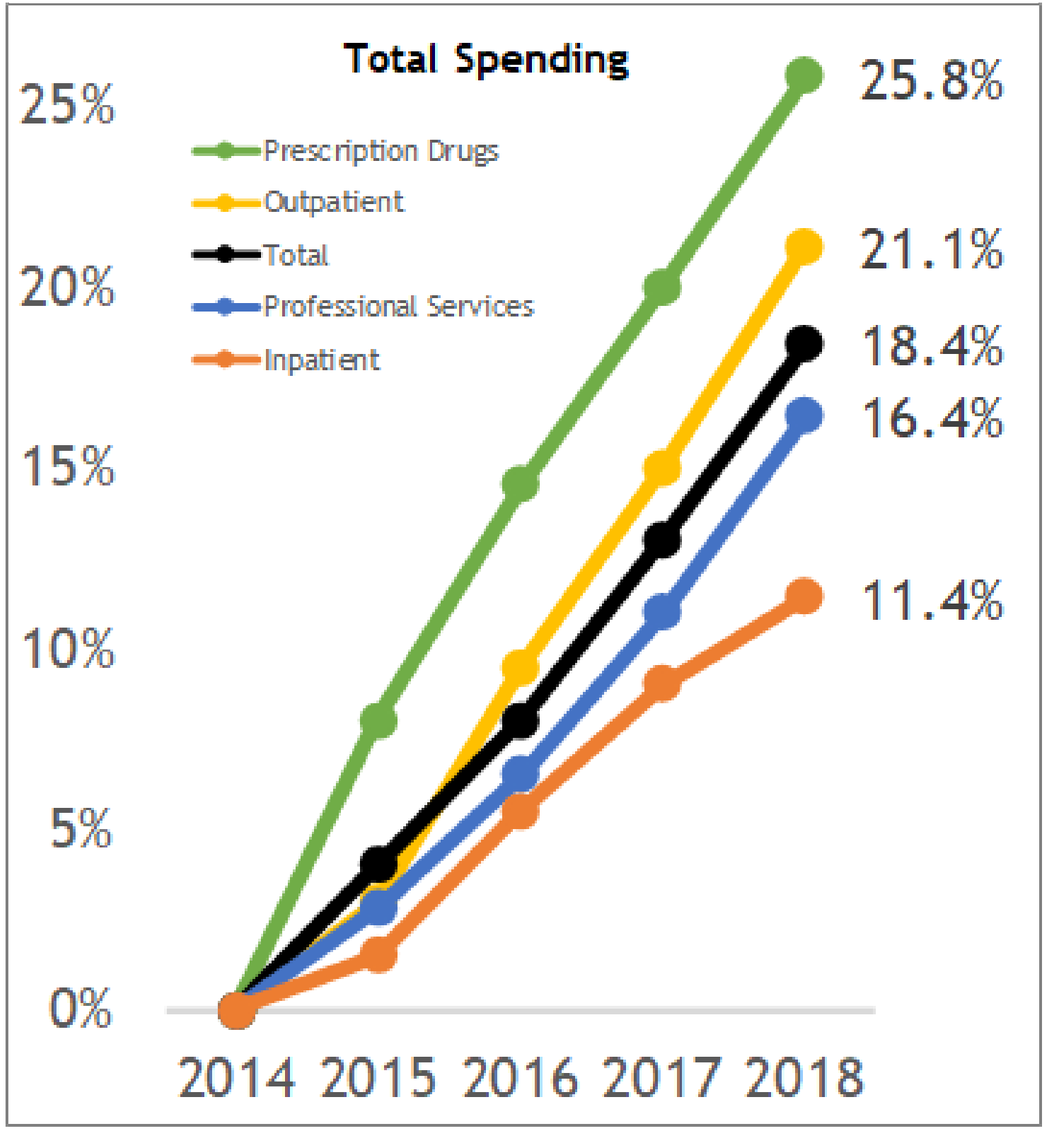
Robust stakeholder engagement for each of the models proposed in the R-6 request



Value Based Payments (R-06)
Questions 10-13
Pharmacy Tool

Kim Bimestefer, Executive Director

Prescription drugs are the leading contributor to rising health care costs



This affordability impact hurts patients:

One in **three** Coloradans cannot fill a prescription, cuts pills in half or skips doses because of the cost.

The Prescriber Tool was the most broadly supported initiative from all stakeholders to address cost and quality in 2019 & 2021 Dept. Prescription Drug Reports

Source: *Reducing Prescription Drug Costs in Colorado, 2nd ed.*, 2021, https://hcpf.colorado.gov/publications

Collaborative Design

Aug.-Sep. 2021

- Colorado Academy of Family Physicians
- Colorado Hospital Association
- Colorado Community Health Network (CCHN),
- One Colorado
- University of Colorado Department of Family Medicine
- Individual medical providers (specialists and primary care) enrolled in Medicaid
- Disability advocates
- Colorado Center on Law and Policy
- Colorado Medical Society

This does not capture all stakeholder engagement that has been undertaken, and stakeholder engagement continues.

Sep. 2021 Statewide Survey

Oct.-Nov. 2021

- Colorado Chapter of American College of Physicians
- University of Colorado Family Medicine
- SCL Health
- Mountain Blue Cancer Center
- Centura Health
- Highlands Health for Family Medicine Clinic
- Peak Vista Community Health Center
- Mountain Family Community Health Center
- Valley Wide Health Systems
- Salud Family Health Centers
- Colorado Community Health Network (CCHN)
- Independent Specialists
- Regional Accountability Entities (RAEs)

Prescriber Tool affordability module: Single tool for commercial & Medicaid prescribers that eases admin & drives affordability

Real-Time E-Prescribing	• Prescribers can send prescriptions electronically to pharmacies for Colorado Medicaid members. • Makes it quicker and easier to provide care to Colorado Medicaid patients.
Real-Time Benefits Inquiry	• Doctors receive more affordable medication options. • Point-of-care insights incorporate preferred drug list. • Prescriber makes clinical decision.
Real-Time Prior Authorization	• Real-time prior authorization insights reduces forms and rework. • Check eligibility and submit prior authorization requests (PARs) electronically.

To learn more:
https://hcpf.colorado.gov/prescriber-tool-project

Impact of PDL Compliance

Medicaid Preferred Drug List (PDL) is crafted and maintained by HCPF's experts and the P&T committee to improve member outcomes and affordability

PDL Compliance	Rx Cost Reduction
91.29%	Q4 2021
92.20%	$16 million
93.20%	$32 million
94.20%	$48 million
95.20%	$64 million
96.20%	$80 million

Value Based Payments (R-06)
Questions 14-18
Primary Care Partial Capitation

Pete Walsh, MD, Chief Medical Officer

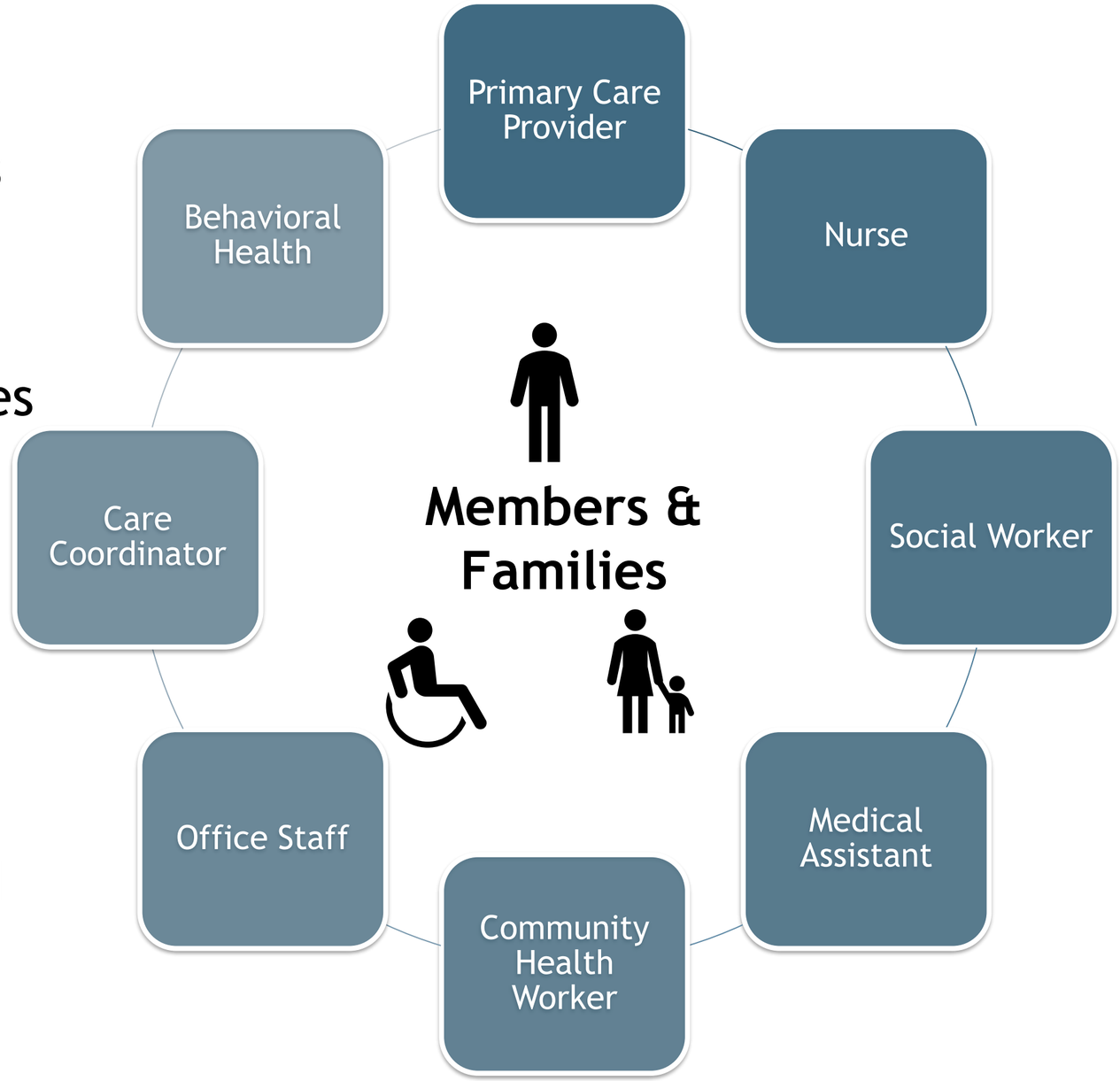
Collaborative Design Mar.-Jun. 2021

- The Colorado Medical Society
- Colorado Academy of Family Physicians
- Farley Health Policy Center at CU
- Colorado Chapter of the American College of Physicians
- Practice Innovation Program at CU
- Colorado Association for School-Based Healthcare
- Denver Health
- University of Colorado School of Medicine
- Children's Hospital Colorado
- Healthcare Consulting Inc.
- Pediatric Care Network
- SCL Health/Saint Joseph Hospital GME Community Clinics
- Summit Medical Clinic*
- Primary Care Partners (Grand Junction)
- Miramont Family Medicine
- Gunnison Valley Family Medicine*
- Pediatric Partners of the Southwest*
- Planned Parenthood of the Rocky Mountains
- Nextera Healthcare
- Every Child Pediatrics
- Stepping Stone Pediatrics
- Children's Medical Center
- Colorado Community Health Alliance*
- Colorado Access
- Rocky Mountain Health Plans*
- Community Reach Center
- Sunrise Community Health

This does not capture all stakeholder engagement that has been undertaken, and stakeholder engagement continues.

Partial Capitation

- Creates predictable revenue for providers
- Enables adoption of key tools like eConsults or the Prescriber Tool
- Supports team-based care, which increases time spent with patients (i.e., diabetes coaching, social determinants of health)
- Supports the docs in their quest to refer care more thoughtfully – to higher performing providers
- Supports the operations necessary to operate in an environment of value-based payments

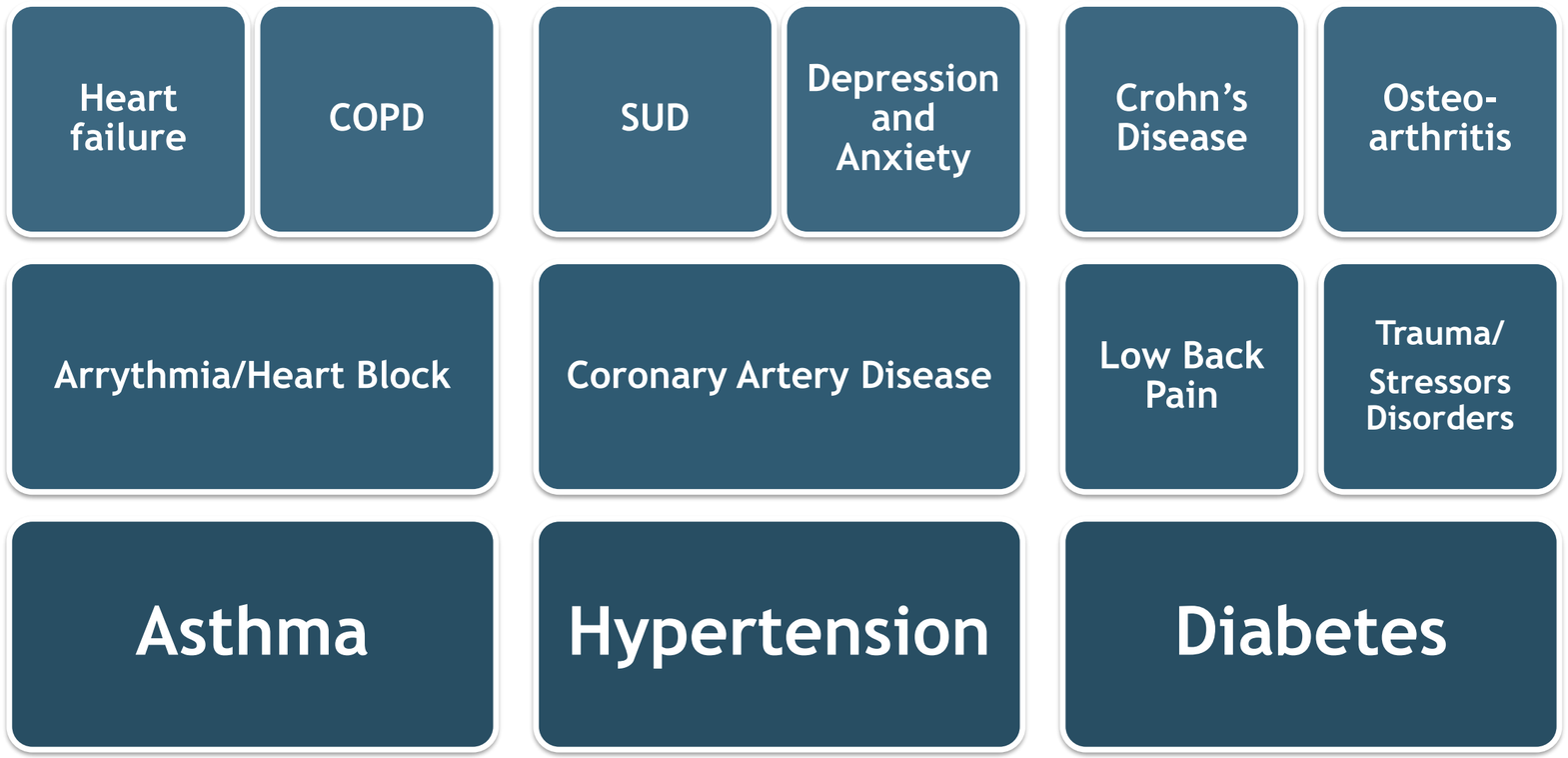


Chronic Condition Episodes

Value-based payments to reward performance

83% of annual Medical spending is attributed to a patient with one or more chronic condition

Chronic condition episodes are based on the success of Tennessee. R-6 will fund the innovation to support PCMPs with actionable information & insights



Value Based Payments (R-06)
Question 19
Providers of Distinction

Kim Bimestefer, Executive Director
Pete Walsh, MD, Chief Medical Officer

Providers of Distinction Program Features

Transforming Industry Affordability, Outcomes, Incentives

- Identifies/ranks providers delivering Medicaid affordability and better outcomes (quality/safety) for Medicaid and Commercial
- Evaluates and reports on outcomes and episode prices for specific procedures
- Data insights tools used by Medicaid primary care providers, consumers and others to inform patient referrals
- Value-based payments to reward performance
- Supports related eConsults work

Rural Providers of Distinction Program Features

Transforming Industry Affordability, Outcomes, Incentives

- Aligns with the $30M stimulus proposal
- Ensures patient care is provided when possible in rural communities (procedure example)
- Increases rural jobs, revenues, stimulates rural economy
- Helps rural providers build agreements with front range providers when such referrals are necessary:
  - Puts power back in the hands of rural providers in their partnerships with front range partners ("affiliation agreements")
- Improves access & patient experience for rural Coloradans
- Improves rural affordability
- Value-Based Payments to rural referring provider and receiving provider (rural PoD or front range PoD)

Eastern Plains Healthcare Consortium

Colorado Rural Health Center

Providers of Distinction Program Goals

1. Improve patient outcomes, patient satisfaction & health equity
2. Improve affordability of care
3. Increase reimbursements to Providers of Distinction via VBP
4. Via VBP, make it more desirable for providers to see Medicaid patients; improve patient access to specialty care
5. Improve rural provider sustainability and care access for rural Coloradans

Value-Based Payments (R-06)
Questions 20-24
Maternity Bundle

Tracy Johnson, PhD, Medicaid Director

Yearly, CO Medicaid covers >40% of births. Focus on improving outcomes for families

Current Services & Programs Addressing Equity

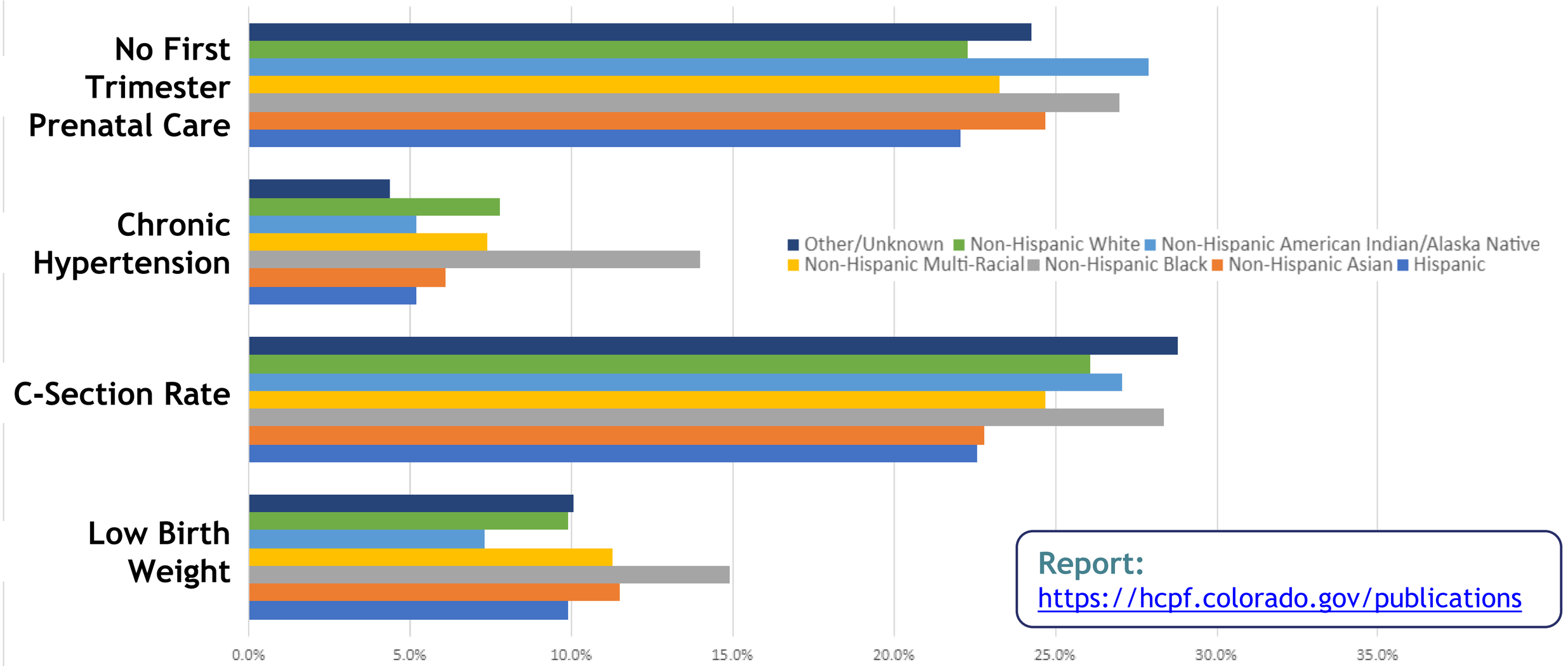
- Prenatal care visits and testing
- Imaging (ultrasounds)
- Labor and delivery
- Depression screens
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use
- Postpartum visits
- Specialized programs

for first time and high risk

Strategies to Close Gaps

- RAE maternity programs
- Hospital (HTP) maternity programs
- Recent maternity-related coverage expansions
- Maternity Stakeholder Advisory Council for Medicaid members who have given birth
- Measuring quality improvement, dashboards, and annual reporting
- Value-based bundled payment to improve outcomes and close health equity gaps improving on the success of Arkansas, Ohio, and Tennessee

Health First Maternity Outcomes by Race/Ethnicity



Report:
https://hcpf.colorado.gov/publications

Collaborative Design & Operation

New Maternal Advisory Committee (composed of primarily Black, Indigenous and People of Color Health First Colorado members with lived experience in Colorado Medicaid maternity care) to bring members' perspectives, insights, and knowledge to the program.

Key stakeholders include:

- **Health First Colorado members**: Maternal Advisory Committee (MAC), etc.
- **Consumer advocates**: Colorado Perinatal Care Quality Collaborative (CPCQC); Elephant Circle, Colorado Children's Campaign, Colorado Consumer Health Initiative (CCHI), Colorado Center on Law and Policy (CCLP), Colorado Organization for Latina Opportunity and Reproductive Rights, Family Forward Resource Center, Colorado Community Health Network (CCHN), etc.
- **Maternal care providers/specialists**: urban and rural obstetrical providers, certified nurse midwives, mental health & substance use disorder clinicians, Regional Accountable Entities (RAEs), etc.
- **Professional networks**: Colorado Medical Society (CMS), American College of Obstetricians and Gynecologists (CO-ACOG), Colorado Academy of Physicians, etc.
- **Other state agencies**: Department of Public Health & Environment, Division of Insurance, Department of Personnel and Administration etc.
- **HCPF internal advisory committees/SMEs**: Program Improvement Advisory Committee (PIAC), Maternal Advisory Committee (MAC), Maternal Child Health team, etc.

This does not capture all stakeholder engagement that has been undertaken, and stakeholder engagement continues.

Maternity Bundled Payment Program

PRESENT	By 2025
Pilot Program	Cover all Medicaid Deliveries

Program Goals

Improve Quality, Address Health Equity & Preventable Maternal Mortality, Reduce Cost

Program Methodology

Program covers **Prenatal, Delivery, and Postpartum Care**

Comprehensive Budget → **Quality Metrics** → **Incentive Payments**

Maternity Bundled Payment Program

Quality Measures as Gateway for Incentive Payment

Closing Health Disparities (gateway to incentive payment)
Postpartum Depression Screenings (tie-to-payment)
Contraceptive Care — Postpartum (tie-to-payment)
Severe Maternal Morbidity (tie-to-payment)
Unexpected Complications in Term Newborns (tie-to-payment)
Percentage of Low Birthweight Births (tracking)

Questions 25-28
Reproductive Health Care Program
SB 21-009

Tracy Johnson, PhD, Medicaid Director

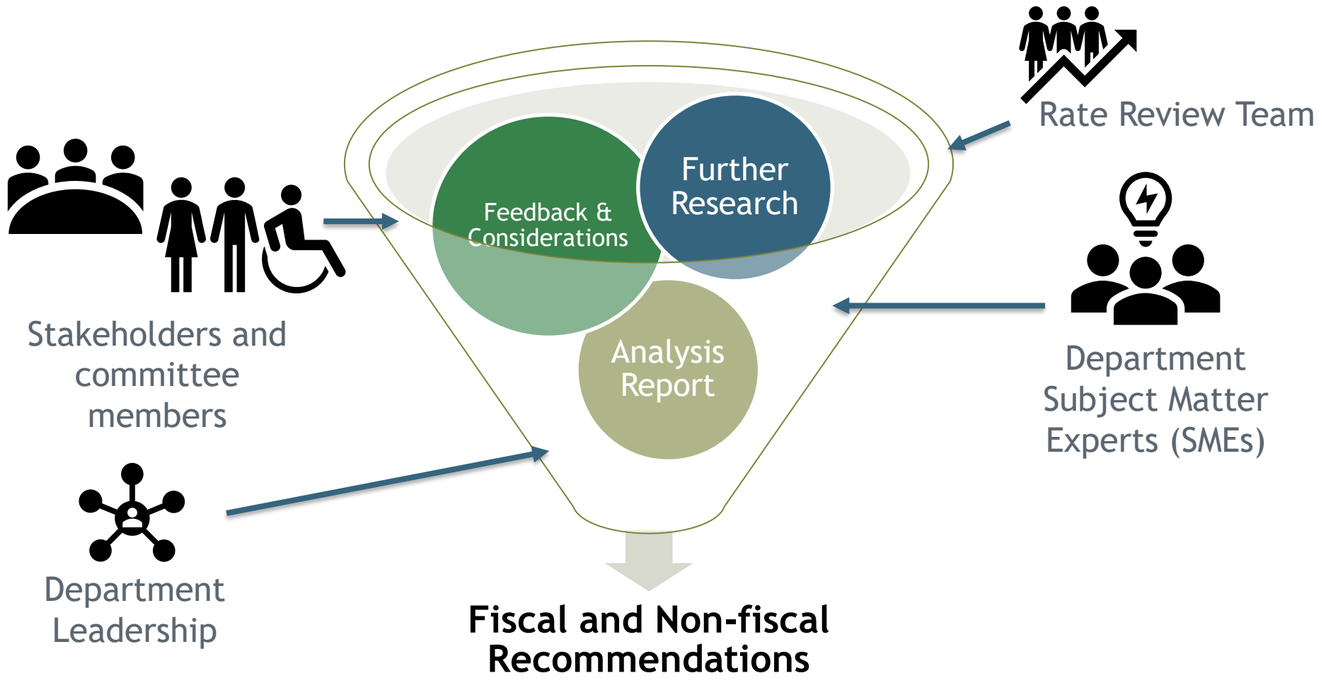
Provider Rates (R-10)
Questions 29-32

Kim Bimestefer, Executive Director
Bettina Schneider, Chief Financial Officer

Medicaid Provider Rate Review Advisory Committee (MPRRAC) (R-10) **Questions 33-36**

Bettina Schneider, Chief Financial Officer

Rate Review & Recommendations Process



Equity across all services

Objective, Evidence-Based Process

Long-term Objectives

Evaluation includes a multitude of factors, including (but not limited to):

- regulatory compliance
- clinical standards and best practices
- access to care
- federal and state authority
- budgetary authority

Recommendations must be approved by Department, OSPB, JBC, and frequently CMS

Behavioral Health
Questions 37-40

Kim Bimestefer, Executive Director
Tracy Johnson, PhD, Medicaid Director

Behavioral Health Transformation

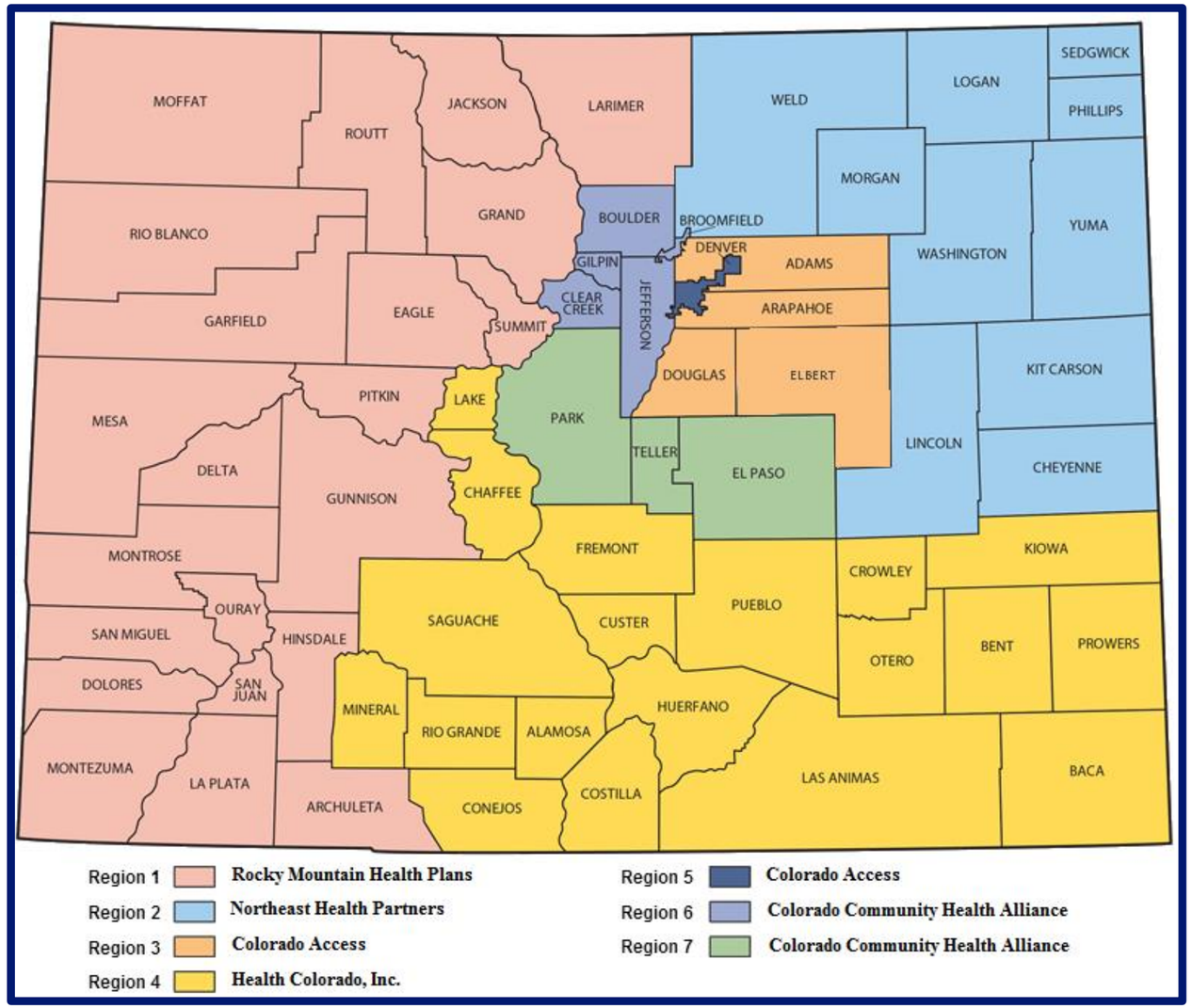
Improving behavioral health benefits, access & services for members

- Investments last several years in partnerships, providers & programs to improve Medicaid behavioral health system & expand access & reimbursements to meet rising demand
- Grown network of behavioral health providers by 20%, >1,716 providers over last 2 years
- Added Inpatient and Residential Substance Use Disorder Treatment benefit eff. 1/1/21, served ~5,000 Medicaid members in first six months
- Expanded behavioral health access through telemedicine so members could access care safely & through the privacy of their own home

Transformation for betterment of Coloradans

- Supporting Behavioral Health Administration (BHA) path toward a more coordinated, patient-centered and effective infrastructure, which will help address many of our system's current challenges
- Participating on the Behavioral Health Transformational Task Force to leverage one-time funding for long-term improvements
- Building safety net system capacity to increase access to comprehensive safety net behavioral health system

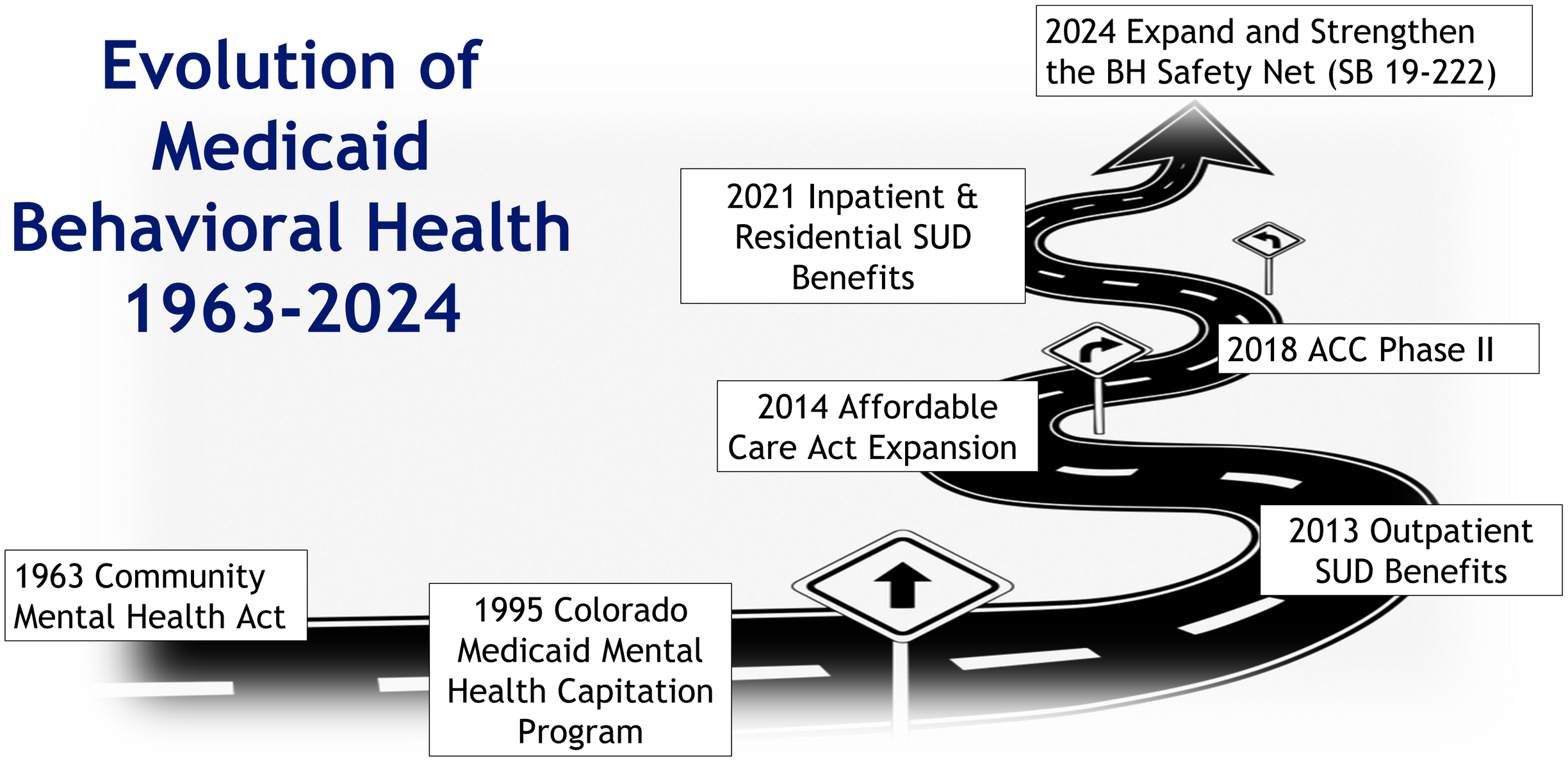
Regional Accountable Entity

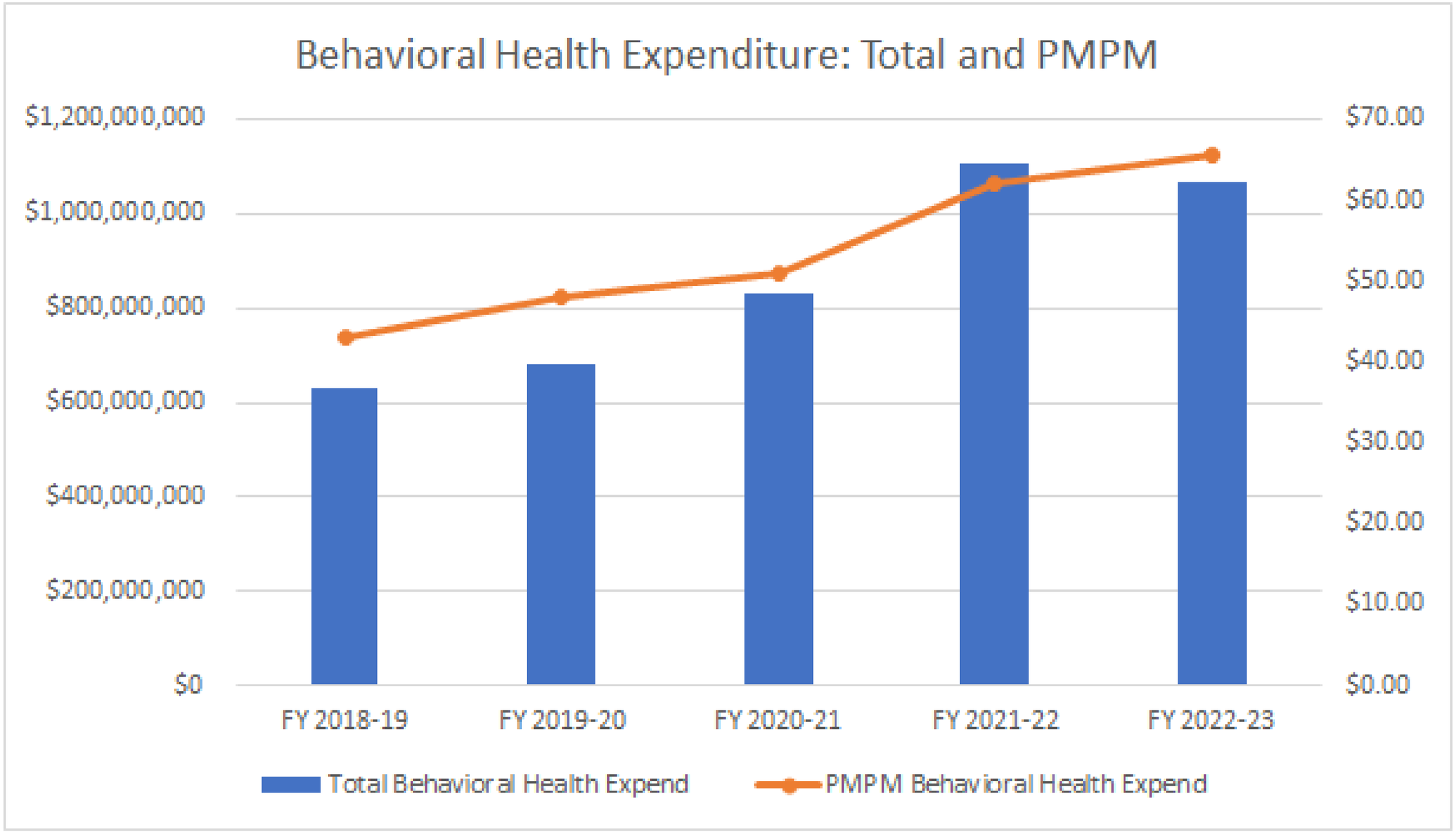


RAE Payment Model

Physical Health Care	Behavioral Health Care
Fee For Service* except PRIME, DHMP	Behavioral Health Capitation
	New SUD services

Evolution of Medicaid Behavioral Health 1963-2024




Behavioral Health Expenditure: Total and PMPM
$1,200,000,000
$1,000,000,000
$800,000,000
$600,000,000
$400,000,000
$200,000,000
$0
$70.00
$60.00
$50.00
$40.00
$30.00
$20.00
$10.00
$0.00
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
Total Behavioral Health Expend
PMPM Behavioral Health Expend

ARPA HCBS Funding: Targeted Investments to Accelerate BH Transformation

- Supportive housing pilot; improving wraparound supports
- Implement plan to enhance and strengthen the Safety Net (SB 19-222)
  - RAE incentives for high-intensity outpatient and culturally competent care
  - Stakeholder planning with BHA, provider training, helping providers join/bill Medicaid
- Local grants for innovations in transitions of care for youth and adults
- Mobile crisis planning, new benefit, connection to secure transportation
- Flexible funds for workforce development, program expansion, construction, planning for child and youth step-down alternatives
- Care coordination platform to include social determinants of health data to drive whole person care

Question 37

Substance Use Disorder Capacity

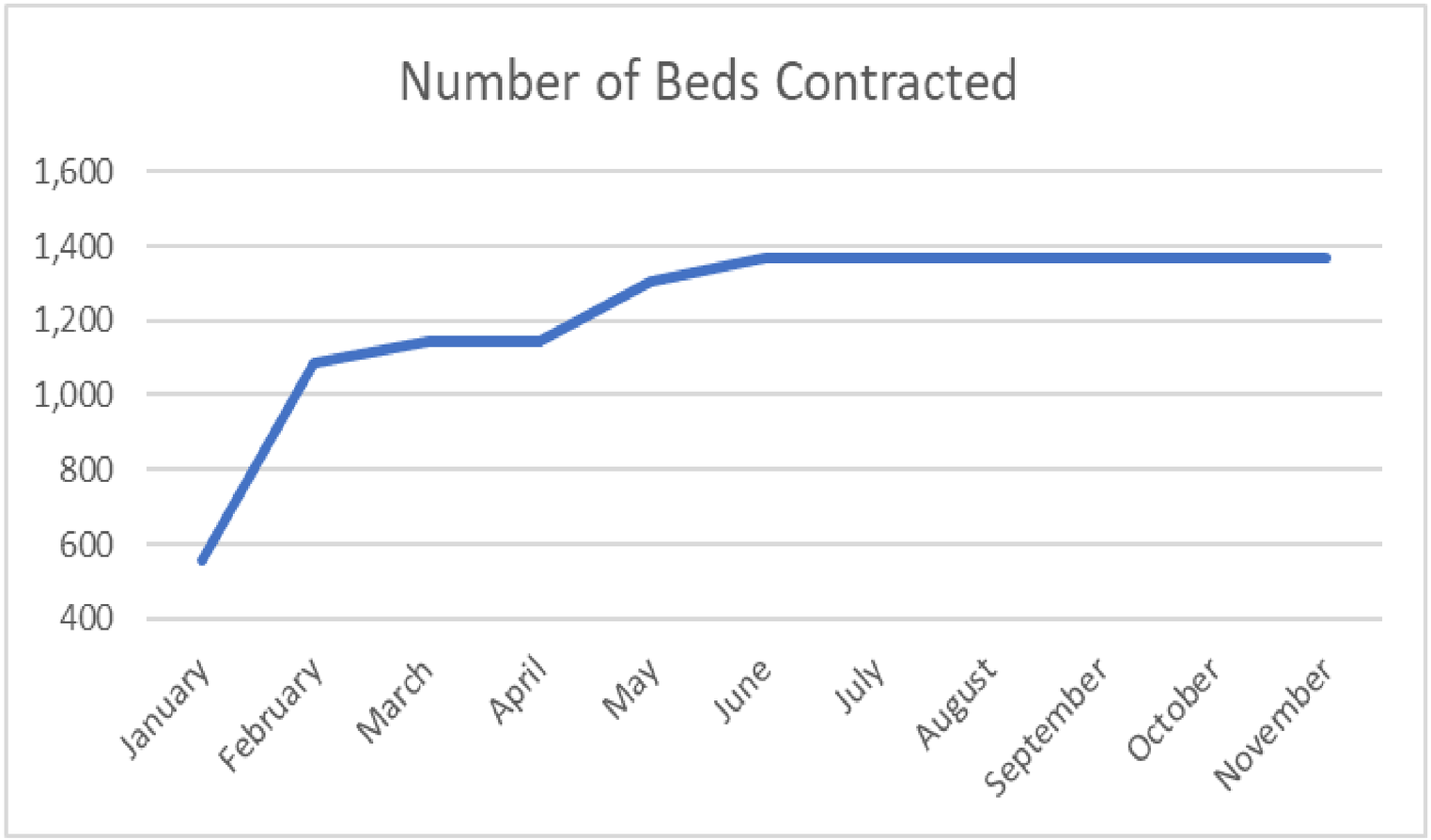
Tracy Johnson, PhD, Medicaid Director

Substance Use Disorder

Member Utilization: 1/1 - 10/31/21

12,162: Withdrawal Management

2,363: Residential Treatment



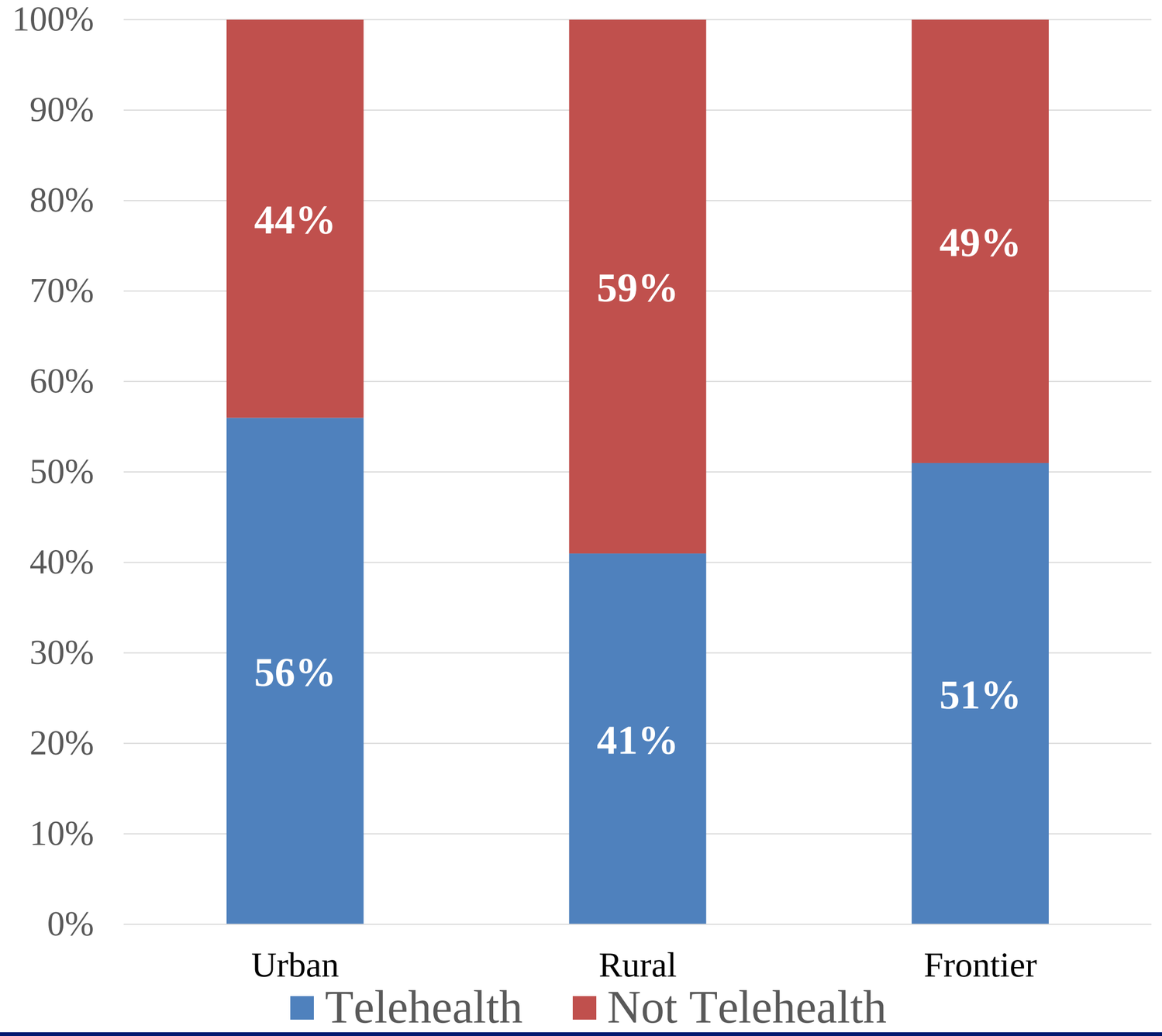
Question 38

Telemedicine Utilization

Tracy Johnson, PhD, Medicaid Director

Average of Capitated Behavioral Health Telemedicine Visits by Members Located in Urban, Rural, and Frontier Counties

March 2020 to Late March 2021



Questions 39

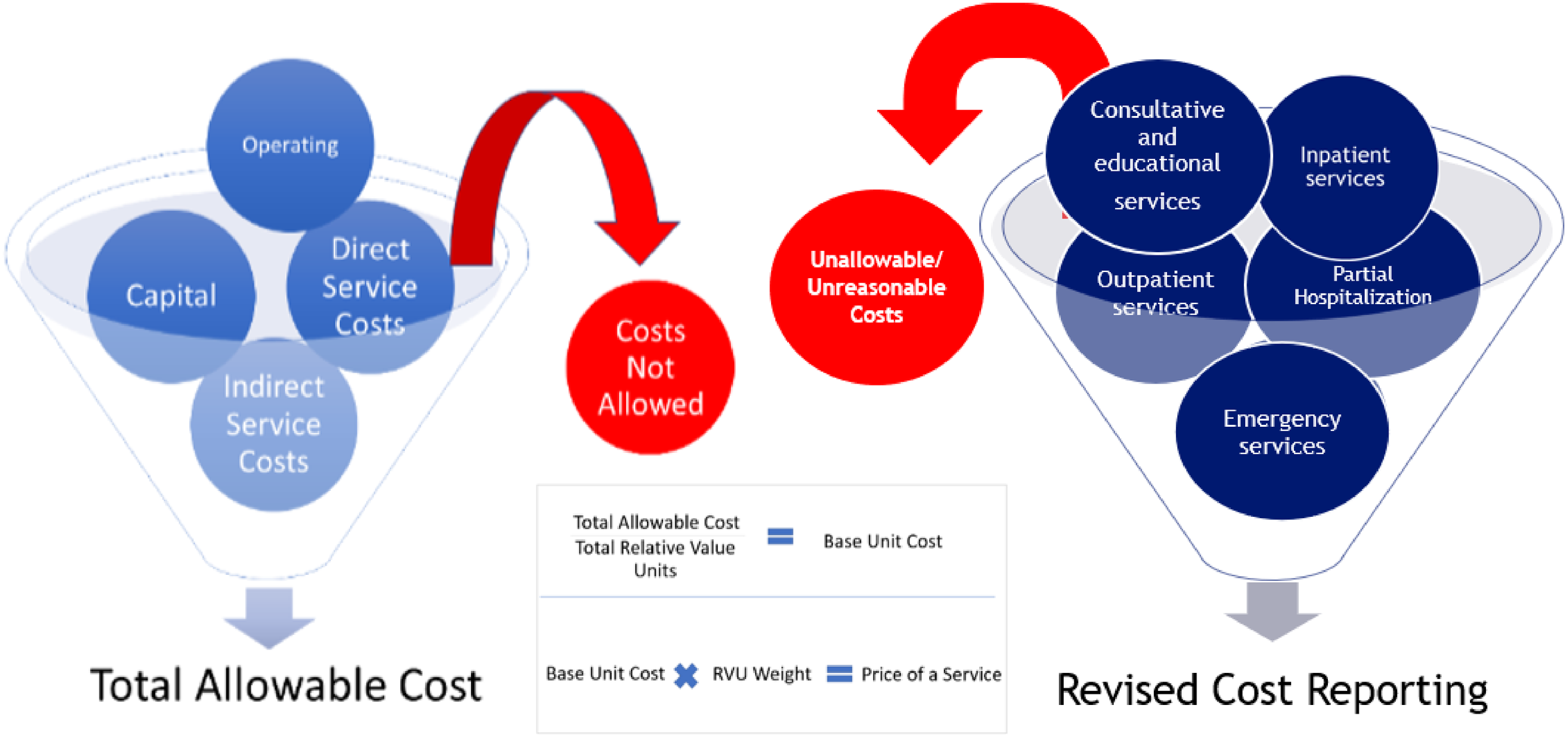
CO Client Assessment Record
Drug Alcohol Coordinated Data System

Tracy Johnson, PhD, Medicaid Director

Question 40

Behavioral Health Provider Reimbursement

Tracy Johnson, PhD, Medicaid Director



Community Mental Health Center Cost-Based Reimbursement

Questions 41-51

Other Discussion Questions: Adult Dental, Other Benefits, Home Health Prior Authorization, Utilization Management, Drug Importation, All Payer Claims Database (APCD), MMIS, Compliance FTE, Contractor FTE

Kim Bimestefer, Executive Director
Tracy Johnson, PhD, Medicaid Director
Pete Walsh, MD, Chief Medical Officer

Drug Importation Program

- **Mar. 2020** - Submitted draft Sec. 804 Importation Plan (SIP)
- **Nov. 2020** - FDA released Final Rule with regulatory framework for state-led programs
- **Early 2021** - HCPF released competitive solicitation; negotiating contracts with supply chain partners since
- **Early 2022** - Once contracts finalized, final development & formal SIP application to the FDA to operate the program
- **2023** estimated for operational program, pending federal timelines for review and approval

Common Questions for Discussion 1-2

Kim Bimestefer, Executive Director

THANK YOU