DEPARTMENT OF HEALTH CARE POLICY & FINANCING
FY 2021-22 JOINT BUDGET COMMITTEE HEARING AGENDA
Thursday, Jan. 7, 2021
9 a.m. – 5 p.m.

9:00 – 9:50 COMMISSION ON FAMILY MEDICINE

Main Presenters:

- Lynne Jones, Executive Director, Commission on Family Medicine
- Tom Westfall, Board Chair, Commission on Family Medicine
- Dr. Emillia Lloyd, Board Chair, Colorado Association of Family Medicine Residencies

9:50 – 10:00 BREAK

10:00 – 10:10 INTRODUCTION

Main Presenters:

- Kim Bimestefer, Executive Director

10:10 – 12:10 EXECUTIVE DIRECTORS OFFICE OVERVIEW SECTION & QUESTIONS

Main Presenters:

- Kim Bimestefer, Executive Director
- Tracy Johnson, Medicaid Director
- John Bartholomew, Chief Financial Officer/Finance Office Director

Topics:

- Questions 1-36, Pages 21-66, Slides 23-51
- COVID-19 & Economic Downturn Impacts
- Commission on Family Medicine Funding
- Hospitals
- Budget Request & General
- Provider Rates

12:10 – 1:30 LUNCH

1:30 – 2:20 BEHAVIORAL HEALTH OVERVIEW SECTION & QUESTIONS

Main Presenters:

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

Topics:

- Questions 37-45, Pages 66-76, Slides 52-62

2:20 – 2:30 **BREAK**

2:30 – 4:10 **OFFICE OF COMMUNITY LIVING OVERVIEW SECTION & QUESTIONS**

Main Presenters:

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

Topics:

- Questions 46-65, Pages 76-98, Slides 63-107
- COVID-19 Response
- Nursing Home Funding
- Program of All-Inclusive Care for the Elderly (PACE)
- Remote Supports & Electronic Visit Verification Update
- Local Minimum Wage Increase Reporting
- Buy-In Program
- Waiver Consolidation & New Assessment Tool
- Supported Living Services (SLS) and Developmental Disability (DD) Waiver
- Consolidation of Appropriations for Case Management Agencies

4:10 – 4:15 **CLOSING REMARKS & ADDITIONAL QUESTIONS**

DEPARTMENT OF HEALTH CARE POLICY & FINANCING
FY 2021-22 JOINT BUDGET COMMITTEE HEARING QUESTIONS
Thursday, Jan. 7, 2021
9 a.m. – 5 p.m.

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 2008-2020: 285

Bills Not Fully Implemented with a HCPF Fiscal Impact 2008-2019: 8

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 240 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	Fiscal Impact
HB 20-1361 Reduce the Adult Dental Benefit (Esgar, McCluskie/Moreno, Zenzinger)	The bill reduces the adult dental benefit cap to $1,000 per year for each recipient.	HB 20-1361 has not been implemented due to the public health emergency (PHE). The targeted implementation date is currently April 1,2021,following the expiration of the PHE and maintenance of effort (MOE) period. However, if the PHE is extended, the next date of implementation would be July 1, 2021. It is our understanding that decreasing the adult dental benefit would be considered a reduction in services and benefits, which is not allowed based on the MOE and additional FMAP (Federal Medical	FY 2020-21 Reduction of $5,565,000 FY 2021-22 Reduction of $11,130,000

		Assistance Percentage) received by the state.	
HB 19-1210 Local Government Minimum Wage (Melton, Galindo/Danielson, Moreno)	The bill permits a local government to establish a minimum wage law for individuals. If a local government enacts a minimum wage that exceeds the statewide minimum wage, the law requires the Department to submit a report with recommendations about whether provider rates need to be increased to accommodate the local government minimum wage increase. Additionally, the Department must establish a process for eligible nursing facility providers to apply for a local minimum wage enhancement payment whenever a local government increases its minimum wage above the statewide wage.	This bill is not fully implemented. Rules have been adopted by the Medical Services Board, but the Department is awaiting CMS (Centers for Medicare and Medicaid Services) approval of our State Plan Amendment. CMS approval is expected in January 2021 and the first payments will be made before the end of FY 2020-21.	FY 2020-21 $311,825 and 0.9 FTE FY 2021-22 $422,749 and 1.0 FTE
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, as set forth in SB 19-005, will not be implemented according to statutory deadlines. State statute required the Department to submit a formal application for federal approval of an importation program by Sept. 1, 2020. The Department notified the bill sponsors on Sept. 1, that we would not meet this deadline due to the impending release of the final federal rule that would codify the regulatory framework for state-led importation programs. The final rule was released on Sept. 24 and went into effect on Nov. 30. The Department intends to apply for	FY 2019-20 $1,043,414 and 4.8 FTE FY 2020-21 $2,043,587 and 5.8 FTE During the 2020 legislative session, the Department FTE was reduced to 4.0 FTE and the budget was reduced to $1,366,964 - contracting budget was

		federal approval according to the framework set forth in the final rule and estimates that a final application will be ready for submission in early 2022.	reduced from $1,000,000 to the FY 2019-20 amount of $410,000.
SB 16-120 Review by Medicaid Client for Billing Fraud (Roberts/Coram)	The bill requires HCPF to provide explanation of benefits (EOB) statements to Medicaid members beginning July 1, 2017. The EOB statements must be distributed at least once every two months and HCPF may determine the most cost-effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only. The bill specifies the information to be included in the EOB statements, including the name of the member receiving services, the name of the service providers, a description of the service provided, the billing code for the service, and the date of the service.	In February 2020, the project was placed on hold to obtain legal guidance from the Attorney General's Office on one of the business requirements. In late November 2020, the Department received the awaited guidance, and the business requirements have been drafted to obtain an estimate and prioritization.	FY 2016-17 $188,000 FY 2017-18 $858,509 and 0.5 FTE FY 2018-19 $865,806 and 0.5 FTE
HB 15-1318 Consolidate Intellectual and Developmental Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid Home and Community-Based Services (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 waiver.” Over the past year, the Department and stakeholders have met on several occasions to review an actuarial analysis of the cost impact and to perform case studies to test the proposed Needs Based Criteria (NBC) as targeting criteria for a consolidated waiver. The Department’s actuarial findings from this work reveal a	FY 2015-16 $1,188,491 and 2.7 FTE FY 2016-17 $988,204 and 3.0 FTE

		significant fiscal impact of a redesigned consolidated waiver. 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 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. This year the Department was able to make significant strides on launching a supportive employment pilot program aimed at incentivizing waiver providers to increase quality outcomes for our members and at a cost savings for the Department, creating a new telehealth service delivery option that provides flexibility and access to needed services for our members, and lastly, expanding and making improvements to day services that have led to a more customizable and streamlined approach benefiting both our providers and our members alike. 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 in order for the Department to fully redesign the SLS and DD waivers in an efficient, coordinated, and thoughtful manner.	
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 'pass-through' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through the state plan or waivers 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 and Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I	FY 2010-11 $102,570 FY 2011-12 $42,168

		nursing facility to be reimbursed by the state for room and board with federal financial participation.	
HB 08-1072 Medicaid Buy-In for Persons with Disabilities (Soper/Williams)	This bill establishes a Medicaid Buy-in Program for people with disabilities who earn too much to qualify for Medicaid and for those whose medical condition improves while participating in the program.	The Medicaid Buy-in Program for people with disabilities has been implemented. The Department has not implemented a buy-in for the "medically improved" group. The goal of the buy-in for the medically improved was to allow members with improved but preexisting conditions to access health care. Under federal rule, the earliest any of these potential members could have been covered was March 2013. With SB 13-200 and SB 11-200, these members will either qualify for Medicaid as part of the expansion population or be able to seek subsidies on private health insurance through Connect for Health Colorado regardless of a preexisting condition.	FY 2008-09 $55,000 FY 2009-10 $779,472 and 2.0 FTE
HB 05-1243 Consumer Directed Care Under Medicaid* (Jahn/Johnson)	This bill extends the option of receiving Home and Community-Based Services (HCBS) through the Consumer-Directed Attendant Support Services (CDASS) delivery model to all Medicaid recipients who are enrolled in an HCBS waiver for which the Department of Health Care Policy & Financing has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from their current HCBS waiver to receive services through the consumer-directed care service model.	The legislation authorized the Department to seek federal approval to expand Consumer-Directed Attendant Support Services (CDASS) to all the HCBS waivers, but the fiscal note assumed significant savings. While a valuable and important delivery model, research and data show that participants in CDASS do not produce significant savings. The Department has received federal approval and implemented CDASS into five HCBS waiver programs, including the recent addition of CDASS into the Support Living Services HCBS waiver program in 2018. The Department continues to review opportunities	FY 2005-06 Reduction of $803,395 FY 2006-07 Reduction of $10,638,763

		to expand consumer direction into additional waivers and services.	

*While the Department does not have a complete record of the implementation status of bills prior to 2008, HB 05-1243 was included because the Department is aware that this bill was not fully implemented and would have been included on this list if the Department had a comprehensive record of legislative implementation.

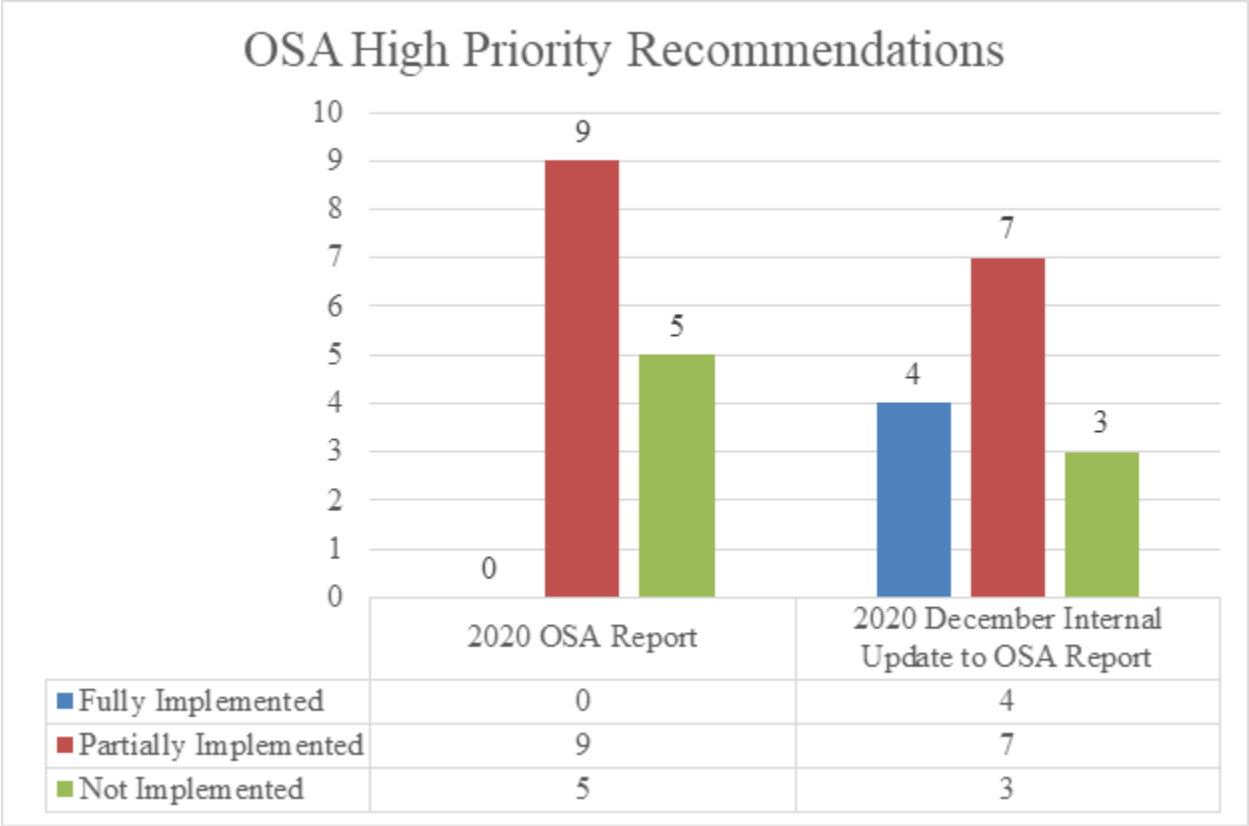
2. **Does the Department have any HIGH PRIORITY OUTSTANDING recommendations with a fiscal impact identified in the Office of the State Auditor's "Annual Report: Status of Outstanding Audit Recommendations"? What is the Department doing to resolve these HIGH PRIORITY OUTSTANDING recommendations? Please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

RESPONSE

In reference to the outstanding audit recommendations identified in the Office of the State Auditor's "2020 Annual Report of Audit Recommendations Not Fully Implemented," the Department has 14 recommendations that are considered high priority.

The Department has an increase from last year's Not Fully Implemented high priority audit recommendations. There are several reasons. They include but are not limited to:

- Timing differences between when Office of the State Auditor (OSA) conducts their audit and when the Department prepares its update to the JBC.
- Some audit recommendations are deferred to the following year.
- Some recommendations fall under a major topic area, but the subtopic is different, and the actual recommendations are very different from year to year. For example, the major topic of the Provider Eligibility Recommendation dates back to 2016, but each actual recommendation has been different. This original recommendation was made during the 2016 OSA audit when the legacy Medicaid Management Information System (MMIS) was still operational. The Department addressed the recommendation in the new MMIS that was implemented in 2017 to avoid the additional funding needed to update two core systems. Although internal controls have been strengthened through manual processes and system enhancements, changes are still required to automate the remaining manual processes and correct a display issue with several data points. They are on target for completion by July 2022.
- Some recommendations have not been implemented. For example: Personnel Costs. The Department did not meet the original and other implementation dates because the of the reliance on the Office of the State Controller's statewide implementation of its human resources information system. This project was abandoned within the last year and the Department implemented its own solution. The audit recommendation is now fully implemented.



High Priority Recommendations

1. OSA SSWA Recommendation 2019-042A (2018-044A, 2017-054A) relates to the Department strengthening internal controls over the Medicaid program by training to ensure caseworkers are updating information in the Colorado Benefits Management System (CBMS) identified in the audit.

<u>Implementation Status Update</u>
Partially Implemented. Estimated completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The Staff Development Center (SDC) is in the process of enhancing all their foundational training materials into a "Process-Based Training" (PBT) model to be more effective and efficient based on training industry best practices. In addition to focusing on PBT, the SDC is converting all training materials into a "Blended Learning Model" (BLM) to increase accessibility and the transfer of learning rather than relying primarily on live, in-person, instructor-led training which is difficult for all impacted users to access. BLM is a training model that includes several different training modalities (instructor-led courses, eLearning courses, desk aids, process manuals, infographics, workbooks, etc.) to be more engaging, effective, and accessible to adult learners with varying needs and preferences across large geographical areas.

Historically Linked Recommendation Implementation:
The Department continues to strengthen and improves its internal controls over the Medicaid program by updating and revising training materials to ensure caseworkers are accurately updating information in CBMS. The Department has found the processes mentioned above are more effective than our previous practices. Between the counties and other eligibility sites, the Department has thousands of technicians who need to

be trained. Turnover with eligibility technicians is also a factor. Both PBT and BLM are on track to be fully implemented by July 31, 2021.

2. OSA SSWA Recommendation 2019-042B (2018-044B, 2017-054B) relates to the Department strengthening its internal eligibility controls over the Medicaid program by monitoring local counties and Medical Assistance sites by performing Medicaid eligibility reviews.

Implementation Status Update
Partially implemented. Estimated completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The Department identified the Medicaid Eligibility Quality Improvement Program (MEQIP) was not a sufficient process for ensuring compliance with eligibility requirements. The Department changed the audit and oversight process to align with our auditing partners and updated auditing processes. The Department started the Eligibility Site Accountability and Oversight Program. The Department is on track to meet the July 2021 implementation date.

Historically Linked Recommendation Implementation:
The Department implemented the monitoring of eligibility sites through MEQIP in previous years, but the Department found this was insufficient. The Department is revising the oversight process to align with our auditing partners and is on track to meet the July 2021 implementation date.

3. OSA SSWA Recommendation 2019-042C (2018-044C, 2017-054C) relates to the Department strengthening its internal controls by researching and resolving CBMS issues identified in the audit.

Implementation Status Update
Not Implemented. Estimated completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

Project 13764 - CBMS Medical Assistance Period of Ineligibility (POI) and Community Spouse Resource Allowance (CSRA) updates will ensure that the Community Spouse Resource Allowance limit amount is in alignment with rules. This project has been delayed until February 2021 due to COVID-19 projects.

The Department provided the Centers for Medicare and Medicaid Services (CMS) with documentation of training and any monitoring methods implemented to ensure that approval of social security number changes is documented, and to ensure beneficiaries are enrolled in the correct Medicaid program.

Historically Linked Recommendation Implementation:
Due to the prioritizing of projects, the implementation date was pushed back but the Department is in the testing phase and is on track to meet the implementation date of February 2021.

4. OSA SSWA Recommendation 2019-043B (2018-044B, 2017-054B) relates to the strengthening of its internal controls by researching and resolving CBMS and Colorado interChange interface issues, so the Department only pays provider claims on behalf of eligible beneficiaries.

Implementation Status Update
Partially implemented. Completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The Department created several reconciliation reports between the interChange, CBMS and Trails to ensure that Colorado does not pay providers for individuals who are not eligible for Medicaid or CHP+ services. CMS notified the Department that members enrolled as of March 18, 2020, must remain enrolled through the end of the month in which the public health emergency (PHE) ends. The implementation date remains on schedule for Jan. 31, 2021, due to the PHE ending on January 20, 2021. The date may change if the PHE is extended. The Department has corrected the interface issues between the MMIS and CBMS.

Historically Linked Recommendation Implementation:
This finding was from the 2019 SSWA audit. The findings from 2017 and 2018 are related to different issues. The 2017 finding was a display issue concern that has since been fixed. The 2018 finding relates to county monitoring. Please see 2019-042B and 201943C.

5. OSA SSWA Recommendation 2019-043C (2018-044C, 2017-054C) relates to the strengthening of its internal eligibility controls by effectively training and monitoring local counties and Medical Assistance sites as identified in the audit.

Implementation Status Update
Partially implemented. Completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The Department provided the Centers for Medicare and Medicaid Services (CMS) with documentation of training and any monitoring methods implemented to ensure that approval of social security number changes is documented, and to ensure beneficiaries are enrolled in the correct Medicaid program.

Both PBT and BLM are on track to be fully implemented by July 31, 2021.

Historically Linked Recommendation Implementation:
Please see historical information listed in 2019-042B

6. OSA SSWA Recommendation 2019-044A (2018-045A) relates to the strengthening its internal controls for Medicaid claims payments by researching and resolving the Colorado Benefits Management System, Trails, and Colorado interChange interface issues as identified in the audit.

Implementation Status Update
Partially implemented. Completion date: July 31, 2021. Original completion date: June 30, 2018.

The Department created reconciliation reports to ensure that only eligible beneficiaries were in the interChange. The Department was set to start an appropriate termination process of ineligible beneficiaries when CMS notified the Department that members enrolled as of March 18, 2020, must remain enrolled through the end of the month in which the public health emergency (PHE) ends. The implementation date remains on schedule for Jan. 31, 2021 due to the PHE ending on Jan. 20, 2021. The date may change if the PHE is extended. The Department has corrected the interface issues between the MMIS and CBMS.

Historically Linked Recommendation Implementation:
The Department has corrected the interface issues between the MMIS and CBMS. The Department was set to correct all member eligibility until notified by CMS as above.

7. OSA SSWA Recommendation 2019-046A (2018-046A, 2018-056A, 2017-059A, 2016-051A) Relates to the Department strengthening its internal controls over Medicaid and Children's Basic Health Plan program provider eligibility determination and enrollment by working with its fiscal agent to ensure that Colorado interChange performs all required database matches as identified in the audit.

Implementation Status Update
Not implemented. Completion date: July 31, 2022. Original completion date: July 31, 2017.

The implementation date remains on target for July 2022 to comply with the recommendation for the entirety of FY 2022-23. The Department is working with its fiscal agent to ensure all necessary database screening functions not completed automatically are performed manually. The system will also be updated so several data points are displayed correctly on the provider enrollment record.

Historically Linked Recommendation Implementation:
This recommendation was made during the 2016 OSA audit covering a time period when the legacy Medicaid Management Information System (MMIS) was still operational. The Department addressed the recommendation in the new MMIS that was fully implemented in 2017 to avoid the additional funding needed to update two core systems. Although internal controls have been strengthened through manual processes and system enhancements, changes are still required to automate the remaining manual processes and correct a display issue with several data points that was discovered after the original recommendation. They are on target for completion by July 2022.

8. OSA SSWA Recommendation 2019-048A (2018-047) relates to the Department strengthening its internal controls over the monitoring of provider health and safety standards.

Implementation Status Update
Fully implemented. Completion date: July 31, 2020. Original completion date: June 30, 2019.

The Department implemented its operations procedure on June 30, 2019, and now has completed a full state fiscal year of monitoring under the new plan. The Department now has standardized reviews of CDPHE survey activity in place.

Historically Linked Recommendation Implementation:
The delay since the original implementation date is related to OSA's request that recommendations be in place for a substantial period of time before being considered implemented.

9. OSA SSWA Recommendation 2019-048B (2018-047B) relates to the Department strengthening its internal controls over provider health and safety standards by creating a mechanism to identify delays in surveys and certifications as identified in the audit.

Implementation Status Update
Fully implemented. Completion date: July 31, 2020. Original completion date: June 30, 2019.

The Department implemented its operations procedure on June 30, 2019, and now has completed a full state fiscal year of monitoring under the new plan. The Department now has standardized reviews of CDPHE survey activity in place.

Historically Linked Recommendation Implementation:
The delay since the original implementation date is related to OSA's request that recommendations be in place for a substantial period of time before being considered implemented.

10. OSA SSWA Recommendation 2019-049B (2018-057B, 2017-056B) relates to the Department strengthening its internal controls over the timely processing of medical claims paid by Medicaid Managed Care Entities (MCE).

Implementation Status Update
Partially implemented. Completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The MCE contracts have been updated to include reporting requirements for the timely payment of clean claims to the Department. The deliverable template is in draft form and will be implemented in February 2021. The Department expects to fully implement this recommendation as planned by July 31, 2021.

Historically Linked Recommendation Implementation:
The audit recommendations for 2017 and 2018 were related to fee-for-service claims payment and were implemented.

11. OSA SSWA Recommendation 2019-050A (2018-049, 2017-061, 2016-053) relates to the strengthening of its internal eligibility controls by effectively training and monitoring local counties and Medical Assistance sites as identified in the audit.

Implementation Status Update
Partially implemented. Completion date: July 31, 2021. Original completion date: Dec. 31, 2017.

This recommendation is in progress with a completion date of July 2021. The electronic subrecipient determination form and database was implemented in February 2020. This addresses that the subrecipient determination is completed as part of the procurement process and correctly identifies Department subrecipients. The Accounting Division reviews the reported subrecipients for reporting purposes.

Training has been done with various Divisions and Department staff who are directly responsible for subrecipient monitoring and is ongoing as needed. Division director training will be completed by July 2021.

Historically Linked Recommendation Implementation:
The prior recommendation had asked the Department to update the subrecipient policy, which was completed in August 2018.

12. OSA SSWA Recommendation 2019-051A (2018-058, 2017-058, 2016-055, 2015-033, 2015-034C, 2014-034, 2013-024, 2013-027, 2012-028) relates to the Department strengthening its internal

controls over personnel costs and ensuring it complies with state and federal regulations for the Medicaid program by implementing the Time/Effort Reporting Policy as identified in the audit.

Implementation Status Update
Fully implemented. Completion date: July 31, 2020. Original completion date: June 30, 2013.

The Department completed its review of all Department staff and identified them as 100% time tracking, periodically time certifying, or directly cost allocated prior to July 31, 2020. A master list that includes all this information was compiled and will be used to ensure compliance with time tracking requirements going forward.

Historically Linked Recommendation Implementation
The Department did not meet the original and other implementation dates because the of the reliance on the State Controller's Office statewide implementing of its Human Resource Information System. This project was abandoned within the last year.

13. OSA SSWA Recommendation 2019-052A (2018-055, 2017-053) relates to the Department strengthening its internal controls over its financial reporting, and ensuring it complies with state and federal regulations for the Medicaid program by working with its service organization on the Colorado interChange SOC 1, Type II reports as identified in the audit.

Implementation Status Update
Fully implemented. Completion date: Sept. 30, 2020. Original completion date: Dec. 31, 2018.

The Department verified that the SOC 1, Type II report from the Department's Service Vendor, DXC, clearly identified the system components and controls that are in scope, such as database change management and database backup and recovery controls. The SOC 1, Type II report from DXC was provided to the Office of the State Auditor (OSA) and OSA confirmed that this recommendation was implemented.

Historically Linked Recommendation Implementation:
The controls were evaluated by the service auditor in the previous year. However, the SOC report control verbiage didn't clearly identify that databases were in scope until the Department requested this control specifically be listed in the service auditor's scope going forward.

14. OSA SSWA Recommendation 2019-052B (2018-055, 2017-053) relates to the Department strengthening its internal controls over its financial reporting, and ensuring it complies with state and federal regulations for the Medicaid program by creating a process for conducting reviews of the SOC 1, Type II reports as identified in the audit.

Implementation Status Update
Not implemented. Completion date: July 31, 2021. Original completion date: Dec. 31, 2018.

The Department is documenting all processes and reports, and implementation of a process for conducting reviews of the SOC 1, Type II reports will be completed by the July 2021 due date.

Historically Linked Recommendation Implementation:
The Department did review SOC 1, Type II reports but did not have a document that described the process. This document will be completed by July 2021.

3. **For the FY 2020-21 hearing process, the Department was asked to respond to the following questions related to public awareness campaigns.**

   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?

   Please provide an update to your response from last year, including any changes to existing campaigns and/or the addition or discontinuation of campaigns.

RESPONSE

The Department was not appropriated money for public awareness campaigns last year. We have used existing staff resources thus far to communicate Medicaid benefits and covered services to members during the COVID-19 public health emergency and anticipate needs for significant communications in partnership with CDPHE next year to ensure public health messaging on vaccines reaches members and providers. The Department has leveraged channels other than paid media such as issuing public statements and working with stakeholders – providers, Connect for Health, advocates, counties, etc. - to message to Coloradans about (a) safety measures during the pandemic such as wearing masks, social distancing, washing hands, celebrating holidays safely with household members only; and, (b) to increase awareness of our program to help Coloradans stay covered during this economic downturn. Neither of these efforts generated additional costs for the state.

4. **Please identify how many rules you have promulgated in the past year (FY 2019-20). 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 2019 to October 2020, the Department promulgated 98 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 on the Department's website and in the rule-making document packet that accompanies each rule the Department proposes.[1] The cost-benefit analysis includes the following components:

[1] https://www.colorado.gov/hcpf/medical-services-board

- 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 one of the rules. Section 24-4-103(2.5), C.R.S., states that anyone may request a cost-benefit analysis within five days of the publication of notice of proposed 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 98 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.

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.**

RESPONSE

Major Cost Drivers

The primary cost driver impacting the Department's FY 2021-22 General Fund request is the anticipated end of temporary funding used to reduce the General Fund cost of the Medicaid program. The largest of these temporary funds is 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% increase in federal matching dollars. The current forecast anticipates the enhanced federal funds (specifically, the federal medical assistance percentage, or FMAP) will end March 31, 2020, therefore leading to a significant General Fund increase in the FY 2021-22 budget. The Department is projecting that it will need an increase of $688.2 million General Fund in FY 2021-22 compared to FY 2020-21 to fund its Medicaid and CHP+ services lines. About half of that amount, $342.6 million is due to the projected end of the enhanced FMAP. The Department's budget also includes a net increase of $22.4 million General Fund to account for the expected

end of financing mechanisms associated with the enhanced FMAP that reduced overall General Fund expenditure.

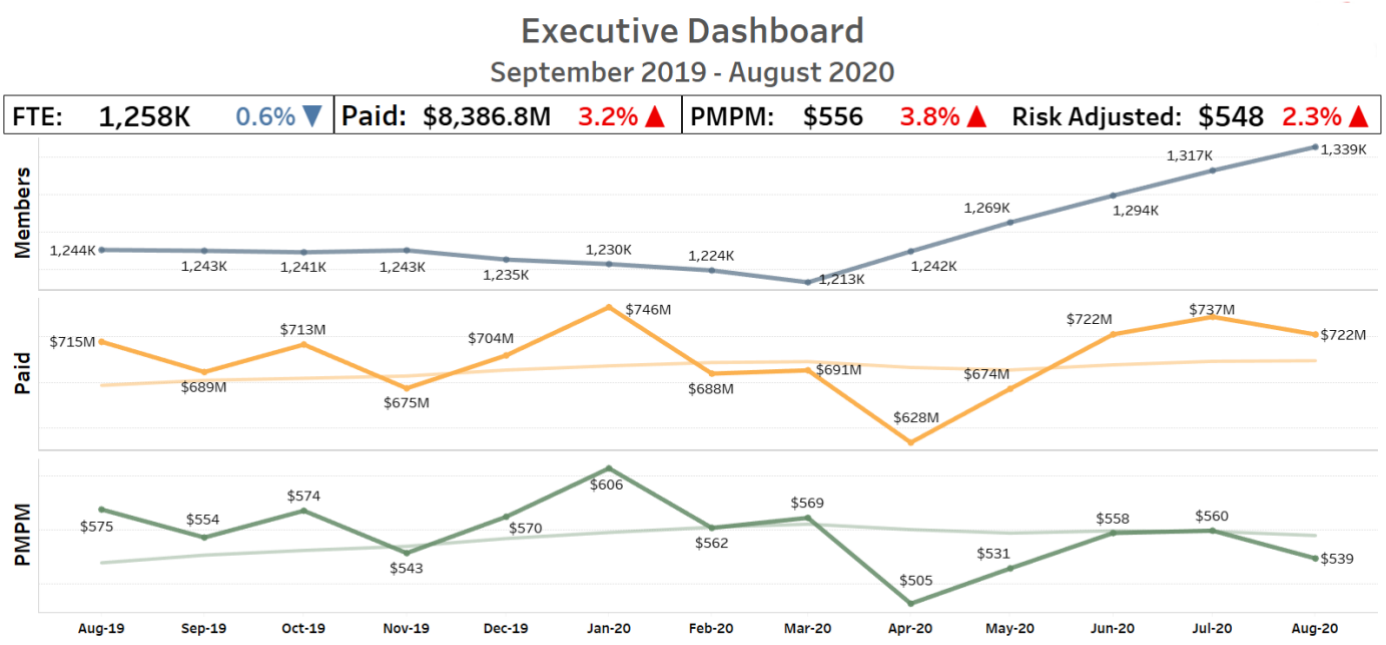
In addition to the expiration of the enhanced FMAP, the Department's General Fund appropriation will need to increase to account for the end of $161 million in one-time funding from the Healthcare Affordability and Sustainability Fee cash fund, which was used to offset General Fund expenditure in Medical Services Premiums.

An additional cost driver for this forecast is the year-over-year growth for overall Medicaid caseload which is projected at 3.5% for FY 2021-22. Medicaid caseload grew significantly from FY 2008-09 through FY 2015-16, primarily for children and adult populations. For several years after that, overall caseload growth has been low or decreasing due to improving economic conditions. In this forecast, however, the Department is projecting strong, positive growth in overall caseload as the ongoing economic recession is expected to continue. The Department is projecting overall growth of 11.44% in FY 2020-21 and 3.53% in FY 2021-22. Growth is driven primarily by income-sensitive groups which are projected to grow by 12.6% in FY 2020-21 and 3.82% in FY 2021-22. Caseload growth is driving $68.3 million General Fund of the year-over-year growth.

Finally, the Department's FY 2021-22 budget includes funding for anticipated increases in per capita costs in certain key areas:

- $88.8 million General Fund for anticipated growth in utilization of services for adults 65 and older and people with disabilities, such as long-term services and supports, nursing facilities, the Program for All Inclusive Care for the Elderly (PACE), long-term home health, and private duty nursing.
- $10.6 million General Fund for increases in acute care per capita costs, which includes services that have grown rapidly in the last few years, such as outpatient specialty drugs.
- $6.7 million General Fund for the annualization of HB 18-1136, implementing a residential and inpatient benefit for individuals with a substance use disorder.

The chart below shows recent trends in caseload and per capita costs.



Price Inflation

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, the increasing cost of benefits, or increasing rents, they generally must absorb those cost increases until the General Assembly appropriates funding to increase Medicaid rates.

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.

The chart below shows the Department's overall Medicaid per capita growth for prior years and projected per capita growth for future years, compared to the general CPI and medical CPI in those years. The per capita growth is not correlated with CPI trends, as it is more affected by year-over-year demographic changes within the Medicaid program and changes to rates and benefits funded by the General Assembly.

Medicaid Per Capita Growth Compared to CPI Year over Year Percent Change			
Fiscal Year	**CPI - Medical**	**CPI - All Items**	**Medicaid Per Capita**
FY 2016-17	3.75%	1.84%	-3.45%
FY 2017-18	1.99%	2.25%	10.11%
FY 2018-19	1.85%	2.07%	6.41%
FY 2019-20	4.27%	1.56%	12.79%
Average of Recent Years	**2.97%**	**1.93%**	**6.47%**
FY 2020-21 Projected	2.28%	1.07%	0.89%
FY 2021-22 Projected	2.20%	2.20%	1.71%
FY 2022-23 Projected	2.10%	2.10%	-0.91%
Average of Projected Years	**2.19%**	**1.79%**	**0.56%**

CPI only captures one component of health care trend. According to a December 2019 report from the Peterson Center on Healthcare and the Kaiser Family Foundation,[2] hospitals represented 33% of health care costs and grew at a rate of 4.8% over the period 2010-2018, while expenditures for physicians and clinics represented 20% of costs and grew at a rate of 3.8%; prescription drugs represented 9% of spend and 4.4% average growth. Another perspective is that, according to Human Resource Executive's October 2020 publication, annual premiums rose 4% according to the group's 2020 benchmark survey.[3] The average cost for an individual health plan for 2020 also increased 4% from last year. Those figures compare closely to the above; however, the risk score associated with the Medicaid population is higher than that of the employer comparison group, while our programs also cover long-term services and supports, which are the leading driver of our increasing costs.

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 recession is expected to continue. The Department is projecting overall growth of 11.44% in FY 2020-21 and 3.53% in FY 2021-22. Growth is driven primarily by income-sensitive groups which are projected to grow by 12.6% in FY 2020-21 and 3.82% in FY 2021-22.

[2] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-nhe-trends_year-over-year-growth-in-health-services-spending-by-quarter-2010-2019
[3] https://hrexecutive.com/employer-sponsored-healthcare-costs-top-21k-a-year/

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 2.87% in FY 2020-21 and 1.93% in FY 2021-22. 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), nursing facilities, 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 will receive a 50% federal match rate once the public health emergency (PHE) ends.

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 2018-19 that were not the result of legislation or a decision item.**

   For all FY 2021-22 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

New Positions Created since FY 2018-19

HCPF Positions created since FY 2018-19				
Row	**Fiscal Year**	**Class Code**	**Class Title**	**Working Title**
A	FY 2019-20	H1A3XX	Program Management II	PEAK Manager
B	FY 2019-20	H1K1XX	Project Coordinator	Maternal Opioid Misuse Model (MOM) Grant

FY 2021-22 Budget Requests with increase in FTE

The Department's purpose for requesting an additional FTE for R-9 Medicaid Blue Button Program is to improve oversight of the CMS Patient Access and Interoperability rule (CMS-9115-F); serve as the single

point of contact on the Colorado Medicaid Blue Button project; and facilitate collaboration between the Department and vendors creating the infrastructure. With increased federal and state regulations, the Department requires an additional FTE to more effectively oversee compliance with the Department's existing vendors (CORHIO, Deloitte, IBM) in areas of testing and results, deficiencies in existing functionality, and resolving gaps in functionality to comply with regulations.

The Department assumes that if existing staff apply for the position, they will be trained for the roles and duties. If internal staff do not apply, then the Department will select a candidate with the qualifications necessary to assume the roles and responsibilities of the position. Without adding this position, the Department will be out of compliance with federal regulations and Colorado may fall "behind the curve" for patient data sharing nationally. In addition, CMS will begin to withhold 90/10 funding and issue other corrective actions to bring the state into compliance with this rule.

The Department considered the current data sharing arrangements set forth to meet federal compliance and determined it did not have a central repository to comply with the regulation and facilitate collaboration between the Department and its vendors. The Department determined that one project manager could be the central focus point to ensure the project remains on schedule, assure vendor compliance, and meet the goals with minimal disruption to federal compliance.

The Department's purpose for requesting additional FTE for R-10 Convert Contractor Resources to FTE for the Medicaid Management Information System (MMIS) and Fiscal Agent Services is to provide provider field representatives and project management in-house versus utilizing a contractor, streamline costs, and allow more personal outreach to providers who need more assistance than the contractors can provide. The Department currently utilizes contractors that provide portfolio and project management that require additional review and approval by existing staff. Converting the portfolio and project management duties to internal staff that perform all the work would create efficiencies by removing an unnecessary layer of contractor involvement. In the past, the Department has experienced difficulty in maintaining continuity of knowledge and processes when the work transitions between vendors. The Department has identified opportunities to strengthen the portfolio and project management framework through governance, project selection/prioritization, project life cycle management, metrics tracking, training and mentoring, and agile approaches by converting the resources in-house versus utilizing a contractor.

The Department's goal is to offer the opportunity of advancement to existing staff and train them for these new positions. Some of the positions will not be filled with internal staff due to skills and knowledge requirements and thus will be hired externally. The Department identified the major system issues and field representations needed to provide continuity of service that contractors were providing. Having field representatives and project managers in–house offers the Department rapid redirection of focus and energies to address the Department's changing priorities without renegotiation contractor/contracts duties. The in-house staff will have access to enhanced career opportunities, training, and more flexibility in providing direct oversight of the program.

The Department reviewed ongoing projects, the Department's size, Agile/Lean maturity level, and staffing model to determine the FTE needed to ensure projects and deliverables are aligned with strategic initiatives,

properly prioritized, on schedule and within budget, so that taxpayer's resources are spent wisely in support of the Governor's and Department's initiatives.

8. **Please describe any programmatic impacts resulting from cash fund transfers impacting the Department 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:

- HB 20-1385, "Use of Increased Medicaid Match," required the Department to use a temporary increase in federal financial participation 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 net payments to each program remained net neutral, resulting in no programmatic impacts.
- 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 hospitals.
- 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. In order to ensure enough funding remains in the cash fund for those programs, the Department reduced the estimated expenditure from the IDD Services cash fund by $1,084,435 and increased estimated expenditure from General Fund by the same amount in the FY 2021-22 R-5, "Office of Community Living Cost and Caseload."

EXECUTIVE DIRECTORS OFFICE

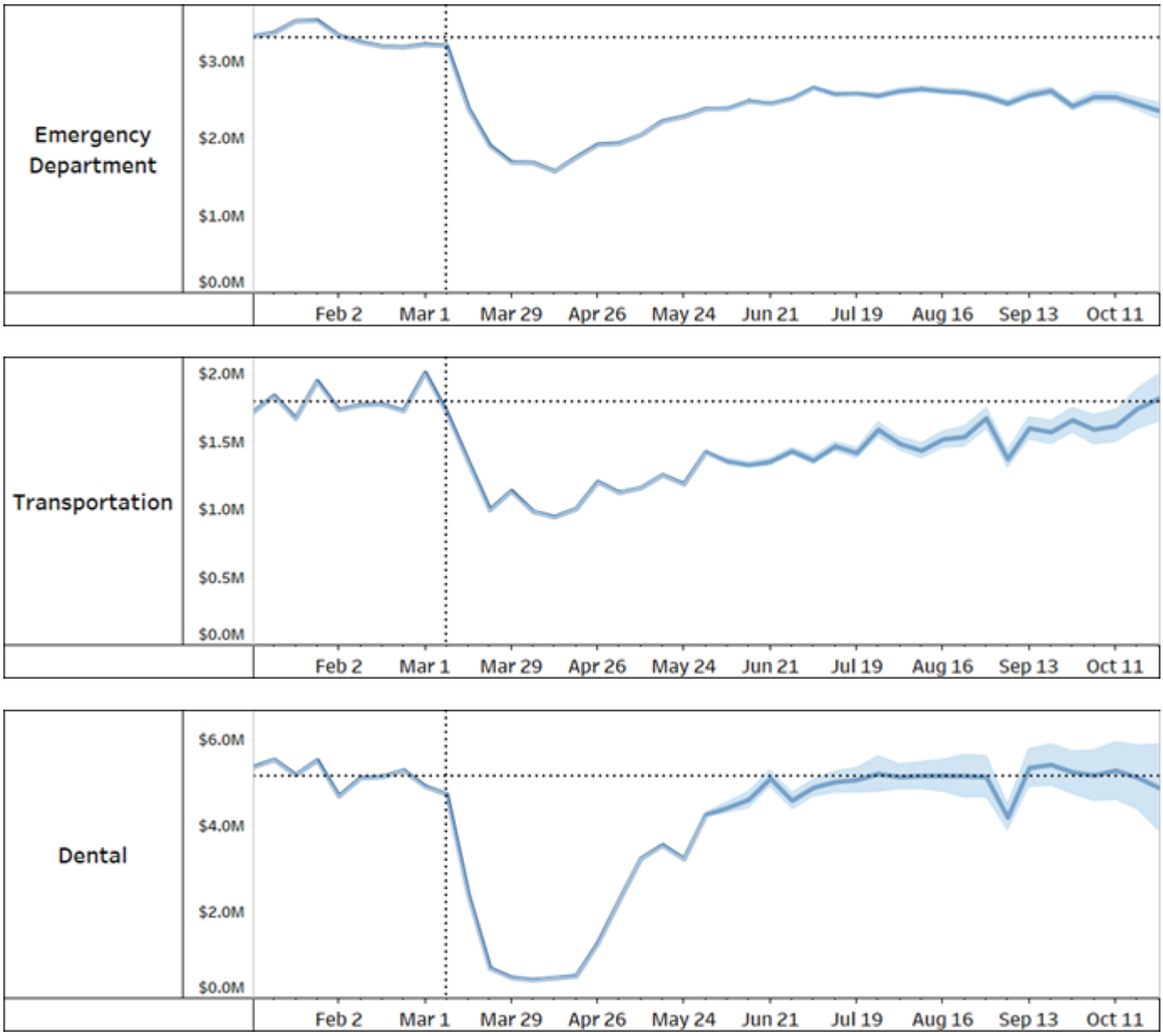
COVID-19 & ECONOMIC DOWNTURN IMPACTS

1. **[Rep. Herod] How is the decreased utilization of medical care under COVID-19 (e.g., delaying routine medical appointments and other services) being reflected in Medicaid expenditures?**

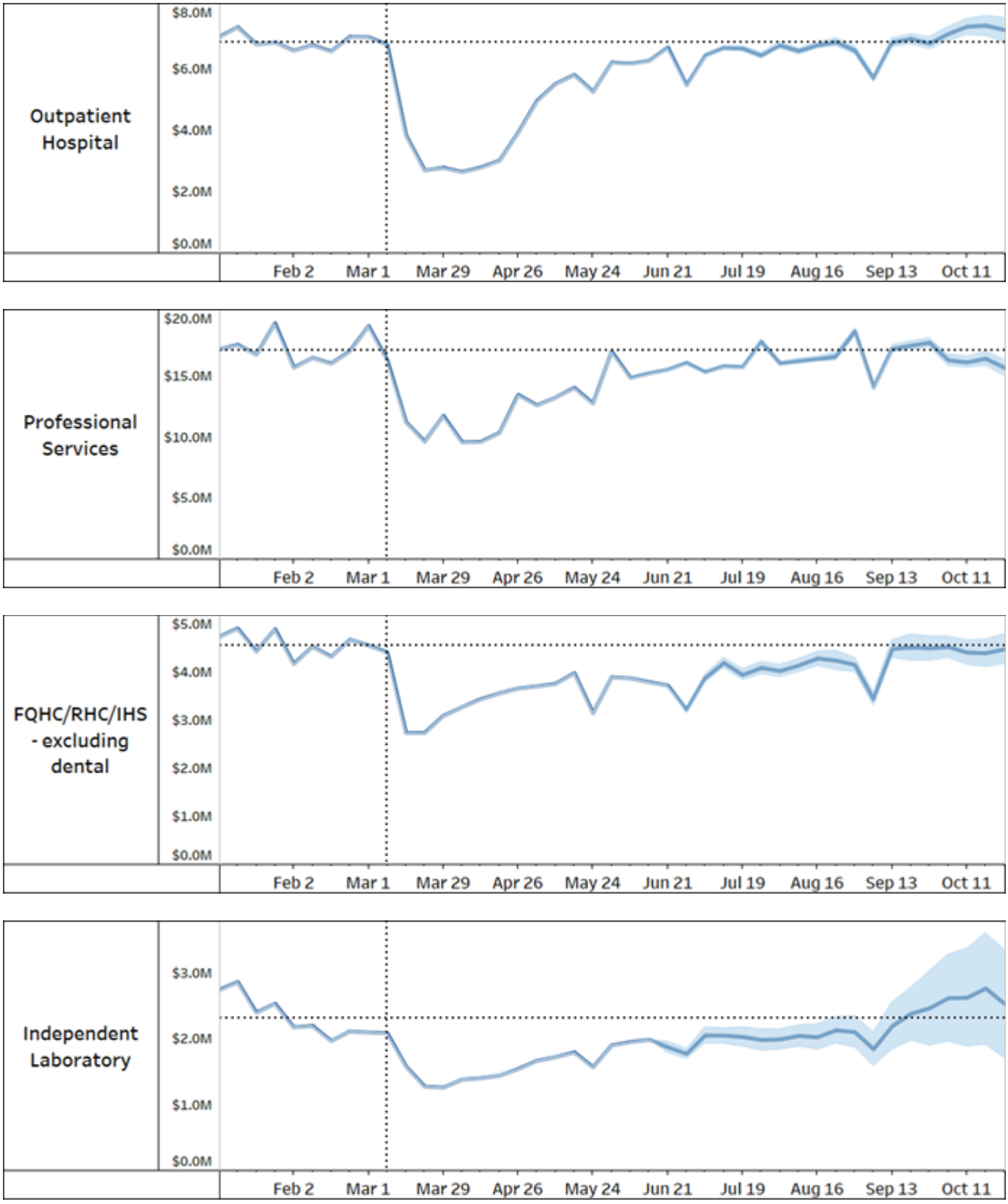
RESPONSE

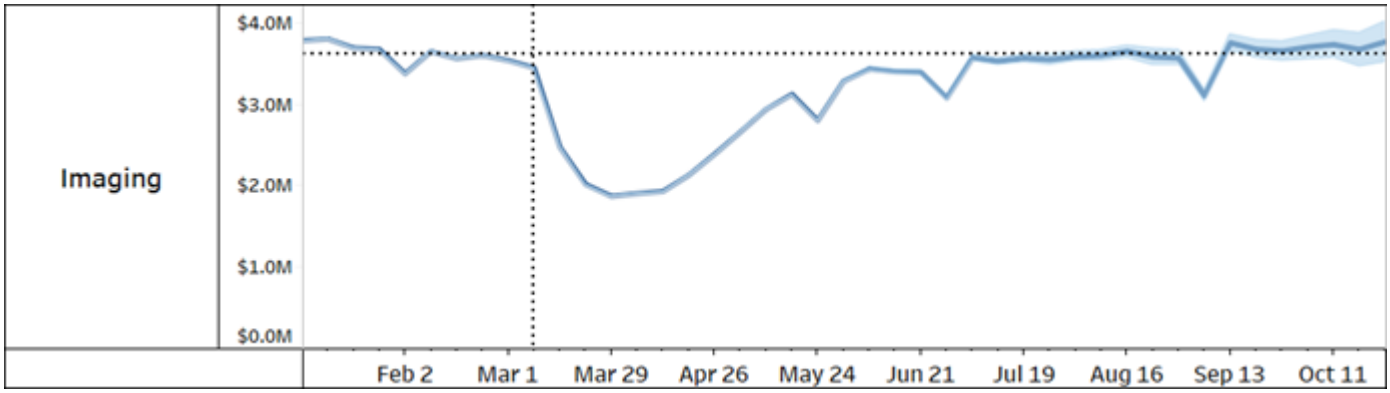
Expenditures decreased during the height of social distancing and recovered for most services by the end of FY 2019-20. The primary exception to this was emergency department expenditures. Emergency department expenditures are down around 20% per week from the calendar year 2020 average pre-COVID-19.

The charts below show a sample of services where expenditure declined and their subsequent recovery. The blue line is weekly incurred but not reported (IBNR) adjusted expenditure.[4] The blue shading is the range of uncertainty in the IBNR estimates. The vertical dotted line is the last week prior to the start of social distancing. The horizontal dotted line is the weekly average paid before social distancing.



[4] There is a lag between when a provider renders a service to a member and the time it takes for the provider to bill Medicaid to receive payment for the claim. This causes the most recent weeks of claims data to be artificially deflated. The Department adjusts for this by projecting how much expenditure is outstanding for services that were incurred but not yet paid based on historical billing patterns by service category.


Outpatient Hospital
$8.0M
$6.0M
$4.0M
$2.0M
$0.0M
Professional Services
$20.0M
$15.0M
$10.0M
$5.0M
$0.0M
FQHC/RHC/IHS - excluding dental
$5.0M
$4.0M
$3.0M
$2.0M
$1.0M
$0.0M
Independent Laboratory
$3.0M
$2.0M
$1.0M
$0.0M
Feb 2
Mar 1
Mar 29
Apr 26
May 24
Jun 21
Jul 19
Aug 16
Sep 13
Oct 11



The Department is accounting for these changes in utilization through the budget process, notably the Department's Nov. 2, 2020, budget request R-1, "Medical Services Premiums." The Department will provide an update to this forecast on Feb. 15, 2021.

2. **[Rep. Herod] Is HCPF taking these costs into account, and if so, how?**

The Department's projections for FY 2020-21 assume that the COVID-19-related utilization reductions observed in FY 2019-20 do not persist into the current fiscal year, consistent with the latest data. The Department continues to monitor expenditure and will provide an update to its forecast for Medicaid expenditures on Feb. 15, 2021.

3. **[Sen. Hansen] Please put the Medicaid enrollment growth in the context of changing demographics. Is Medicaid growing faster or slower than the state population? What about sub-groups, like the elderly?**

RESPONSE

The state demographer indicates that the Colorado population has grown by 4% from 2016-2019. In the same time period, the Medicaid population decreased by 7%. With regard to specific populations, the state demographer indicated that the age 65 and older adult population in Colorado increased by 14% from 2016-2019, whereas the 19 to 64 population grew by 3% and the 0 to 18 population decreased by 0.1%. In Medicaid from FY 2016-17 to FY 2018-19, the 65 and older adult population grew by 7%, low income adults and expansion adults decreased by 7%, and children decreased by 11%. Overall, Medicaid caseload growth among the income sensitive populations was decreasing while Colorado's population was increasing due to the economy recovering from the earlier part of the decade. There is generally a lag in the time between changes in economic conditions and when Medicaid enrollees respond. Between 2016 and 2019, incomes among Medicaid eligible groups had sufficiently risen such that they began to lose Medicaid eligibility, with the exception of people age 65 and older and people with disabilities.

Since the beginning of the public health emergency (PHE), overall Medicaid caseload has grown by 16% from March 2020 to November 2020. Medicaid has grown faster than the demographer's projection of Colorado's population growing by 0.96% from 2019-2020. Since March, low income adults and expansion adults comprise 61% of the growth; children make up around 30%; adults 65 and older and adults with disabilities make up 5%; and pregnant adults and noncitizens each respectively account for 2%. This is in

line with the Department expectations of caseload growth during the recession, and adults 65 and older and people with disabilities being less sensitive to income changes. Additionally, the Department must adhere to a continuous coverage requirement and cannot disenroll members during the PHE, causing net enrollment growth to stay high.

4. **[Rep. McCluskie] Schools assist in enrolling children in the Children's Basic Health Plan (marketed as Child Health Plan *Plus*, or CHP+). Are we seeing enrollment in CHP+ affected by remote learning in the same way as enrollment in the free and reduced lunch program?**

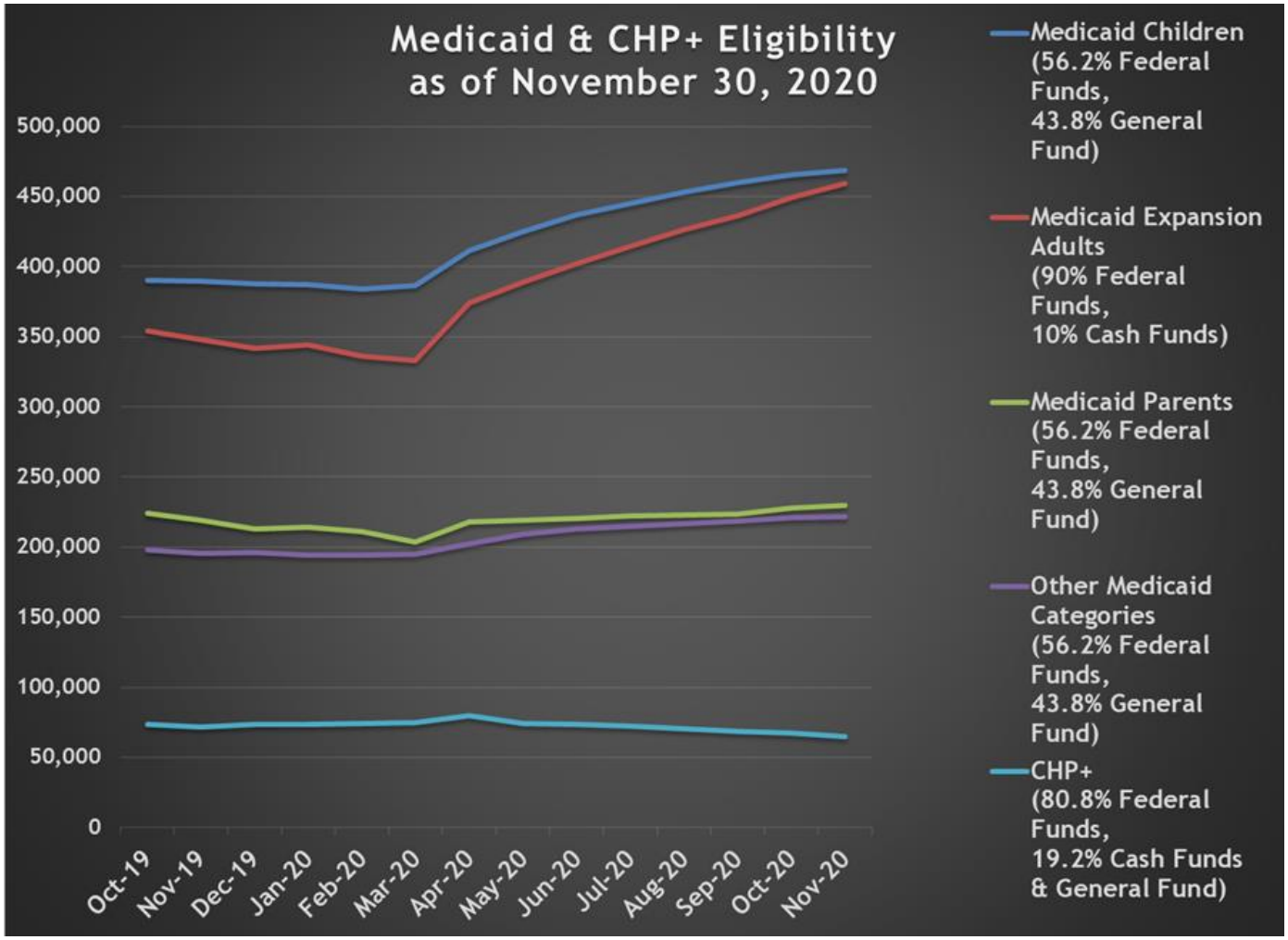
RESPONSE

The Department does not have data or other information on how remote learning has impacted CHP+ enrollment. Overall, the number of children covered by CHP+ and Medicaid in total has risen over the course of the pandemic, and the Department sees no obvious evidence that remote learning is having an adverse impact on coverage.

CHP+ enrollment is affected by complex interactions among CHP+, Medicaid, and new federal requirements associated with the public health emergency (PHE). CHP+ enrollment is trending down due to the continuous coverage requirement as part of the state's response to the PHE, which affects CHP+ differently than it does Medicaid. The continuous coverage policy prohibits Medicaid members from being disenrolled during the PHE even when their income changes, whereas in CHP+, members who experience loss of income and subsequently meet the Medicaid qualifications are disenrolled from CHP+ and enrolled in Medicaid where they are locked in until the end of the PHE. CHP+ members who experience an increase in income would continue to be covered under CHP+ as part of continuous coverage.

Historically, CHP+ and Medicaid experience a degree of churn between the programs. Between July 2019 and February 2020, an average of 2,800 clients churned from CHP+ to Medicaid each month, and an average of 3,000 clients churned from Medicaid to CHP+ each month. Since the beginning of the PHE, an average of 3,300 members have churned from CHP+ to Medicaid each month, while only a handful of members have churned from Medicaid to CHP+ due to the continuous coverage requirement working differently in each program with respect to the income qualification thresholds.

As noted in the graphic below, CHP+ enrollment has remained flat or decreased, while children enrolled in Medicaid (blue line) have significantly increased. Concurrent with these trends are over 50,000 Medicaid members in a "locked in Medicaid status" in accordance with the PHE and as of November 2020. Many of those members will move from Medicaid to CHP+ at the end of the PHE through required eligibility redeterminations, which will increase the CHP+ population and decrease the Medicaid population accordingly.



5. **[Rep. Herod] How are the medical costs related to COVID-19 diagnosed patients, including ongoing expenses for "long-haulers," affecting Medicaid expenditures?**

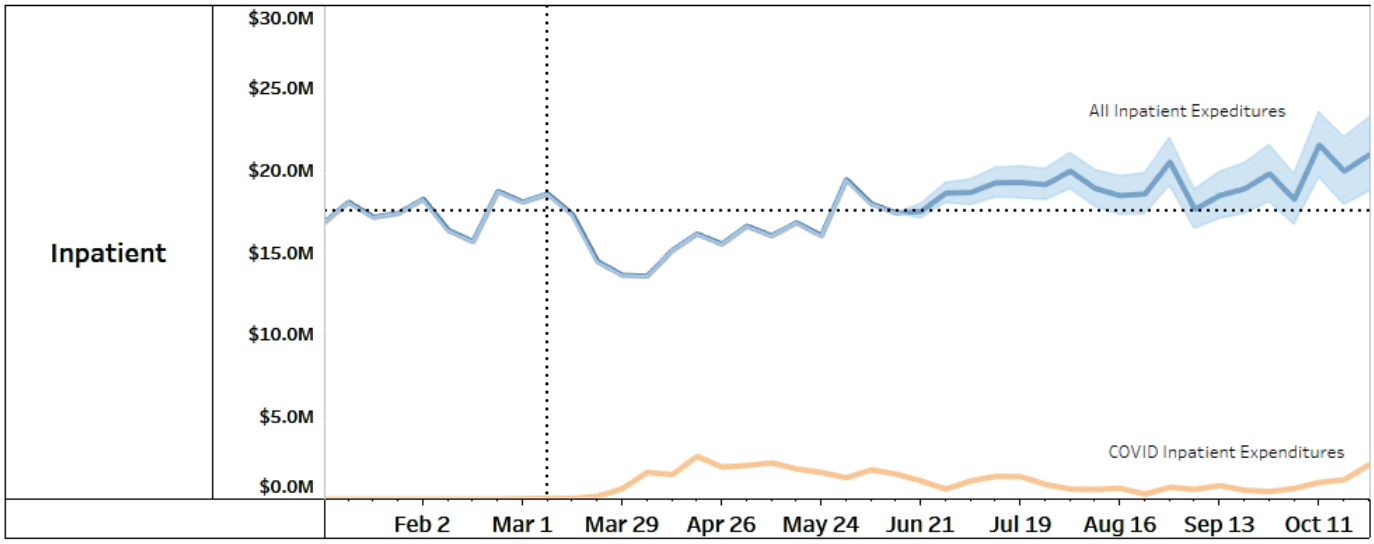
RESPONSE

Expenditures for COVID-19 diagnosed patients are a relatively small subset of the Department's overall inpatient expenditures, apart from a spike during the initial surge in April and May. The chart below shows overall inpatient expenditures by date of discharge and the COVID-19-related subset expenditures.

The data shown is based on service dates through Oct. 31, 2020, and does not fully reflect the recent COVID-19 surge in Colorado. The blue line represents weekly incurred but not reported (IBNR) adjusted expenditure.[5] The blue shading is the range of uncertainty in the IBNR estimates. The orange line is the

[5] There is a lag between when a provider renders a service to a member and the time it takes for the provider to bill Medicaid to receive payment for the claim. This causes the most recent weeks of claims data to be artificially deflated. The Department adjusts for this by projecting how much expenditure is outstanding for services that were incurred but not yet paid based on historical billing patterns by service category.

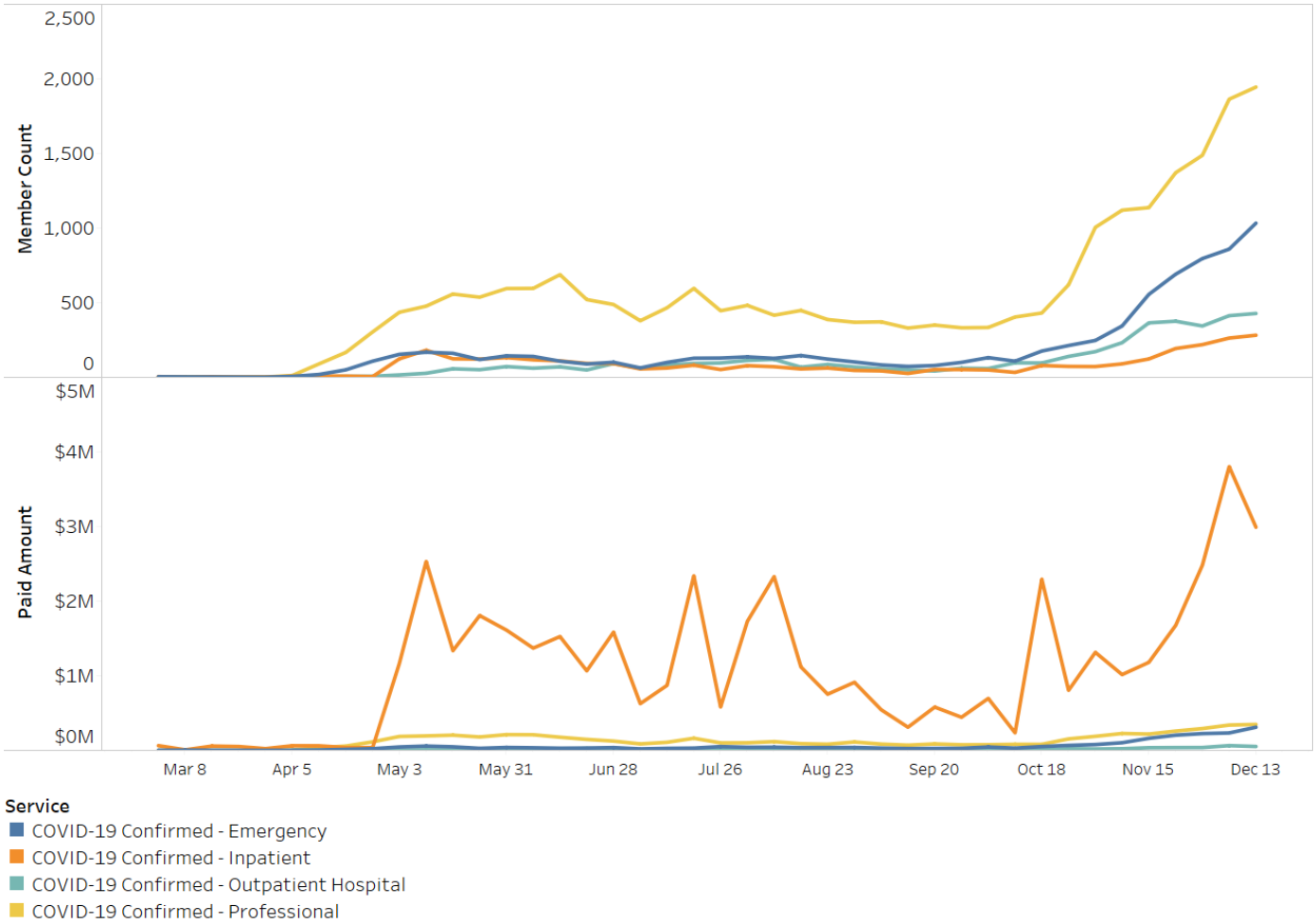
COVID-19 subset of the inpatient expenditures. The vertical dotted line is the last week prior to the start of social distancing. The horizontal dotted line is the weekly average paid before social distancing.



The Department anticipates an increase in expenditure on COVID-19-related inpatient treatment in the next several months as the surge in cases continues and people avoid social distancing during the holidays. This is informed by the report[6] published on Sept. 30, 2020, by the Colorado COVID-19 Modeling Group. The Department incorporated the projected increase in the Department's R-1 budget request, "Medical Services Premiums."

The chart below contains the members served and expenditure by weekly date of claim payment for those with a confirmed COVID-19 diagnosis on the claim. This differs from the incurred IBNR adjusted graph above in that the date of payment occurs after the date of service. Although inpatient is the setting that serves the fewest COVID-19 positive members, it accounts for the large majority of the cost. The member counts below are only those who sought treatment and the provider placed the confirmed COVID-19 diagnosis on the claim. This is not a count of all Medicaid members positive to date for COVID-19.

[6] https://drive.google.com/file/d/1SK_IQREZ9FGwjJlQePdHCsnz45GmBOzY/view



The Department does not receive enough information in the claims data to identify 'long haulers.' The Department continues to monitor cost and utilization trends by service category and will update the budget forecast accordingly.

6. **[Rep. McCluskie] When the federal public health emergency ends the Department expects a large correction in Medicaid enrollment. Please describe how the Department estimated the size of the correction. What is the impact on clients? Also, please describe the process the Department will use to terminate eligibility and the administrative impact on county staff.**

RESPONSE

There are currently over 275,000 members "locked in" to coverage during the federal public health emergency (PHE). The Department has been running all eligibility data interfaces, mailing and processing annual renewal packets, and reviewing eligibility throughout the PHE in order to keep eligibility determinations up to date. The locked-in population is comprised of members who had a determination of ineligibility but are remaining continuously covered due to requirements under the Families First Coronavirus Response Act (FFCRA). The Department estimates that if the PHE ends in January as presently set, there will be over 300,000 members locked into coverage, with approximately an additional 30,000 Coloradans added each month if the PHE continues after January. At the end of the PHE there will be a correction to

Medicaid enrollment when the continuous coverage requirement expires. The Department estimates that 55% of members in the locked-in population will be transitioned off Medicaid at the end of the PHE. This is based on the historical breakdown of reasons why people are disenrolled, including:

- 38% of people estimated to be locked in due to failure to provide verification; the Department estimates that only 25% of this population would be disenrolled, as most people could provide the necessary documentation to clear up their cases.
- 53% of people estimated to be locked in because they are over income limits; the Department estimates that 75% of this group will still be over income and will be disenrolled; 25% of people in this group will have had a change in their situation, such as job loss, and will maintain coverage.
- 9% of people are estimated to be locked in for other reasons; the Department estimates that 65% of this group will be disenrolled, based on myriad reasons people are currently locked in.

Members will retain medical assistance benefits for as long as the PHE remains in effect. At the end of the PHE, the Department and Colorado's counties will conduct an eligibility review of every member who remains locked into coverage. In order to minimize impact to the member, no one will be terminated without a thorough review of current eligibility and proper noticing. All remaining locked in members will receive notice to provide updated information at the end of the PHE. It is imperative that the Department conduct a last review of eligibility, as member circumstances have likely changed throughout the course of the PHE. Final eligibility determination will be based on the member's existing circumstances at the end of the PHE. Members who are determined ineligible will receive notices of disenrollment with appeal rights. These members will also qualify for a 60-day special enrollment period to enroll in coverage through Connect for Health Colorado.

Of paramount concern is an accurate eligibility determination and a smooth transition for all members impacted at the end of the PHE. The Department has requested that the Centers for Medicare & Medicaid Services (CMS) provide ample notice of the end of the PHE, as well as adequate time after to conduct required eligibility reviews. While we are awaiting explicit direction and instructions, we anticipate CMS will give states no more than three months from the expiration of the PHE to complete the eligibility review of all members in the locked-in population. This directive will require additional resources. The workload of eligibility reviews is not currently absorbable by existing staffing. Reviewing 300,000members or more is an enormous task, insurmountable for already over-taxed eligibility workers. Despite the fact that the Department has provided tips, shortcuts, and locked-in files by county to help streamline this work, Colorado counties do not have the capacity to handle this increase in workload without additional staff or overtime. In order to minimize the impact on members, as well as the counties who process eligibility, the Department is requesting supplemental funding to support the eligibility reviews of the locked-in population.

The Department has submitted a supplemental budget request, S-10, Public Health Emergency End Resources, to support the counties in conducting locked-in member eligibility reviews and processing an increase in county appeals. The Department will provide funding to counties in two different ways: by increasing available funds for eligibility determinations and appeals through the existing cost-based reimbursement methodologies and by providing grant funding to counties when counties are unable to contribute to the cost of eligibility redeterminations and appeals.

7. **[Sen. Moreno] Please summarize federal funds that have been made available to providers in response to the pandemic.**

RESPONSE

As of November 2, the Department of Health and Human Services has distributed more than $143 billion of the $175 billion appropriated to the Provider Relief Fund (PRF)[7].

As of Dec. 16, 2020, Colorado had received approximately $1.66 billion of federal (non-repayable) stimulus for providers, the bulk of which is PRF funds with more yet to be distributed. Hospitals have received the largest portion – more than 55% - of this funding.[8][9]

Provider Type	Percentage	Sum of Payment
Hospitals	55.8%	$926,048,095
Government[10]	17.5%	$291,026,977
Other/Not Tagged*	17.0%	$281,842,535
FQHCs	3.1%	$50,864,252
Nursing Homes/SNFs	1.6%	$25,797,065
Universities	1.4%	$22,500,430
Medical Groups	1.1%	$18,765,430
Hospices	0.8%	$14,055,468
Schools	0.8%	$12,950,189
Mental Health	0.6%	$10,100,151
Native	0.2%	$4,097,180
Medical Equipment	0.1%	$1,123,254
	100%	**$1,659,171,025**
*Many amounts too small to be attributed manually		

See appendix for an itemization of all COVID-19-related federal funds provided to Colorado hospitals to as of Dec. 16.

In addition to the information above, the Health Resources and Services Administration (HRSA) announced on Dec.16, 2020,[11] that it will begin a Phase 3 COVID-19 Provider Relief Fund distribution of an additional $24.5 billion to more than 70,000 providers. Payment distribution began mid-December and will continue through January 2021.

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[7] https://crsreports.congress.gov/product/pdf/IN/IN11438
[8] These figures do not include Paycheck Protection Program (PPP) loans or FEMA disaster grants.
[9] Department of Health and Human Services. (n.d). Tracking Accountability in Government Grants System (TAGGS) website. Retrieved August 2020 from https://taggs.hhs.gov/coronavirus
[10] State and local government entities, such as the Department of Local Affairs, the Department of Human Services, the Department of Public Health and Environment, the State Board of Education, and Colorado counties.
[11] https://www.hhs.gov/about/news/2020/12/16/hhs-increases-begins-distributing-over-24-billion-in-phase-3-covid-19-provider-relief-funding.html

In total, PRF funds distribute to providers up to 88% of their reported losses. All providers eligible for a previous PRF distribution, plus new 2020 providers and behavioral health providers, may apply for this Phase 3 distribution. Providers may be eligible regardless of whether they were eligible for, applied for, received, accepted, or rejected payment from prior PRFund distributions, including providers who do not bill Medicare, Medicaid, or CHP+. Providers who experienced no changes in revenues or net expenses due to COVID-19, and those who have already received funds that equal or exceed reimbursement of 88% of reported losses, will not receive additional funding.[12]

Colorado providers will receive at least $147 million of this funding. Additional provider funding may be included in the stimulus bill that Congress is expected to pass in December 2020. We will continue to track this Congressional action and provide details on any provider funding if it becomes available.

8. **[Rep. McCluskie] How is the pandemic affecting the insurance landscape in Colorado? In particular, please provide updated enrollment information for the health insurance exchange, Connect for Health Colorado, and how it has been impacted by the pandemic.**

RESPONSE

The pandemic, and associated economic downturn, has meant some Coloradans who have lost their jobs have also lost employer-sponsored coverage. The next Colorado Health Access Survey conducted by the Colorado Health Institute will further inform our understanding of the pandemic's impact on the health insurance landscape. That survey is published every two years and will be conducted starting in February 2021 with results expected to be published later in 2021.

To gain more real-time insights on this topic and help connect Coloradans who have recently lost their job to health care coverage, the Department partnered with Connect for Health Colorado and the Colorado Department of Labor and Employment, Employment Insurance Division, to outreach directly to unemployment insurance claimants in July and November. The informal survey showed some claimants were uninsured and planning to stay uninsured mainly due to the high cost of coverage.

To help as many people as possible get covered at the onset of the COVID-19 outbreak, Connect for Health Colorado opened an emergency Special Enrollment Period in the spring, which resulted in more than 14,000 Coloradans enrolling in a health insurance plan.

Connect for Health Colorado

Connect for Health Colorado is currently in the midst of the Open Enrollment Period for 2021 coverage. Initial enrollment totals show that more Coloradans are getting covered during this open enrollment period as the pandemic grows in Colorado. Through Dec. 6, more than 148,000 Coloradans have signed up for a health insurance plan through Connect for Health Colorado. To ensure as many people as possible can sign up for 2021 coverage, Connect for Health Colorado provided an extension from Dec. 15, 2020, to Dec. 18, 2020, for customers to enroll for coverage starting Jan. 1, 2021. Nearly 7 out of 10 Coloradans are qualifying for financial help to make premiums and other insurance costs more affordable. Residents can also access

[12] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#phase3

free virtual and phone assistance with the application and plan selection from certified Brokers and Assisters in their communities.

Throughout open enrollment, Connect for Health Colorado has been working to get the word out virtually this year to make sure Coloradans in every corner of the state know that it's open enrollment time. They launched a message board campaign on social media, partnering with several key community leaders to help get the word out by posting open enrollment information on Instagram, Twitter and Facebook.

The open enrollment period for 2021 coverage closes on Jan. 15, 2021.

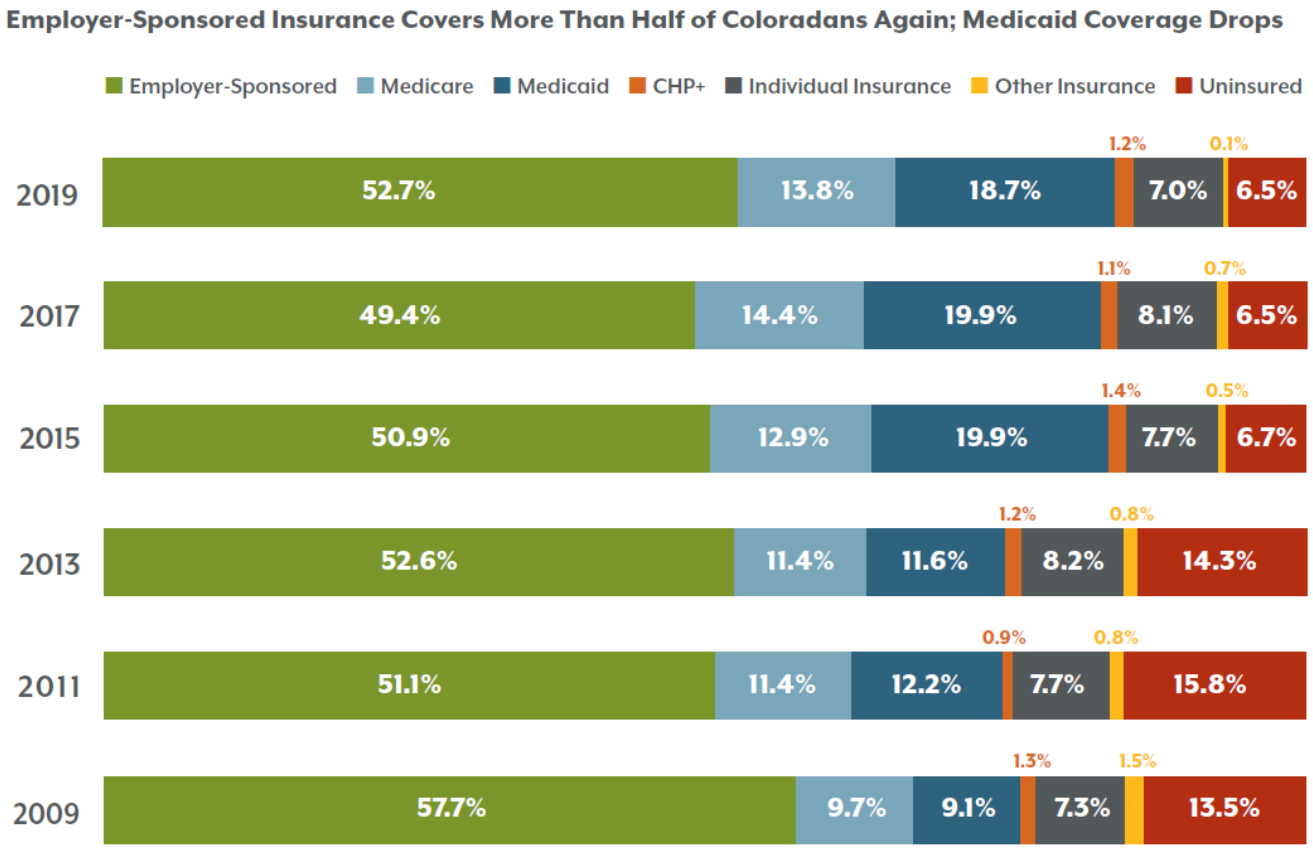
9. **[Sen. Moreno] Please compare how private insurance enrollment and Medicaid enrollment have changed over time. Has there been a shift from private insurance to Medicaid? Are increases in Medicaid enrollment decreasing the number of uninsured?**

RESPONSE

Analysis on insurance enrollment trends over time in private insurance, Medicare, Medicaid, CHP+ and the number of uninsured Coloradans is conducted and published by the Colorado Health Institute every two years through the Colorado Health Access Survey (CHAS).

The last CHAS survey was published in September 2019;[13] an overview of the coverage data is below.

[13] https://coloradohealthinstitute.org/research/CHAS, page 16.



The next survey will be in the field starting in February with analysis expected to be published between October and December 2021. More recent 2020 information indicates that Medicaid and CHP+ are now covering more than 1.4 million Coloradans, which reflects 24% of the population while Medicare is covering 16%.

It has been a record-breaking year for the number of individuals who have applied for and qualified for unemployment insurance, at one time representing more than 20% of the workforce. Job loss also often means that workers lose their employer-sponsored insurance, and this has had a definite and meaningful impact on the uninsured rate and is concurrent with an increase in Medicaid enrollment. To gain more real-time insights on this topic and help connect Coloradans who have recently lost their job to health care coverage, the Department partnered with Connect for Health Colorado and the Colorado Department of Labor and Employment, Employment Insurance Division to outreach directly to Unemployment Insurance Claimants in July and November. Two informal but insightful surveys indicated that Medicaid and Connect for Health Colorado were popular alternatives for Coloradans who have qualified for unemployment insurance. Last, it indicated that an increasing number of these individuals were remaining uninsured and planned to stay that way because they felt insurance coverage was unaffordable – both from the premium and out of pocket (co-pay, coinsurance) perspective.

10. **[Sen. Moreno] How has the extension of the federal public health emergency declaration impacted the Department's ability to implement budget balancing measures approved by the**

General Assembly last year? Has the implementation of some of those budget balancing measures been delayed due to the prohibition on benefit restrictions during the emergency?

RESPONSE

As part of the Families First Coronavirus Response Act (FFCRA), the Department may claim an enhanced 6.2 percentage point FMAP increase through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services terminates. As part of receiving this enhanced FMAP, the Department must maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of Jan. 1, 2020. This condition is also referred to as a "maintenance of effort" requirement.[14] This condition has prevented the Department from implementing the following budget balancing measures:

- Reduction of adult dental benefit cap from $1,500 to $1,000 per member.
- Increasing co-pays to the federal maximum for pharmacy, physician services, FQHCs, RHCs, inpatient services, outpatient services, durable medical equipment, lab & x-ray and adding co-pays on anesthesia, non-emergent medical transportation (NEMT), and dental.

Based on the extension of the public health emergency declaration to Jan. 21, 2021[15], the earliest the Department could implement these changes is on April 1, 2021. The Department's Nov. 1, 2020, budget request has taken this delay into account in the FY 2021-22 R-1, "Medical Services Premiums."

11. **[Rep. McCluskie] What budget balancing strategies implemented by the General Assembly last year had the most negative impacts? Are there lessons learned from the balancing process last year that should inform the General Assembly's budget approach this year?**

RESPONSE

The unprecedented economic downturn caused by the pandemic forced many difficult choices for policymakers trying to balance the budget while protecting essential services and the most vulnerable Coloradans. The Department appreciates the difficulty and complexity of these decisions and worked closely to provide the General Assembly and JBC staff the information needed to make these decisions.

When the FY 2020-21 budget was set, the Department had virtually no data about how the pandemic was affecting caseload and expenditure. In some cases, such as for long-term services and supports, data did not reflect any change in services because the Department was still receiving claims for services provided prior to the pandemic. In other cases, such as the implementation of higher co-payments, planned reductions could not be achieved because of changes in federal law. Without closer to real time information, budgetary decisions were made based on national reports, emerging expert economist opinions, worst-case scenario planning, and anecdotal information. Since initial estimates, the Department has evolved its forecasting models, leveraging more real time expenditure and enrollment data and is leveraging new analytics to more

[14] https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf
[15] https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

closely estimate impacts of the pandemic. These tools were crafted by expert Department staff and made possible by investments in analytics approved by the General Assembly. We suggest that the Department share these updates with the JBC on a more frequent basis as part of an evolving budget process.

Given the urgency of the pandemic, the expedited process did not allow for any significant back-and-forth dialogue between the JBC and the Department. Given the Department's wealth of financial expertise, creativity and insights, this was a lost opportunity, which we would like to avoid going forward. A more open and free dialogue with the JBC through this unique chapter would drive a better outcome for all parties, including the Coloradans we serve, our contracted partners, the JBC, our elected officials and the Department. It would also provide the JBC with the insights, support and options needed during this incredibly difficult chapter.

Although vaccines are now being distributed, there may still be both short and long-term effects on state revenue, which will likely introduce additional variability and uncertainty into budget balancing.

Going forward, the Department will continue to provide current information to the Joint Budget Committee in advance of figure setting, such as monthly expenditure reports, and a Medicaid and CHP+ forecast revision on Feb. 15, 2021. In addition, Department staff will be available to provide other data, and on a more frequent basis as necessary to ensure that the Joint Budget Committee has the most up-to-date information when setting the FY 2021-22 budget.

Co-pays

The Department believes that the Joint Budget Committee's action to maximize member co-pays is a key area for lessons learned. The strategy of maximizing member co-pays negatively impacts Medicaid members and creates provider abrasion. In a normal non-pandemic budget year, such alternatives could have been evaluated more thoroughly and presented as options prior to setting all co-pays at the maximum federal allowable amounts. The Department would rather set co-pays based on evidence that informs a strategy to drive healthier outcomes and lowers costs. For example, setting the maximum co-pay for non-emergency emergency room utilization while setting a low co-pay on primary care visits may provide a better, more targeted strategy. Parallel strategies that maximize telemedicine as an alternative to emergency room utilization would provide an even more promising outcome for both members and the state budget.

The unintended consequences of increasing all co-pays run counter to Medicaid's aim of improving health care access, equity, and outcomes for the members we serve. A 2017 literature review of copayment studies from the Kaiser Family Foundation[16] shows that even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services. Co-pays in commercial health care plans serve as a deterrent to their enrollees seeking unnecessary services, but for the Medicaid population studies have shown that deterrent does not occur. Co-pays for the Medicaid population are expected to have the following negative consequences as documented in a Review of Research:

- Result in unintended utilization trend consequences, such as increased use of the emergency room.

[16] https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101707786-pdf

- Increase financial burdens for families, causing some to cut back on necessities (e.g., rent, food) or borrow money to pay for health care.
- Increases in co-pays to the federal maximum applied to Non-Emergent Inpatient Hospital stays may have the unintended result of more Medicaid members being sent to collections.
- Providers often consider co-pays to be a rate cut. For example, the co-pay increase for Non-Emergent Medical Transportation may result in a 4% rate reduction if the providers cannot collect the co-pay.
- Increasing co-pays or imposing co-pays on provider groups that did not collect co-pays in the past creates risk for our provider network by turning providers away from accepting Medicaid members or enrolling in the program.

Providers report frustration with co-pay administration which is exacerbated by issues that only certain Medicaid populations are subject to co-pays (e.g., children are excluded from payments) and members can reach their co-pay limit at any time. This is due to federal regulations that limit a member's co-pays to no more than 5% of a household's monthly income. This causes providers to either refund the over collection of co-pays which can be a manual and costly process, or not collect any co-pay as a business practice.

In addition, new co-pays for services that did not previously have them (e.g., dental, anesthesia, non-emergent medical transportation) are not easy for providers to operationalize. It is not practical to have co-pays for anesthesia services because it will result in surprise bills to our members (anesthesia providers do not have 'offices' where a member will pay their co-pay up front). Nor is it practical to have co-pays for non-emergent medical transportation (NEMT) because it would require either the driver to collect co-pays or force companies to send notices for payment, and both decrease the likelihood that a co-pay will even be collected from the member. Dental services should not have a co-pay because we do not want to dissuade members from seeking dental care as this benefit serves to avoid future emergency dental services.

12. **[Rep. McCluskie] In R17 Medicaid benefit adjustments the Department proposes reducing benefits. What is the rationale for reducing these benefits and why these specific benefits over others?**

RESPONSE

In R17, the Department proposes three reductions: eliminating the Preventive Dental Hygiene appropriation; limiting enrollments in the Program of All-Inclusive Care for the Elderly (PACE); and, a limitation on the number of outpatient speech therapy evaluations that will be reimbursed before a prior authorization is required.

The Department proposes a reduction in funds in order to eliminate an existing contract with the Dental Lifeline Network. This vendor is contracted to provide outreach and support with oral health for Coloradans with intellectual/developmental disabilities (I/DD). Rather than seeking a reduction to dental benefits for members with a I/DD, the Department proposed to reduce funds which are designated to fund referral and

outreach services. The elimination of this contract will not result in any fewer funds being available for dental services, and the Department is recommending this reduction over a reduction to actual dental coverage.

The Department proposed a limitation on PACE enrollments to help address the rise in cost of the PACE program. Enrollment in the PACE program has grown significantly recently, by 75% over the last five years. The Department's projected enrollment for FY 2020-21 shows a significant increase of 10% from FY 2019-20. Newly enrolled members are younger and incur less costs on average outside of PACE. The average annual cost of a PACE enrollee is about $51,000, compared to the average cost of a member over the age of 65 on the Elderly, Blind, and Disabled waiver of about $27,000. This will allow the Department to ensure reasonable growth rather than seeking a reduction in the PACE budget through rate cuts. Allowing the PACE Organizations to replace members lost from disenrollment of any type (voluntary, involuntary, member death, etc.) coupled with an average of 16 net new enrollments per month does not present any anticipated issues with enrollment limitations. In addition, limiting enrollment would not result in any reduction in member access to critical benefits, including acute care services, behavioral health care, and personal care and homemaker services through the Home and Community-Based Services waivers. The Department looks forward to engaging PACE organizations and other interested stakeholders to determine a fair and equitable policy that also acknowledges innovation and increased quality. It should also be noted that a reduction in projected enrollment (revenue) to the PACE organizations is concurrent with a reduction in their variable expenses as well, which mitigates the net financial impact of this savings measure to the PACE organizations.

The Department proposed a limitation on the number of outpatient speech therapy evaluations that will be reimbursed before a prior authorization is required. This is not a strategy meant to reduce services for members, rather it is a strategy meant to combat fraud, waste, and abuse against providers who are overbilling these services beyond what is medically necessary. Requiring prior authorization for more than two evaluations per year will ensure only those which are necessary can be reimbursed. This will not create undue administrative burden on speech therapists because they must already obtain a prior authorization for other speech therapy procedure codes, nor will it impact members. Historically, 90% of members receiving outpatient speech therapy had only one evaluation per year and 95% had two or fewer per year.

13. **[Rep. McCluskie] How is turnover and burnout based on the pandemic affecting health care workers and providers?**

RESPONSE

Health care worker burnout was a national problem before the pandemic hit. While there is little data other than anecdotal evidence (nationally or in Colorado), the pandemic is likely worsening the issue. Provider burnout symptoms are extensive and often include working long hours, no sleep and poor eating, anxiety around liability and compliance, fears of contaminating loved ones and dying, and watching patients die.[17] Even before COVID-19, health care workers experienced high rates of burnout, with 43.9% of surveyed

[17] Friedberg, M. W., Chen, P. G., Van Busum, K. R., Aunon, F., Pham, C., Caloyeras, J., ... & Crosson, F. J. (2014). Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. *Rand health quarterly*, *3*(4).

physicians reporting at least one symptom of burnout in 2017.[18] Burnout is also common among direct care workers employed in long-term care, likely a key contributor to the 40%-60% turnover rate.[19]

Early studies and news reports indicate that the pandemic is likely to exacerbate burnout among frontline health care workers; however, it is too early for data to be available regarding the impact of COVID-19 on burnout. The American Hospital Association has stated that they do not, and will not, collect data on how many workers are leaving the field in order to avoid placing more stress on providers overwhelmed by the pandemic.[20]

Local home care services in Colorado report that home care workers and caregivers are facing even higher rates of turnover due to concerns about the virus and low salaries.[21] Staff shortages within the state's residential care settings have been steadily rising, reaching critical levels in recent weeks. As an increasing number of staff are sent home due to illness or quarantine, there are fewer replacements available, even from temporary staffing agencies that have traditionally stepped in to help. Data from EM Resource, a daily reporting tool for congregate settings, illustrates the issue: 34% of nursing homes, 20% of assisted living residences, and 28% of group homes report current staffing shortages; within these facilities there are 710 open positions needed to fill immediate shortages, 135 of which were needed within 48 hours of when they provided the data (Dec. 9, 2020) to support our most vulnerable Coloradans living in nursing homes.

In Colorado, the state and provider partners are working together to help provide much needed support for essential workers, health systems and the safety net system. The University of Colorado Hospital system will be providing one year of free mental health care (including both therapeutic and psychiatric) to their health care providers and their families one year after the pandemic.[22]

Staffing Resource and Support

Early on in the pandemic, the Department built a job search platform, ConnecttoCareJobs.com, to assist long-term services and supports providers in need of staffing support to connect with job seekers with related skills. Additionally, within the Department of Public Safety's Division of Homeland Security & Emergency Management, the Unified Command Center has created the Staff Shortage Fusion Center to oversee and manage all critical staffing requests being received across the state. The Residential Care Strike Team, co-led by HCPF and CDPHE, is collaborating with the Fusion Center to distribute $1.3 million in funding to support Colorado residential care facilities experiencing staffing shortages. Finally, the Colorado National Guard and clinical staff from the Alternative Care Site Shock Team have provided direct staffing support at no cost to providers.

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[18] Shanafelt, T. D., West, C. P., Sinsky, C., Trockel, M., Tutty, M., Satele, D. V., Carlasare, L. E., & Dyrbye, L. N. (2019). Changes in burnout and satisfaction with work-life integration in physicians and the general us working population between 2011 and 2017. *Mayo Clinic Proceedings*, *94*(9), 1681–1694. https://doi.org/10.1016/j.mayocp.2018.10.023

[19] Espinoza, R. (2020). Would you stay? Rethinking direct care job quality. *PHI*. https://phinational.org/resource/would-you-stay-rethinking-direct-care-job-quality/

[20] Christ, G. (2020, November 25). Workers leaving "healthcare prisons" over COVID-19 stress. *Modern Healthcare*. https://www.modernhealthcare.com/nursing/workers-leaving-healthcare-prisons-over-covid-19-stress

[21] Hauff, B. (2020, September 16). For Colorado's rural seniors, Coronavirus strains access to home-based care—Just as it's needed most. *The Colorado Sun*. https://coloradosun.com/2020/09/16/rural-home-care-seniors-colorado-covid/

[22] Gessner, C. (2020, November 20). *What keeps you up at night? Perspectives from the C-Suite* [Colorado Healthcare Strategy and Management Webinar].

Supporting Safety-Net Providers
With additional flexibilities provided during the public health emergency, Colorado is working to distribute $3.63 million to primary care providers, which as a class of providers are known to have experienced revenue loss due to the COVID-19 pandemic. At this time, Colorado has released nearly $600,000 to 14 clinics across the state and anticipates all funding to be distributing by Spring 2021. The advanced payments are made possible through donations from a unique partnership with the Colorado Health Foundation, Caring for Colorado Foundation, Delta Dental of Colorado Foundation, Rocky Mountain Health Foundation and Rose Community Foundation. These payments protect practices that rapidly shifted to telemedicine – which while protecting Medicaid members – caused practices to suffer financial losses. These providers will have more cash on hand as the public health emergency continues to impact their day-to-day operations.

Eligibility for these advanced payments was limited to Medicaid-enrolled primary care physicians (PCPs) that also provide behavioral health services and/or dental care. The Department has worked for more than 20 years to increase access to behavioral health and dental services through integrating services into primary care settings. The first round of payments went to 14 diverse practices statewide including small Federally Qualified Health Center sites, pediatric practices, a sole proprietor and several rural practices averaging $41,000 per recipient. The lump-sum payments were based on these practices' 2019 pre-COVID-19 monthly revenue for a 90-day period. Colorado is currently working to distribute the rest of the funds by spring 2021.

Provider outreach and support during COVID-19
The Department understands increased provider enrollment is critical to handle rising member enrollment since the start of the public health emergency. In June, the Department began efforts to enroll 10,000 new providers in FY 2020-21 to increase member access to care and reduce the burden on existing providers. The Department received CMS approval through a waiver to section 1135 of the Social Security Act to pause specific provider enrollment requirements temporarily to encourage program participation. They include the enrollment fee for group providers, fingerprint-based criminal background checks, and site visits. To support the enrollment effort, a new, **We're Here for YOU, Colorado!** webpage was created to provide guidance for the enrollment process in a central location, and the Department partnered with the Department Of Regulatory Agencies (DORA) to outreach licensed, unenrolled providers to encourage participation. To date, over 3,500 providers have enrolled this fiscal year.

14. **[Common] Please describe how the changes implemented in response to the COVID-19 pandemic have changed the nature of the Department's work. Please address programmatic, budgetary, and office space impacts.**

RESPONSE

The COVID-19 pandemic and resulting recession have had a significant impact all across Department operations. New or expanded workstreams include:

- **Managed the enrollment of, and the service to, over 160,000 new members** since March, while maintaining customer service standards, including the HCPF-staffed Member Call Center, the contracted enrollment center, and the contracted provider call center. From July 2018 to June 2020,

and through the pandemic, the Department has made improvements in customer service a focus area. This focus is exemplified in Member Contact Center call wait times reduced as follows:

  - Average speed of answer (ASA) from 58 minutes down to 20 seconds
  - Abandonment Rate (ABN) - the percent of people who hang up - from 23% down to 0.04%
  - Reduced staff turnover rate to less than 1% each month this fiscal year, with zero turnover in October and November

- **Co-chaired the COVID-19 Residential Care Strike Team**, which rapidly deployed strategies to mitigate the spread of COVID-19 in nursing facilities, assisted living residences, group homes and intermediate care facilities. This includes completion of 1,478 infection control surveys across all 1,052 residential facilities, implementation of surveillance and outbreak testing resulting in approximately 88,396 tests conducted with staff and residents on average per week in nearly 900 of Colorado's residential care settings, and launching the ConnectToCareJobs site to address provider staffing shortages, which presently has 757 job seekers registered with 157 engaged employers. The results of this Strike Team have been recognized by AARP as industry leading and a model for other states to consider.
- **Submitted and executed over 20 emergency waivers, emergency rules, and State Plan Amendments** , including making all systems changes to address new changes in eligibility, benefits, and claims payment, as well as making preparations to unwind all of this work at the eventual end of the public health emergency. The Department also had frequent and enhanced communication with providers and stakeholders to get feedback and answer questions on these policy changes and flexibilities.
- Worked with the **counties and Medical Assistance sites** to increase utilization of PEAK, address CBMS transformation challenges, and implement other operational best practices to streamline processes with the goal of improving application processing efficiency given the increasing demand from Coloradans impacted by the economic downturn.
- Actively participated in the **Behavioral Health Task Force** in recognition of the increasing need for behavioral health solutions to meet increasing demands.
- **Supported the development of alternative care sites**, including development, execution, and management of contracts, billing models consistent with federal guidance, and clinical pathways to decompress hospitals in danger of exceeding capacity.
- **Expanded telemedicine policy** to authorize new provider types to deliver telemedicine services and allow certain services to be delivered by telephone only or through live chat formats.
- **Leveraged the flexible nature of the Accountable Care Collaborative and the Regional Accountable Entities (RAEs)** to provide essential support to both providers and members. This included collaborative efforts to outreach and engage members identified as being most at risk; re-allocating pay-for-performance funds for the RAEs' immediate distribution to support struggling providers; providing operational, technical, and practice support to network providers to support the transition to telemedicine and other virtual care models; and implementing alternative funding strategies with Community Mental Health Centers to support their efforts to creatively meet members' needs.
- **Provided eight HCPF temporary staff volunteers as members of the EOC PPE Sourcing Team** that was leading the state's effort to source and test PPE in the early months of the pandemic. HCPF

also led several safety, prevention, and compliance campaigns to educate our members, communities and stakeholders on the importance of wearing a mask, social distancing, washing hands, and celebrating holidays in person within households.

- **Partnered with CDLE to release two surveys** to individuals applying for unemployment insurance to understand how they were (or weren't) planning to get or maintain health insurance coverage. That information was used to develop insights into modeling trends and potential coverage and awareness gaps. As a result, **HCPF launched the "We're Here for You, Colorado" campaign** to partner with advocates, providers, and other stakeholders to help raise awareness about Medicaid and other coverage options, recognizing the many Coloradans who lost their jobs and their related employer-sponsored coverage.
- **Hosted hundreds of stakeholder meetings** with hospitals, providers, counties, advocates and others to clarify COVID-19 impact, forecast trends, lead best practices to protect and serve our members and to pursue other shared goals with our contracted partners.
- **Transitioned to a nearly fully virtual operating model,** with over 95% of staff working remotely since March. We are currently working with DPA to determine options for rightsizing our physical footprint as we develop our post-COVID-19 workforce flexibility plans and adapt over the long term to a new normal.
- **Created new processes and insight reporting to better forecast COVID-19 impact to caseload, utilization and our budget**. Increased the cadence of these reports, reflecting the impact of market volatility and the importance of emerging insights and reporting frequency to forecast accuracy.
- **Adjusted Senior Executive Team, Executive Leadership, and staff responsibilities** to ensure the proper management of Department obligations while also addressing entirely new and unplanned COVID-19-related workstreams, without additional resources.

The HCPF staff did this work, as well as running the normal operations of the Department, without additional staff or administrative resources.

15. [Common] Please describe the Department's actions to implement the Health, Life, and Dental decrease in lieu of a 5.0 percent General Fund salary base reduction. Please include dollar and percentage share data on planned "allocations" of the decrease to all divisions and programs within the Department. Please describe the use of vacancy savings, delayed hiring, and the implementation of one-time or ongoing operating savings. Please describe the urgency of the Department's need to engage in a furlough in FY 2020-21 due to the inability to achieve savings in other ways.

RESPONSE

To balance the budget for FY 2020-21, the General Assembly imposed a 5% reduction to each department's General Fund appropriations for Health, Life, and Dental. In total, the Department received a reduction of $891,254 General Fund. The Department's reduction was allocated fully to the Department's Executive Director's Office appropriation for General Administration.

To ensure that expenditures remain within the total appropriation, the Department has absorbed the reduction through changes to its hiring and contracting processes. These controls include:

- Executive director review of requests to hire positions;
- Recommending a waiting period before filling positions to maximize vacancy savings;
- Reviewing discretionary pay differentials;
- Reviewing the Department's standard hiring and promotional compensation policies, for example, offering lower promotional increases;
- Consolidating and repurposing important but less urgent positions;
- Limiting operating expenses; and,
- Reducing contract costs in the Department's General Professional Services and Special Projects line item.
- Reducing travel, which has aligned with COVID-19 safety protocols.

By using these mechanisms, the Department has been able to manage its General Administration spending such that its expected costs for FY 2020-21 do not exceed its available appropriations. The mandatory statewide furlough helped the Department achieve the necessary savings; without the furlough, the Department may have needed more severe measures to reduce spending, such as leaving key positions unfilled or eliminating needed contracts.

COMMISSION ON FAMILY MEDICINE

16. **[Sen. Moreno] In R13 Family medicine residency funding the Department proposes partially restoring funding in FY 20-21, but the residency year has already started. How does that work?**

RESPONSE

The Commission on Family Medicine (COFM) is using its small reserves to support the funding shortfall at the family medicine programs and has reduced the fees charged to programs. While this is not sustainable long term, it is manageable in FY 2020-21.

17. **[Sen. Rankin] How has the reduction to the family medicine residency program impacted rural communities? What would it take to fully restore the program?**

RESPONSE

There are three rural training track programs supported within the family medicine residency line item. As with all the residencies, the shortfall in funds is being supported currently by the Commission on Family Medicine's (COFM) reserves.

In order to fully restore the program, $938,696 General Fund is required and can be broken down into three separate items:

a. Restoration of the $500,000 General Fund budget cut to COFM line item during the 2020 legislative session.
b. Approval of R-13. The restoration of the COFM portion of the State University Teaching Hospital line item accounts for $379,468 General Fund.
c. An additional appropriation of $59,228 General Fund to the State University Teaching Hospital line item to keep the University Family Medicine Residency program payments equitable to the other Commission on Family Medicine Residencies.

HOSPITALS

18. [Sen. Moreno] For hospitals in particular, please describe the adequacy of the federal funds in relation to the pandemic costs and revenue losses and any information the Department has on the overall financial health of the hospitals.

RESPONSE

To date, hospitals have received more than $1.042 billion in stimulus dollars, and are due according to a Dec. 16, 2020, announcement from the Health Resources & Services Administration (HRSA) to receive an additional $147 million, with payments beginning immediately.

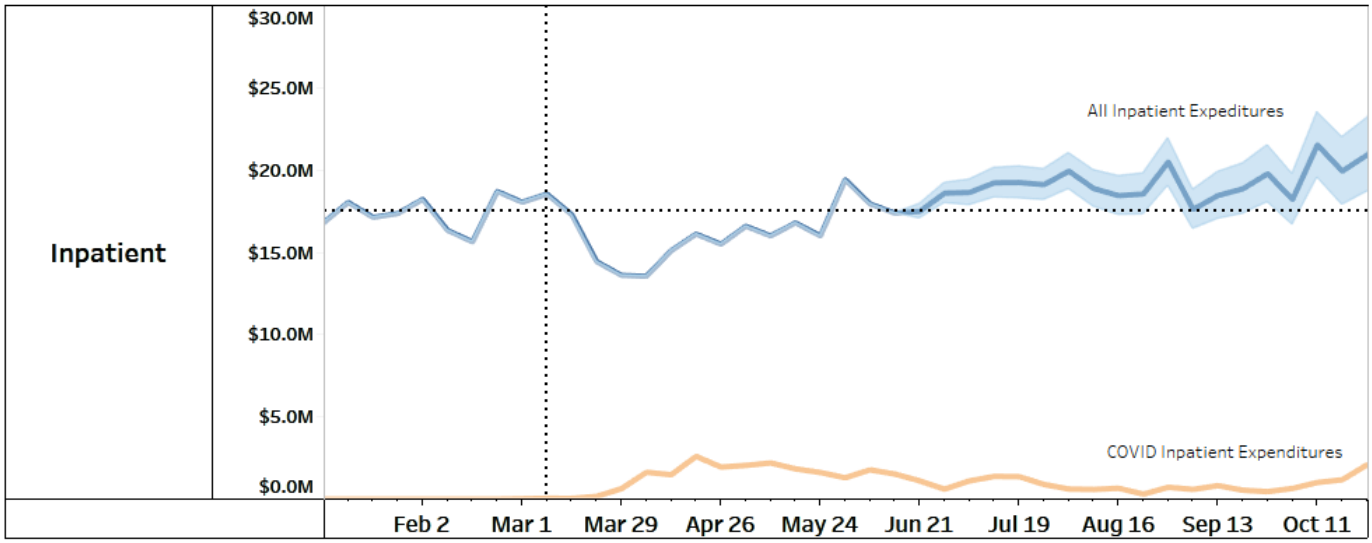
Since the pandemic began, the Department has been tracking changes in utilization and provider payments. Below are two charts that illustrate that for inpatient and outpatient hospital services, Medicaid revenues have returned to normal after major reductions impacted by the national PHE and the state's stay-at-home order. We believe that in the areas of inpatient and physician administered drugs, that hospital revenue from Medicaid has returned to pre-pandemic, without the application of the stimulus dollars. We believe the hospitals have not yet made up the losses in revenue on an outpatient basis caused by the PHE, not including the application of stimulus dollars. As many as 27% of emergency department visits in the United States could be managed in physician offices, clinics, and urgent care centers.[23] The reduced emergency department utilization we believe represents more appropriate use – perhaps a new normal coming out of the COVID-19 pandemic, and concurrent with increases in the less costly and highly effective telehealth services. We intend to introduce strategies and initiatives to help continue and propel these most cost-effective and appropriate emergency department utilization patterns.

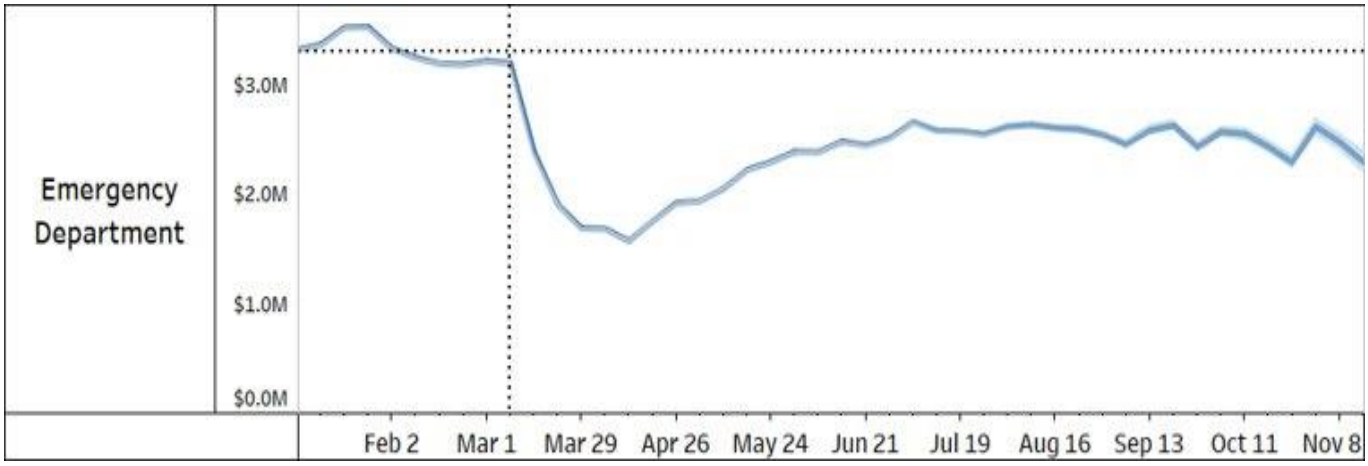
The Department is working on an analysis of whether the $1.2 billion in stimulus dollars provided by the federal government to Colorado hospitals covers or exceeds the downfall in revenue caused by the pandemic. However, it should be noted – as reported in Department studies - that Colorado is the top 10 nationally for the highest hospital prices, highest profits, and the highest administrative costs. Therefore, the Department is firm about how "hospital revenue losses" should be defined. For example, "losses" should not include – nor should we try to help hospitals recoup – the impact of the reduction in inappropriate emergency department utilization. This efficiency gain is something the hospitals should plan for - a "new normal in health care" that the Department and the entire industry should continue to propel as we teach Coloradans the benefits of telehealth as an emerging, important alternative to inappropriate emergency department utilization. This

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412873/

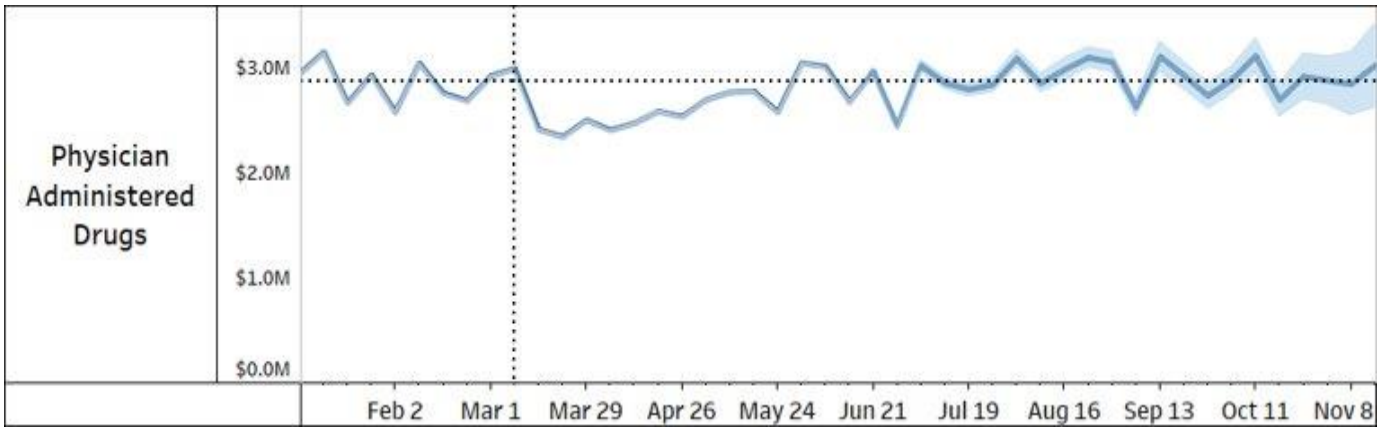
further aligns with the Department's January 2019 letter to hospitals requesting that they cease all emergency department marketing efforts, which drive inappropriate and unnecessary, high cost emergency department visits; this "new normal" will benefit the Medicaid program going forward.

The charts below illustrate utilization and payments through the PHE and through Nov. 21, 2020, including hospital inpatient, hospital emergency department, hospital outpatient and physician administered drugs. The blue line is weekly incurred but not reported (IBNR) adjusted expenditure.[24] The blue shading is the range of uncertainty in the IBNR estimates. The vertical dotted line is the last week prior to the start of social distancing. The horizontal dotted line is the weekly average paid before social distancing.





[24] There is a lag between when a provider renders a service to a member and the time it takes for the provider to bill Medicaid to receive payment for the claim. This causes the most recent weeks of claims data to be artificially deflated. The Department adjusts for this by projecting how much expenditure is outstanding for services that were incurred but not yet paid based on historical billing patterns by service category.



When considering all pandemic-related federal funding to date including Paycheck Protection Program (PPP) loans, Colorado hospitals have received more than $1 billion in funding from the Coronavirus Aid, Relief, and Economic Security (CARES), Paycheck Protection Program and Health Care Enhancement (PPHCE), and Coronavirus Preparedness and Response Supplemental Appropriations (CPRSA) Acts.

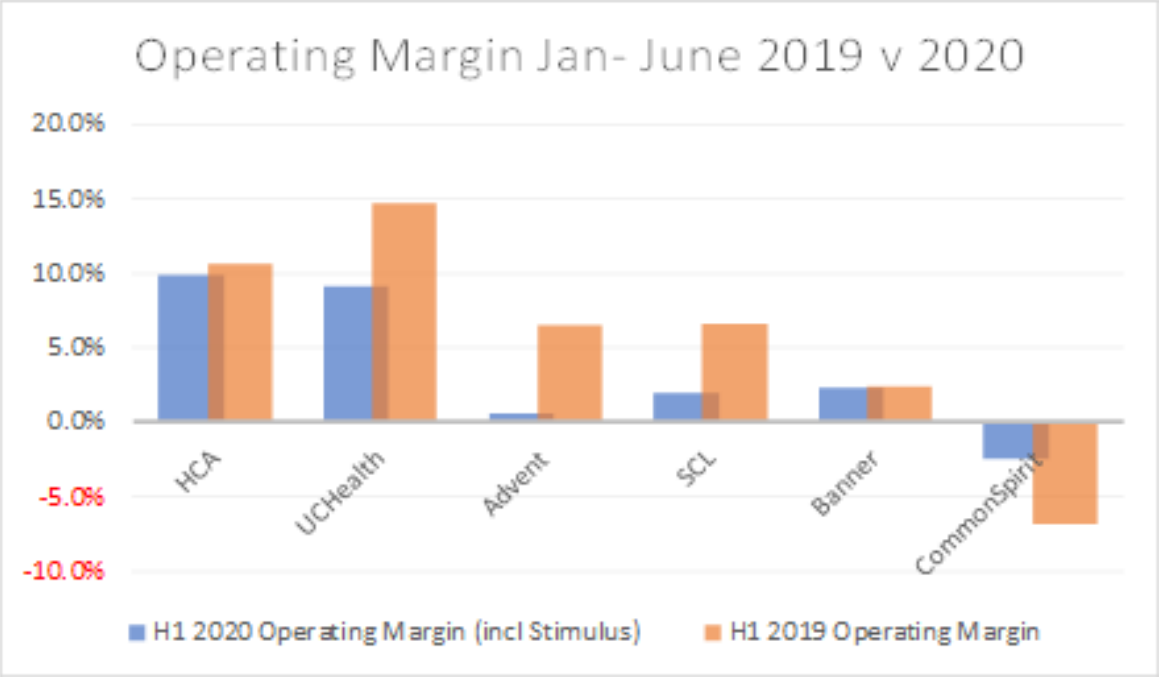
Publicly available quarterly financial filings by hospitals and hospital systems show that, when including federal funds related to the pandemic, Colorado nonprofit hospital systems have often recorded operating profits in the first half of 2020[25]. Pre-pandemic, urban hospitals and systems were better positioned than rural hospitals, with urban hospitals having over eight months of cash on hand before the public health emergency. While less information is available for rural, independent hospitals, some information is available. With some variation, federal stimulus monies provided Colorado rural hospitals with about three months' worth of additional cash.

Available financial data from hospital systems required to report quarterly financials due to bond covenants is shown below. This data shows Colorado's hospital systems have maintained positive operating margins, without needing to dip into significant cash reserves. Two systems were successful enough in 2020 to make operating profits **without any federal stimulus**: UCHealth and HCA. Financial impact is shown as operating

[25] *Municipal Securities Rulemaking Board::EMMA.* (n.d.). EMMA Municipal Securities Documents. Retrieved Oct-Dec 2020, from https://emma.msrb.org/

margin, excluding non-operating factors such as fluctuations in investment portfolios. CommonSpirit, which are Centura CHI hospitals, reduced its operating loss compared to the previous year.

Operating margin for hospital systems (from public financial documents)



See appendix for an itemization of all COVID-19-related federal funds provided to Colorado hospitals as of Dec. 16, 2020.

We also want to underscore that 87% of Colorado hospital profits are coming from the state's largest systems, and not from our rural providers. The state is firmly in support of additional resources intended to help our struggling rural hospitals. The Department is, in fact, implementing in collaboration with the Colorado Hospital Association, a Rural Support Fund within the Hospital Transformation Program (HTP). This program will provide $12 million a year, over five years, totaling $60 million to help 23 rural hospitals transform for the betterment of access, affordability and service to rural Coloradans.

19. **[Sen. Rankin] What is the impact on struggling rural and critical access hospitals of R15 HAS Fee offset GF that proposes using $80.0 million from the Healthcare Affordability and Sustainability (HAS) Fee to offset the need for General Fund?**

RESPONSE

The Department mitigates the impact of fees on rural hospitals to the extent possible. The 43 hospitals in rural and frontier counties (six or fewer people per square mile), which are about half of all hospitals in the state, pay only 7% of total HAS fees collected. The remaining urban hospitals pay 93% of the fees. Moreover, rural and frontier hospitals realize a greater return on investment from the HAS Fee compared to urban hospitals.

Payments received by rural and frontier hospitals from the HAS Fee are much greater than the fees paid, and more than urban hospitals receive. In the current FY 2020-21, $161 million in HAS fees are being used to offset General Fund in the Department's budget. Even with that transfer considered, hospitals in rural counties receive more than $100 million in payments above their fees paid (a return of 2.5 times their fees paid), with hospitals in frontier counties receiving payments more than $20 million above their fees paid (a return of more than 5.1 times their fees paid). Urban hospitals, on the other hand, receive increased payments about 1.25 times their fees paid. Payments from the HAS Fee to rural and frontier hospitals are consistent year over year and the Department fully expects these hospitals to receive the same benefit from the HAS Fee in the upcoming FY 2021-22, including with the proposed $80 million HAS Fee transfer.

20. **[Sen. Moreno] How much room is there within the federal limits to use money from the HAS Fee to offset General Fund? What are the consequences if the estimates are wrong?**

RESPONSE

The Department estimates it will be within the federal 6% net patient revenue limit with the inclusion of the $80 million HAS fee General Fund offset in FY 2021-22. The Department also estimates it is collecting fees within the 6% net patient revenue limit this current FY 2020-21, in which $161 million in HAS fees are being transferred to offset General Fund expenditures.

Actual hospital net patient revenues are not known until approximately two years after the fact when hospitals have filed their Medicare cost reports with the Centers for Medicare and Medicaid Services (CMS). If actual net patient revenues are lower than estimated, federal funds drawn on the excess fees would need to be returned to the federal government. Because of this, the Department estimates net patient revenue conservatively. To ensure there is no future General Fund obligation to reimburse the federal government, the Joint Budget Committee can include a provision in legislation requiring hospitals repay any overpayment of federal funds as it did in HB 20-1386.

21. **[Sen. Rankin] The pediatric specialty hospital payment goes to Children's Hospital. How is the money used? What is the business case for this funding?**

RESPONSE

Historically, the purpose of the Pediatric Specialty Hospital Payment was to provide funding to the state's only pediatric specialty hospital, Children's Hospital Colorado, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. This is a supplemental Medicaid payment in addition to payments Children's Hospital Colorado receives through claims for services rendered to Medicaid and CHP+ members. While this is a supplemental Medicaid payment, like any other revenue it receives, it is up to Children's Hospital Colorado how it ultimately uses this funding.

This dedicated line item for Children's Hospital Colorado has continued even though the number of uninsured persons in the state has declined by more than half since the implementation of the Affordable Care Act.[26] In

[26] https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage

addition, the hospital provider fee (now Healthcare Affordability and Sustainability fee, or HAS fee) has provided significant increases in hospital funding beginning in FY 2009-10. In fact, Children's Hospital Colorado receives approximately $30 million per year in reimbursement from the HAS fee after the payment of the fee is considered as shown in the CHASE annual reports submitted each January 15[27] and as noted in the chart below ($29.9M). Children's Hospital has also received $52,350,068 in federal COVID-19 stimulus to date.

Children's Hospital Net CHASE Supplemental Payments FFY 2019-20

Hospital	Total HCPF Claims Payments	Total CHASE Fee (Paid In)	Inpatient Suppl. Payment	Outpatient Suppl. Payment	HQIP Suppl. Payment	DSH Suppl. Payment	Total Suppl. Payment (Paid To)	Net Reimburse-ment
Children's Hospital Anschutz	$163,216,051	$39,473,832	$8,229,960	$25,112,206	$6,931,695	$26,173,019	$66,446,880	$26,973,048
Children's Hospital Colorado Springs	$34,229,372	$11,296,505	$5,442,255	$6,709,680	$0	$2,094,368	$14,246,303	$2,949,798
Total	**$197,445,423**	**$50,770,337**	**$13,672,215**	**$31,821,886**	**$6,931,695**	**$28,267,387**	**$80,693,183**	**$29,922,846**

22. [Rep. Herod] What happens to the people served by the programs if the funding for Children's Hospital goes away? Please discuss impacts on the entire ecosystem, including foster care.

RESPONSE

If the Pediatric Specialty Hospital Payment is eliminated, Children's Hospital Colorado can continue to bill for all allowable services provided to Medicaid and CHP+ members, including foster care children, and it will continue to receive supplemental funding through the Healthcare Affordability and Sustainability (HAS) fee. As noted in the earlier response, this is a supplemental Medicaid payment in addition to payments Children's Hospital Colorado receives through claims for services rendered to Medicaid and CHP+ members.

This dedicated line item for Children's Hospital Colorado has continued even though the number of uninsured persons in the state has reduced by more than half since the implementation of the Affordable Care Act[28] and the hospital provider fee (now HAS fee) provided significant increases in hospital funding beginning in FY 2009-10. In fact, Children's Hospital Colorado receives approximately $30 million per year in reimbursement from the HAS fee after the payment of the fee is considered as shown in the CHASE Annual Reports submitted each January 15.[29]

[27] https://www.colorado.gov/sites/default/files/2020%20CHASE%20Annual%20Report.pdf
[28] https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage
[29] https://www.colorado.gov/sites/default/files/2020%20CHASE%20Annual%20Report.pdf

23. **[Sen. Rankin] How do University of Colorado and local governments feel about R21 Federal match for cash funds? Do they have impacts related to COVID-19 that would go unaddressed if this request is approved?**

RESPONSE

The Department's R-21 request is consistent with Congressional intent and in line with action taken via HB 20-1385 (Use of Increased Medicaid Match), for which the Department has not heard concerns from local governments.

The intent of the temporary 6.2% increased Federal Medical Assistance Percentage (FMAP) enacted in the Families First Coronavirus Response Act (FFCRA) is to provide relief to states by reducing the state funding needed to finance the Medicaid program. The increased FMAP is not intended to increase reimbursement to providers. Under the Department's R-21 request, providers will receive the same payments they would without the increased FMAP and the state will realize General Fund savings without having to reduce other Medicaid expenditures, such as through provider rate cuts.

BUDGET REQUEST & GENERAL

24. **[Sen. Rankin] What evidence is available about the performance of the nurse advice line? Is this an evidence-based program, and where does it fall on the continuum?**

RESPONSE

The Department contracts with a vendor to operate a free 24-hour Nurse Advice Line (NAL) for Health First Colorado Medicaid members. The NAL triages callers to the right level of care for their acute medical issues using evidence-based criteria (Schmitt-Thompson guidelines). In addition to tracking NAL compliance to industry-standard URAC data (average speed of answer, abandonment rates, etc.) the Department monitors the performance of the NAL through monthly and quarterly reporting which includes number of callers, caller demographics, reason for call, top guidelines used, and level of care redirection rates.

Nurse advice lines are a standard feature of private and public health plans, where they serve to reduce unnecessary emergency department utilization and urgent care visits. Evidence on nurse advice lines was first established in the early 2000s including a 2004 article from the Department's vendor partner in the American Journal of Managed Care[30], a leading peer-reviewed journal dedicated to issues in managed care. This article demonstrated that, "the simple act of calling a nurse triage and advice line corresponds with a change in the reported actions of uninsured and managed care patients and a potential reduction in costs to the safety net system providing their healthcare."

Studies and data analysis include the following:

[30] Bogdan, M. et al. (2004) "Evaluating Patient Compliance With Nurse Advice Line Recommendations and the Impact on Health Care Costs." The American Journal of Managed Care 10: 534-542.

- A 2014 study in the Journal of Nursing Management[31] found that diverting callers from the emergency department to a lower level of care saved an average of $4,688 per member and diverting from non-emergency department/office visit to a lower level of care saved on average $1,381 per member. Diverting care from a non-emergency level visit to higher level of non-emergency level of care saved on average $453.
- In the study of the Denver Health Nurse Advice Line mentioned above, researchers found that members adhered to the nurse's recommendation 70% of the time. Callers were most likely to adhere when the recommendation was for home care (91%) and were least likely to be compliant when the recommendation was for clinic care (52%).
- In a caller adherence analysis done by the Department in 2017, it was determined that 73% of NAL callers who thought they needed to go to the emergency department but received a recommendation for a lower level of care complied with that recommendation. The analysis also showed that 60% of all callers received a different level of care than their original intent with 52% of callers' intention originally being to receive care in the emergency department. This recommendation to seek a lower level of services results in significant cost savings.

The NAL aligns with Step 4 of the OSPB evidence continuum. The collection and analysis of caller data and corresponding claims data provides the basis for performance measures from which the Department makes informed decisions. In addition to analysis of the care plan outcomes and fiscal impact of the NAL calls, the member-facing operational process of responsive customer service is monitored and subject to performance measures established by the Department.

Utilization of the NAL leads to an overall reduction in health care costs because the attending Registered Nurse (RN) directs the member to the right resource at the right place at the right time. FY 2019-20 shows that 34% of the calls were triaged by the RN to a lower level of care which directly impacts cost and 16% resulted in a recommendation to seek a higher level of care which ensures member safety.

25. [Rep. McCluskie] Please provide more detail about the plan to address health disparities and how R24 advances that plan? How does the request fit with initiatives in other departments, including the health disparities team in the Department of Public Health and Environment?

RESPONSE

Budget Request Detail

If the Department's budget request, R-24 Addressing Health Care Disparities, is approved, data on member and provider race and ethnicity would allow the Department and researchers to better disentangle factors that are associated with health care disparities. Further, collecting and analyzing patterns of health care by patient race, ethnicity, and other demographic data can help the Department to monitor the quality of care provided

[31] Navratil-Strawn, Jessica L, et al. (2014) "Listening to the Nurse Pays off: An Integrated Nurse Healthline Program Was Associated with Significant Cost Savings." Journal of Nursing Management, U.S. National Library of Medicine.

by its provider network. Such monitoring can help to ensure accountability to enrolled members, improve member choice, and allow for evaluation of intervention programs. The work funded through R-24 would enable the Department to condition value-based payments to providers on evidence that they are improving health outcomes where disparities currently exist and enable new quality measurement that better allows the Department and providers to improve health disparities. Specifically, funding R-24 would allow the Department to:

- Address gaps in Medicaid application and claims data collection and analysis.
- Collect and analyze racial and ethnic disparities data from provider electronic health records systems (EHR), which includes information on clinical data and social determinants of health, such as food insecurity and housing.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.
- Enhance internal data analytics and health equity capacity to guide equity-focused, data-informed and evidence-based programmatic interventions to improve health outcomes for marginalized and underserved communities.
- Develop and implement health equity lens or framework to evaluate the Department's policies, systems, programs and services.

The Department is developing an internal plan to address health disparities. The Department's budget request is necessary to develop that plan. Addressing health care disparities first requires the ability to accurately measuring where a health disparity exists. Without accurate and timely data collection on individual demographics such as race and ethnicity, it is difficult (or impossible) to design new payment models to reward providers for working to eliminate disparities. The fact that disparities in care are not always apparent to members or providers in clinical encounters increases the need for data so we can better understand the extent of disparities and the circumstances under which disparities are likely to occur. Data describing racial, ethnic, language, cultural, and socioeconomic characteristics are frequently inaccurate, incomplete, and lacking in detail within the current Department data systems.

If the request is approved, the Department would combine that information with other data to analyze potential disparities. For example, the Department is in the process of collecting better clinical data (e.g., BMI or hbA1c values) that comes from lab results available through the state's Health Information Exchanges which aggregate data from providers' electronic health records. The Department has already initiated conversations with both of Colorado's Health Information Exchange (HIE) organizations – Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN) on the western slope – and they are providing the Department with options to merge their demographic data with our Medicaid data. The Department is beginning similar conversations with the state's All Payers Claims Database (APCD) and the Department of Public Health and Environment. By leveraging all available data sources that can expand the Department's demographic markers, the accuracy of measuring where health disparities exist, and the potential solutions increase.

The Department is uniquely positioned to incentivize Medicaid providers to capture demographic and clinical information from their patients and to build the interfaces to collect the data. The Department invests in HIE infrastructure that allows Medicaid providers and hospitals to securely connect their individual EHR systems with other systems through the health information exchange network. Using enhanced federal funding, the Department has overseen the connection of over 300 clinics and 90 hospitals' electronic health records (EHRs) to Colorado's Health Information Exchange (HIE) organizations which cover over 6,300 providers and over 6.5 million patients (including out-of-state visitors). As detailed in another budget request (R-12, ARRA-HITECH Funding Transition), the Department seeks to maintain these funds to continue connecting providers to the health information exchange and maintain this flow of information. Further, the Department can leverage enhanced federal funding to establish regular data feeds with these external databases to integrate demographic data into the Department's existing data warehouse. Once the data feeds and processes for merging data have been established, the same process can be duplicated so demographic data in the state's APCD can be expanded. That larger data set can be leveraged to address health care disparities statewide, beyond Medicaid.

Alignment with the Colorado Department of Public Health and Environment's Health Equity Efforts

The Department's efforts to address health disparities and advance equity, diversity, and inclusion are aligned with equity-focused guidelines and principles championed by the Colorado Equity Alliance, a cross-agency group founded by staff of the Colorado Department of Public Health and Environment's Office of Health Equity. The alliance, comprised of representatives from both state agencies and community organizations, aims to operationalize equity and make sure it is woven into the fabric of state governance. The Department is represented in the core committee of the Colorado Equity Alliance. The Department of Public Health and Environment's Health Disparities Program is focused on preventing targeted conditions (e.g., cancer, cardiovascular/pulmonary disease) through upstream investments in social determinants such as housing. To the extent that Health Disparities Program investments have an impact on health care for certain populations, they could effectively be measured by the type of health outcomes data mentioned in the Department's request.

Advancing Health Equity at the Department

The Department's person-centered work has always prioritized awareness and recognition of the impacts of social determinants of health on outcomes for the culturally diverse communities our programs serve. For example, Department workgroups have prioritized data collection to address racial health disparities related to maternal and infant health and diabetes care. Support for robust data analyses would complement the work of multiple state agencies to understand and address racial and ethnic health disparities.

The Department's approach to addressing health disparities is anchored in the tenet of ensuring high quality care and services for the people Medicaid serves. Our role as the Medicaid payer in Colorado's health care ecosystem affords the Department the lever to maximize health care investments in underserved and underrepresented communities by working collaboratively with partners to identify and remove obstacles to access and utilization among historically marginalized populations.

In accordance with the Governor Polis' Executive Order D2020-175, the Department is developing an Equity, Diversity, and Inclusion Plan that explicitly addresses nine EDI topic areas. Topic areas pertaining to health equity are highlighted below.

Topic Area #2: Long-Term Plan and Reporting. In an effort to create and continuously update a long-term plan to identify and address barriers as well as metrics to evaluate progress, Department activities will focus on:

- Convening an internal, employee-led workgroup dedicated to advancing health equity among Colorado Medicaid members.
- Developing a health equity lens or framework to guide decision-making across the Department.

Topic Area #3: Community Engagement. This topic area calls upon agencies to involve community partners in decision-making from the beginning to end of projects, as well as measuring equity, diversity and inclusion efforts on state boards and commissions appointed by the Governor's Office. In our focus on health equity, the Department intends to engage with Medicaid stakeholders and partners by:

- Cultivating meaningful and respectful dialogue on equity and diversity issues with Medicaid members, providers, advocacy groups and other stakeholders
- Engaging member and provider advisory groups in the work of health equity
    - Allowing space for regional or geographic differences in defining diversity and equitable health outcomes for diverse Colorado communities
- Intentionally seek feedback from stakeholders about the emerging Department health equity lens or framework

Topic Area #7: Policy, System, Program, and Services Review. To abide by the expectation that agencies shall review, acknowledge, and dismantle any inequities within agency policies, systems, programs, and services, and continually update and report agency progress, the Department's health equity work will be guided by a focus on data analytics for the Medicaid population to include:

- Identify disparities data among marginalized, underrepresented and underserved communities across the state.
    - *Examples:* racial and ethnic disparities in Medicaid enrollment, primary care utilization, emergency department admissions, specific diagnostic and treatment codes.
    - data challenges from Medicaid claims data, as well as electronic health records systems (e.g., gaps in self-reported data).
- Data analytics will focus on ability, race and ethnicity, gender, language, national origin, sexual orientation, and other protected classes.
    - Highlight a focus on intersectionality, for example, specific health disparities linked to race and gender; ability and gender; language and race.
- Acknowledge different conceptualizations of diversity by region and/or geography.

- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.

26. [Sen. Rankin] Does the estimated savings in R10 Convert contractor funds to FTE fully account for all costs for state employees, including benefits and indirect costs? Why should we convert these particular functions from contract resources to state employees?

RESPONSE

The estimated savings in the request is inclusive of all state benefits and operating expenses. By funding these roles as state employees, the Department will be able to build internal efficiencies and develop institutional knowledge that is otherwise lost with vendor changes or contract staff turnover. The Department requested to convert contractor funding to FTE for two roles: provider field representatives and project managers. The request is for no additional General Fund by reallocating previously appropriated contractor funding.

Provider Field Representatives
Bringing these staff in house would increase the line of sight into provider contacts and other activities. There would also be improved efficiency and customer service to providers achieved through direct oversight and the ability to quickly refocus staff based on Department priorities such as provider recruitment.

Project Management Office
The Department requests to convert existing funding for project management to FTE because state employees provide a number of benefits to the Department not generally realized by contractors. For instance, FTE generally allows for better retention of institutional knowledge and subject matter expertise, which are critical for Department projects that typically involve overlapping state and federal regulations, technical requirements, policy concerns, and project management methodologies and tools. Having state employees do this work also allows for greater ability to reprioritize Department projects and quickly refocus staff in response to changes in policy, federal regulations, and other circumstances. The Department is pursuing this budget request based on the recommendations of an independent assessment regarding the need for a department-wide project management team that can work on the Department's strategic initiatives.

27. [Rep. Ransom] Why was the Primary Care Fund set up in a way that does not draw matching federal funds? Why didn't the creators of the program take matching federal funds into account?

RESPONSE

In adopting Amendment 35 in the 2004 statewide election, the voters specified several uses for the increased tobacco taxes, some of which are not eligible for federal matching funds. Specifically, Amendment 35 codified in Section 21 of Article X of the Colorado Constitution, allocated the increased tobacco tax revenue to:

- Increasing CHP+ or Medicaid enrollment,

- Funding comprehensive primary care providers based on their number of uninsured patients, i.e., the Primary Care Fund,
- Funding school and community-based tobacco education initiatives,
- Funding prevention, early detection, and treatment of tobacco-related diseases, and
- Compensating the General Fund, Old Age Pension, and local governments for losses due to a decrease in use of tobacco products.

Following the codification of Amendment 35 in the Colorado Constitution, the General Assembly enacted HB 05-1262, creating the Primary Care Fund at 25.5-3-301, et seq., C.R.S. In alignment with the Constitution, the legislation allocated 19% of the increased tobacco tax revenue for the Primary Care Fund to be distributed to qualified providers based on their numbers of medically indigent or uninsured patients, i.e., not Medicaid or Child Health Plan *Plus* covered individuals where federal funds would be available.

28. [Rep. Ransom] Who receives money from the Primary Care Fund? How many providers are not part of Medicaid and how much money goes to them?

RESPONSE

In FY 2020-21, there are 34 qualified providers receiving funds from the Primary Care Fund. Of those, two are not enrolled as Medicaid providers: Mission Medical Center and Open Bible Medical Clinic.

Mission Medical Center provides comprehensive health and wellness services to the uninsured, low-income, and underserved people of the Pikes Peak Region and operates on gifts and donations without federal funds or insurance reimbursement. It is expected to receive $76,000 from the Primary Care Fund this year.

The Open Bible Medical Clinic is a Christian-based nonprofit organization that exists to provide free access to medical care and life-saving medications to the working, uninsured, low-income adults of El Paso and Teller Counties. It is expected to receive $52,500 from the Primary Care Fund this year.

See the table below for a list of all Primary Care Fund providers this FY 2020-21. Note that the Department includes Primary Care Fund recipient providers and their funding amounts in its annual Colorado Indigent Care Program and Primary Care Fund Report delivered to the General Assembly each February 1.[32]

Primary Care Fund Provider	Medicaid Enrolled
Axis Health System	Yes
Carin' Clinic	Yes
Caritas Clinic at Saint Joseph Hospital	Yes

[32] See https://www.colorado.gov/sites/default/files/2018-19%20HCPF%20Colorado%20Indigent%20Care%20Program%20Annual%20Report.pdf

Primary Care Fund Provider	Medicaid Enrolled
Clinica Colorado	Yes
Clinica Family Health	Yes
Clinica Tepeyac	Yes
Denver Health and Hospital Authority	Yes
Doctors Care	Yes
Every Child Pediatrics	Yes
Family Medicine Clinic for Health Equity	Yes
Fort Collins Family Medicine Residency	Yes
High Plains Community Health Center	Yes
Hopelight Medical Clinic	Yes
Inner City Health Center	Yes
Kids First Health Care	Yes
Marillac Health	Yes
Mountain Family Health Centers	Yes
Northwest Colorado Health	Yes
Peak Vista Community Health Center	Yes
Pueblo Community Health Center	Yes
River Valley Family Health Center	Yes
Salud Family Health Centers	Yes
SET Family Medical Clinics	Yes
Sheridan Health Services, Inc	Yes
Sister Joanne Bruner Family Medicine Center	Yes
Stout Street Health Center	Yes
STRIDE Community Health Center	Yes
Summit Community Care Clinic, Inc.	Yes

Primary Care Fund Provider	Medicaid Enrolled
Sunrise Community Health	Yes
The PIC Place	Yes
Uncompahgre Medical Center	Yes
Valley-Wide Health Systems, Inc.	Yes
Mission Medical Center	No
Open Bible Medical Clinic	No

29. **[Rep. McCluskie] How would the 5.2 percent increase for primary care providers be distributed?**

RESPONSE

The Department would distribute funds consistent with the legislation that would be necessary to enact the proposed change in the Primary Care Fund in the Department Request R-19. The legislation could instruct the Department to mitigate the impacts of the financing change to the Primary Card Fund on providers. The Department will collaborate with stakeholders including the Colorado Community Health Network and the Colorado Safety Net Collaborative and other qualified providers to distribute funds equitably in line with legislative direction.

30. **[Sen. Moreno] If the General Assembly didn't have the 2/3s votes for an emergency declaration last year, why does the Governor's budget request assume things will be different this year? Are there are any elements of this request that could be implemented without the emergency declaration?**

RESPONSE

The Governor's budget request reflects that conditions in the state today are different than they were in the spring. The number of COVID-19 cases, hospitalizations, and deaths are much higher now than in the spring and summer and Congress has yet to pass additional stimulus.

From the Department of Public Health & Environment's COVID-19 dashboard [33], as of Dec. 18, 2020, Colorado has reported 4,368 coronavirus-related deaths since the beginning of the pandemic. Of those, 1,171, or just over one in four, happened in the three-week span between Nov. 16 and Dec. 6. In the worst three weeks of the spring wave, 697 people were counted in the coronavirus toll. The week ending Nov. 29 was the deadliest of the pandemic, as Colorado recorded the deaths of 442 people who had COVID-19. In addition, since the enactment of the Coronavirus Aid, Relief, and Economic Security (CARES) Act on March

[33] https://covid19.colorado.gov/data

27, 2020, and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act on April 24, 2020, no additional stimulus relief for individuals, businesses, or providers has been forthcoming from the federal government while the state's unemployment rate as reported by the Department of Labor and Employment in its October 2020 quarterly report was at 6.4%.[34]

There are components of the Department's R-19 budget request that can be implemented without the declaration of a fiscal emergency. Specifically, the reduction to the Pediatric Specialty Hospital line item and the reduction to the Screening, Brief Intervention and Referral to Treatment training grant program. Pursuant to article 10, section 21(7) of the Colorado Constitution, repurposing the Primary Care Fund to offset costs in the Colorado Medical Assistance program requires a declaration of a fiscal emergency. Historically, using Primary Care Fund as the state share for supplemental Medicaid payments has only been done after the declaration of a fiscal emergency.

PROVIDER RATES

31. **[Sen. Rankin] Is there a correlation between private insurance rates and Medicaid enrollment? As Medicaid enrollment increases, are the low provider rates paid by Medicaid causing a cost shift to private insurance?**

RESPONSE

There is no compelling empirical evidence of any significant cost shift between Medicaid reimbursements and private insurance premiums. The most comprehensive literature review on this topic concluded that "Policymakers should view with a degree of skepticism most…claims of inevitable, large-scale cost shifting….[A]s a whole, the evidence does not support the notion that cost shifting is both large and pervasive."[35] In fact, there is evidence that reductions in public payments to hospitals actually **reduce** rates paid by private insurance—which is the exact opposite of the conventional cost shift argument—because lower public reimbursement rates may induce hospitals to make improvements in their operational efficiency that have "spillover" effects in the private insurance market.[36]

The potential for cost shifting to impact private insurance premiums is likely to be small compared to the more important influence of the relative market power of hospitals and private insurance carriers.[37] And continuing trends towards consolidation in the hospital market are likely to increase their market power and ability to charge private insurance carriers' higher prices.

The Department sees no evidence suggesting that higher Medicaid enrollment leads to higher private insurance premiums. Pueblo county, for example, has 40% of its population enrolled in Medicaid or CHP+ but its ACA marketplace premiums are the lowest in the state at $329 per month. On the other hand, Northern

[34] https://www.colmigateway.com/vosnet/lmi/default.aspx
[35] Frakt AB, "How Much Do Hospitals Cost Shift? A Review of the Evidence," The Milbank Quarterly, 2011;89(1):90-130.
[36] White C, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," Health Affairs, 2013;32(5):935- 943.
[37] Frakt AB, "How Much Do Hospitals Cost Shift? A Review of the Evidence," The Milbank Quarterly, 2011;89(1):90-130.

Colorado counties (Larimer, Weld, and Boulder) have higher premiums than Teller, El Paso, and Pueblo counties, but the Northern Colorado counties have lower Medicaid enrollment.[38]

The need to cost shift is a widespread argument used by hospitals in the defense and negotiation of their commercial prices, but Department analysis repeatedly concludes that cost shifting does not explain most of Colorado hospitals' rising prices.

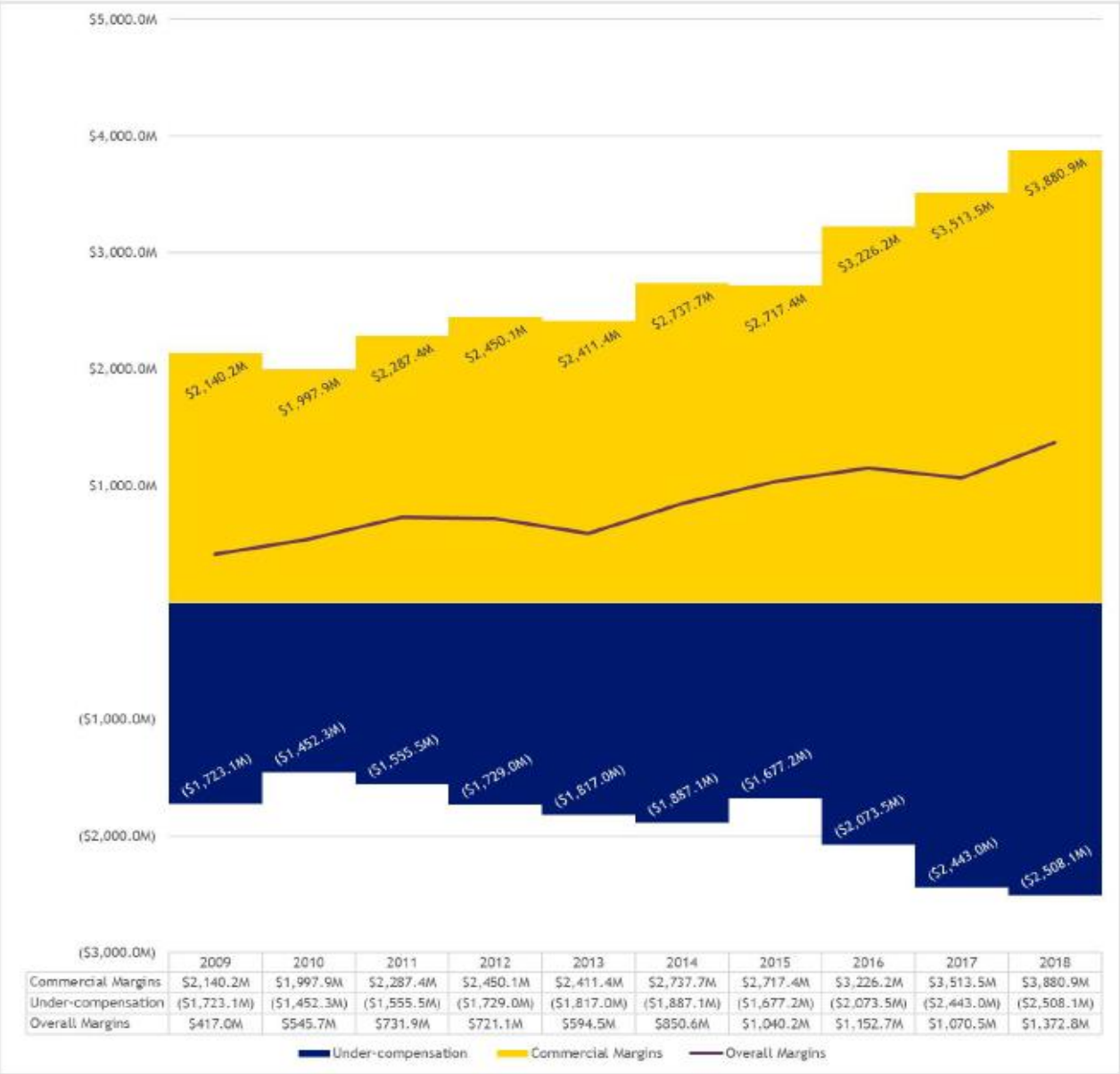
In fact, Department analyses finds that the commercial insurance "cost shift" has consistently been greater than required to offset both the Medicaid and Medicare undercompensated care. The Department considers the strategic decision made by some hospitals to increase prices as separate and distinct from an actual need to "cost shift" due to underpayments from Medicaid and Medicare.

As reported in the Department's January 2020 Cost Shift Analysis Report,[39] following the implementation of the Affordable Care Act (ACA), Colorado hospitals' profits from their commercial patients have grown each year and are far more than needed to cover the undercompensated care for Medicaid and Medicare patients. As shown in yellow in figure 4 from the Cost Shift Analysis report below, for each of the most recent four years, hospitals' commercial margins are more than $1 billion greater than needed to cover the cost of undercompensated care from Medicare, Medicaid, and self-pay/uninsured patients.

[38] Joint Budget Committee Staff . (2020, December 10). JBC Staff FY 2021-22 Briefing Department of Health Care Policy & Financing [PDF slides], slide titled: Statewide 22 percent of population was enrolled in Medicaid or CHP+ in FY 2019-20, but there was significant variations in enrollment by county. https://leg.colorado.gov/sites/default/files/fy2021-22_hcpbrf1_0.pdf. Kaiser Family Foundation. (2020, November). How ACA Marketplace Premiums Are Changing by County in 2021. https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2021/ Data source: Kaiser Family Foundation analysis of premium data from Healthcare.gov and review of state rate filings, which includes the lowest-cost premium data from the Colorado Department of Regulatory Agency. (2019, October). 2020 Individual Silver On-Exchange Plans vs. Off Exchange Substantially Similar Silver Plans Retrieved from www.colorado.gov/dora/health-insurance-plan-filings-and-approved-plans.

[39] https://www.colorado.gov/hcpf/colorado-cost-shift-analysis

Figure 4: Cost Shift[34]



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Commercial Margins	$2,140.2M	$1,997.9M	$2,287.4M	$2,450.1M	$2,411.4M	$2,737.7M	$2,717.4M	$3,226.2M	$3,513.5M	$3,880.9M
Under-compensation	($1,723.1M)	($1,452.3M)	($1,555.5M)	($1,729.0M)	($1,817.0M)	($1,887.1M)	($1,677.2M)	($2,073.5M)	($2,443.0M)	($2,508.1M)
Overall Margins	$417.0M	$545.7M	$731.9M	$721.1M	$594.5M	$850.6M	$1,040.2M	$1,152.7M	$1,070.5M	$1,372.8M

Moreover, 2019 data as reported in the draft 2021 CHASE Annual Report[40] shows that Medicaid has been consistently reimbursing hospitals at or above Medicare reimbursement since the hospital provider fee was first implemented in 2010. Tables 16 and 17 from that report show that Medicare has reimbursed 70 or 72 cents on the dollar of costs while Colorado Medicaid has reimbursed 77 and 75 cents on the dollar in the last two years. In addition, data in that report shows that 2019 was another year of greater than $1 billion in profits for hospitals.

[40] https://www.colorado.gov/sites/default/files/2021 CHASE Annual Report DRAFT.pdf

Table 16. Payment to Cost Ratio

Year	Medicare	Colorado Medicaid	Insurance	CICP/Self Pay/Other	Overall
CY 2009	0.78	0.54	1.55	0.52	1.05
CY 2010	0.76	0.74	1.49	0.72	1.06
CY 2011	0.77	0.76	1.54	0.65	1.07
CY 2012	0.74	0.79	1.54	0.67	1.07
CY 2013	0.66	0.8	1.52	0.84	1.05
CY 2014	0.71	0.72	1.59	0.93	1.07
CY 2015	0.72	0.75	1.58	1.11	1.08
CY 2016	0.71	0.71	1.64	1.08	1.09
CY 2017	0.72	0.72	1.66	0.85	1.07
CY 2018	0.70	0.77	1.70	0.88	1.09

Table 17. Payment to Cost Ratio, Post H.B. 19-1001

Year	Medicare	Colorado Medicaid	Insurance	Self-Pay	CICP/ Other	Overall
CY 2019	0.72	0.75	1.85	0.26	0.71	1.07

32. [Sen. Hansen] Only one of the provider rates reviewed this year by the MPRRAC resulted in a budget request. Why? Does the Department have plans to address the other recommendations from the S.B. 15-228 process in a future year?

RESPONSE

The Department's recommendations are detailed in the Department's annual Medicaid Provider Rate Review Recommendation Report based on its evaluation in the annual Medicaid Provider Rate Review Analysis Report, as well as stakeholder and MPRRAC feedback.

In past years, all of the Department's fiscal recommendations had a corresponding budget request. This fiscal year required unique pandemic-related fiscal considerations by the Department, and as such, only fiscal recommendations resulting in budget savings were included in the Department's FY 2021-22 R-16, "Provider Rate Adjustments" budget request.

As indicated in the Department's 2020 Medicaid Provider Rate Review Recommendation Report,[41] the Department will consider these fiscal recommendations for future budget requests, as noted in:

- Speech therapy recommendation 1:

[41] https://www.colorado.gov/sites/default/files/HCPF 2020 MPRR Recommendation Report_final_nov6.2020.pdf

    - page 5, footnote 10
    - page 17, footnote 43
- Physical and occupational therapy recommendation 1:
    - page 6, footnote 16
    - page 18, footnote 52
- Prosthetics, orthotics, and supplies recommendation 1:
    - page 6, footnote 18
    - Page 19, footnote 55
- Vision recommendation 1:
    - page 6, footnote 20
    - Page 20, footnote 58

33. [Sen. Rankin] Why is the Department continuing to bring back rate change recommendations that were denied by the JBC in the past? Is this part of the process that anything denied comes back?

RESPONSE

The Department provides evidence-based conclusions after conducting extensive analysis and public engagement, as detailed in its annual Medicaid Provider Rate Review Analysis Report. This report, and stakeholder and Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback, inform evidence-based recommendations in the Department's annual Medicaid Provider Rate Review Recommendation Report.

The Department does not have a policy to always bring back requests that were denied by the JBC. The Department makes case-by-case decisions that are based on the strength of the evidence, stakeholder input, equity, the fiscal environment, and other factors. The Department is committed to continued efforts to implement evidence-based fiscal recommendations, as well as to promote provider payment equity within and across services. The Department understands that considerations within any particular fiscal and legislative year may change over time, and additional opportunities to advance recommendations may exist in future years when they did not in past years.

These Department commitments are of particular importance to stakeholders and the MPRRAC, particularly this year, where more considerations and limitations exist than in most years. The commitment to continue efforts to implement evidence-based recommendations is valued by many, as was shared during multiple public meetings this year. It also honors stakeholder and MPRRAC feedback, and Department perspectives on how to improve provider payments and retention, and member access to quality care, that have proven to remain stable over time and cycles of review; the Department may continue to receive the same feedback, be asked to take action to address it, and be held accountable.

34. [Sen. Moreno] What is the process between an MPRRAC recommendation and a related budget request? Why do some recommendations get included in the budget request but not others?

RESPONSE

The Department provides evidence-based conclusions after conducting extensive analysis and public engagement, as detailed in its annual Medicaid Provider Rate Review Analysis Report. This report, and stakeholder and Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback, inform evidence-based recommendations in the annual Medicaid Provider Rate Review Recommendation Report.

In past years, all of the Department's fiscal recommendations had a corresponding budget request. This fiscal year required unique pandemic-related fiscal considerations by the Department, and as such, only recommendations resulting in budget savings were included in the Department's FY 2021-22 R-16, "Provider Rate Adjustments" budget request. As indicated in the Department's 2020 Medicaid Provider Rate Review Recommendation Report,[42] and in earlier responses, the Department will consider budget-positive fiscal recommendations for future budget requests.

35. **[Rep. McCluskie] Is the S.B. 15-228 process working? What has it achieved? Could it be improved?**

RESPONSE

The SB 15-228 rate review process adds immense value and is concluding its first five-year rate review cycle. As with any new process, or process in general, improvement is vital and ongoing. As mentioned in the briefing, prior to SB 15-228, the rate review process was not as transparent and there was not a set review of all rates on a schedule. Policymakers may have heard from provider groups with lobbyists, rather than through an evidenced-based approach reviewing all rates on a schedule.

Rate Review Process Value

The rate review process was created in 2015 as outlined by SB 15-228, which created a standardized process to regularly review services that did not already have an existing review process. It has been a positive contribution to the Department's systematic review of provider rates. This process provides a transparent, consistent, and evidence-based approach to comprehensively evaluate access to quality care, sufficiency of provider rates, and provider retention, and results in fiscal and non-fiscal recommendations. A primary goal of the rate review process is to increase equity of rates within and across services covered by Colorado Medicaid, while also improving access to and quality of care. The rate review process has resulted in many positive changes that improved access and created equity in reimbursement across services. The rate review process helps the Department identify rates, policy, and program priorities, and assists the JBC in identifying how to appropriate funds.

Comprehensive data analyses are informed by stakeholder and MPRRAC feedback, which is evaluated and in turn informs Department conclusions and recommendations. It is a highly transparent public process in which any person may provide feedback. Stakeholder and MPRRAC feedback are valued and equally

[42] https://www.colorado.gov/sites/default/files/HCPF 2020 MPRR Recommendation Report_final_nov6.2020.pdf

important. Feedback is captured in meeting recordings, meeting minutes, on the Department's meetings page, and in the Departments' Medicaid Provider Rate Review Analysis reports and Medicaid Provider Rate Review Recommendation reports, all of which are publicly available on the Department's website. Feedback offers insight and thoughtful, diverse perspectives that span numerous types of providers, advocates, members, and other stakeholders, which is fruitful to the rate review process as a whole.

Several important changes have been made to rates as a result of the process:

- Maternity rates received targeted rate increases after maternity rates were identified, in aggregate, as 69%of the benchmark, with some rates ranging as low as 30%.
- Anesthesia rates were reduced to 120%of the benchmark, including rates that ranged up to 1,162%of the benchmark.
- High-value home and community-based services with rates well below the benchmarks received targeted rate increases.
- Several rebalancing projects have brought rates within 80-100%of the benchmark, bringing equity to rates within and across services.
- Rate and benefit changes to Non-Emergent Medical Transportation (NEMT) and Emergency Medical Transportation (EMT) services have improved transportation services, to include targeted increases for rates well below the benchmark; the creation of the urgent transportation benefit effective in 2020, which bridges the gap in emergent and non-emergent transportation; and creation of an EMT Supplemental Payment program that allows eligible providers to receive an annual supplemental payment for the uncompensated costs incurred by ground or air emergency medical transportation services.

The Department has a rate setting process to determine individual rates for specific services. This process can be initiated in response to the Medicaid Provider Rate Review Recommendation report, Department staff requests, or stakeholder requests or expressed concerns. This is particularly useful when evaluating an individual rate or small subset of rates, when evaluation of a broad service grouping is unnecessary. Historical documentation of how rates are set is now recorded, which captures the rate setting process and supports standardized rate setting processes.

Opportunities for Process Improvement

The Department identified opportunities for improvement in its FY 2020-21 budget request R-8, "Accountability and Compliance Improvement Resources," including 1.0 FTE to conduct additional evaluation and qualitative research and increased contracting funds to conduct more surveys and studies (e.g., cold call studies) that would have supplemented the Department's data analysis. 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 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 five-year rate review

schedule can be changed by either the MPRRAC or the JBC any time before December 1 each year. This can lead to schedule change requests that conflict with MPRRAC or JBC votes, as well as stakeholder feedback. Sole authority for schedule changes by either the JBC or MPRRAC would prevent this possibility. In the past, the Department, with the approval of the MPRRAC, has set the schedule, taking into consideration how services and service groupings relate to one another, in addition to stakeholder requests and stakeholder feedback. The December 1 deadline results in having a separate JBC briefing in November of each year, before the Department's JBC briefings in December. Changes made to the schedule at the November briefing would require additional work for the Department and upend the rate review schedule that was discussed and approved via a collaborative public process. Any changes to the schedule authority would require a statute change.

The MPRRAC is a non-partisan 24-person 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. Any changes to the appointment process would require a statute change. Several concerns have been voiced to the Department by MPRRAC members over the years such as the timeliness of appointments and ensuring expertise on the committee is representative. The MPRRAC is scheduled to sunset in 2025; legislative action would be needed for the MPRRAC to continue beyond 2025. If the MPPRAC were to continue beyond 2025, the value noted above would continue. The Department acknowledges how critical stakeholder input is to the rate review process; the Department would continue to hold quarterly public meetings and to solicit stakeholder feedback if the MPRRAC does not continue, which is in line with the statute and would require maintaining staff to ensure ongoing stakeholder engagement. The Department would also reallocate the administrative time devoted to committee management activities to targeted stakeholder recruitment for greater participation in public meetings so that invaluable input from providers, advocates, and other stakeholders could be further promoted within each year of review.

36. [Rep. Ransom] Why use Medicare as the benchmark for lab testing rates and why target 80 percent of Medicare rates?

RESPONSE

The rate review process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process helped inform the Department's payment philosophy for fee-for-service (FFS) rates.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare; however, there are four primary situations where Medicare may not be an appropriate model when comparing a rate, including, but not limited to:

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., private duty nursing services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g., pediatric personal care and pediatric behavioral therapies).

3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar (e.g., home health services).
4. There is a known issue with Medicare's rates.

When Medicare is not an appropriate comparator, the Department may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While the Department views payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below, must be considered when setting or changing a rate. These include:

- Budget constraints that may prevent payment at a certain amount;
- Investigating whether a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies;
- Identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and
- Developing systems to ensure that payments are associated with high-quality provision of services.

When the rate review process indicates a current rate does not align with the Department's payment philosophy, the Department may recommend or implement a rate change. It is also important to note that the Department may not recommend a change, due to the considerations listed above.

The Department's payment philosophy is included in the Department's annual reports, to include the 2020 Medicaid Provider Rate Review Analysis report[43] and the 2020 Medicaid Provider Rate Review Recommendation report.[44]

BEHAVIORAL HEALTH

37. **[Sen. Rankin] There has been a lot of discussion about integrating physical and behavioral health. Please provide an update on the Prime program and similar integrated approaches. Have they saved money?**

RESPONSE

In 2015, the Center for Medicare and Medicaid Innovation (CMMI) awarded the State of Colorado up to $65 million in the form of a cooperative agreement to implement its State Healthcare Innovation Plan, in support of the goal to integrate behavioral and physical care, care coordination and care management. The state's proposal and planning process was structured to ensure the statewide model would be comprehensive and sustainable. This model was developed to address the Quadruple Aim to improve patient experience (both the quality of and satisfaction with care), improve population health, reduce and avoid health care costs, and

[43] https://www.colorado.gov/sites/default/files/2020 Medicaid Provider Rate Review Analysis Report.pdf
[44] https://www.colorado.gov/sites/default/files/HCPF 2020 MPRR Recommendation Report_final_nov6.2020.pdf

improve the work life of providers. In its initial proposal, the Colorado State Innovation Model (SIM) proposed to include a return-on-investment (ROI) analysis as part of the final evaluation. Milliman, an actuarial firm, was contracted to conduct these analyses. At the time of the SIM proposal, Milliman estimated that the model would save or avoid $127 million with the investment of up to $65 million, equaling an ROI of 1.95. The September 2020 report, including the Milliman July 2020 findings concluded that: "Overall the results presented in the report show an ROI of 2.00, which exceeds the targeted return of 1.89." This 2:1 return on investment clearly shows a savings from integration across the industry, aligned with the goals of integration at the federal and state levels.

The Department is committed to moving toward more coordinated and integrated models of care that improve member health and reduce costs. This work is pursued at multiple levels, from improved administration to alternative financing to individual benefit policies. The most critical of these is the launch of the Accountable Care Collaborative Phase II, through which the Department integrated care coordination and care management. This was accomplished through a multiple year transition to the Regional Accountable Entity structure, and away from the unintegrated BHO/RCCO structure. This transition brought Medicaid into structural alignment with the commercial industry, which also continues to integrate its behavioral health and physical health care support offerings. This is further concurrent with the care delivery system which has also benefited from SIM grant dollars to integrate medical and physical services to the benefit of Coloradans and with a goal of treating the whole person. Also as part of the ACC Phase II work, the Department enabled members to receive a limited number of fee-for-service short-term behavioral health services within the primary care setting.

Rocky Mountain Health Plans (RMHP) Prime is responsible for reimbursing these short-term behavioral health services for its members as the costs have been incorporated into their capitation payment. By supporting the delivery of early interventions in a convenient location for members, the Department seeks to increase member access while also preventing the exacerbation of both medical and behavioral health conditions and to treat them in the most efficient manner. The Department is seeing continued increases in utilization of these short-term behavioral health services and is in the process of analyzing the impact of this policy.

In accordance with statute, RMHP Prime's capitation rates are set at or below what the same population would cost under a fee-for-service arrangement. Based on currently available data, it is not clear whether RMHP Prime provides additional cost savings than those achieved through rate setting. The Department does look at other metrics to assess the performance of RMHP Prime. During FY 2018-19, RMHP Prime increased member engagement in behavioral health services and exceeded the benchmark for performance on management of diabetes and providing follow up care after a positive depression screen.

The Department has been working with the health plans to establish and improve the systems and tools for sharing and analyzing member claims data. This work has included creating a Clinical Risk Stratification Dashboard based primarily on fee-for-service claims data to help RAEs identify members who are most vulnerable so they can implement a continuum of evidence-informed and integrated care coordination resources and condition management programming. Over the past year, the Department has also created a dashboard to analyze the RAEs' behavioral health utilization trends based on their managed care encounter

data. Furthermore, the Department is working with RMHP Prime to analyze and monitor utilization trends within its managed care encounter data. The next step is for the Department and health plans to combine these different data sets to establish a more comprehensive analysis of how utilization in one area may be impacting costs and utilization in another area.

In addition, the Department has established multiple mechanisms to engage with the health plans in order to monitor performance, review trends, discuss and disseminate best practices, and design programs and policies to better meet the changing health care priorities of members, the Department, and the state. Some examples of these mechanisms include quarterly meetings between the executive leadership of the Department and health plans, monthly Program Improvement Advisory Committee meetings of stakeholder representatives, monthly learning collaboratives with all of the health plans and Department staff to share lessons learned, and monthly data review meetings with each of the health plans individually. Lastly, the Department and auditors meet quarterly with each individual health plan to ensure state funds are being appropriately utilized for member services and case management activities. The Department is working to coalesce the different information gathered through all of its mechanisms to better report and share relevant information to the General Assembly and other interested parties.

The Department has helped to lead the work of the Behavioral Health Task Force, taking leadership roles at the Executive Steering Committee level and on all four committees, which created the blueprint recommendation released earlier this year. In all blueprint recommendations, the maintenance of the integration of physical and behavioral care is a firm, fundamental mandate so the strides that have been made nationally and in Colorado continue. This includes reducing the stigma around behavioral health care, improving access and care support for behavioral health care through integration, treating the whole person and improving the affordability of health care. Future work associated with the blueprint recommendations is intended to build upon and strengthen the integration of behavioral and physical health care inside Medicaid as well as the commercial insurance industry. The Department is firmly aligned with this objective. All of our systems, care delivery payments, care coordination and support programs, and staffing and leadership have been integrated through a decade of effort, commitment and investment of state and federal dollars. This firm position of integration maintenance also aligns with the commitments the Department and the state made to CMMI when it accepted the $65 million SIM grant and with the rest of the nation. Last, it aligns with the commercial insurance industry to ensure consistency in best-practices across payers here in Colorado and nationally.

38. **[Rep. Herod] What is the Department doing to ensure that people continue to have access to needed behavioral health services during the pandemic? How is the service delivery model changing and what pandemic-related service gaps are most concerning?**

RESPONSE

The Department took several steps to ensure that members have continued access to behavioral health services during the public health emergency. Regional Accountable Entities (RAEs) were granted the flexibility to expand the utilization of telemedicine, increase use of value-based payment strategies, and intensify outreach and engagement of high-risk members. The Department is also implementing the Inpatient

and Residential Substance Use Disorder (SUD) benefit effective Jan. 1, 2021, adding an important component to our continuum of behavioral health support services.

To protect our members from COVID-19 exposure, while increasing access to behavioral health therapy, the RAEs worked with their providers to transition them to offering as many services as appropriate via telemedicine, including audiovisual, telephone, and live chat modalities. The RAEs also implemented value-based payment strategies with safety net providers to enable them to retain the full continuum of essential behavioral health services throughout the pandemic while offsetting some losses associated with decreased utilization. These payment strategies supported Community Mental Health Centers in implementing innovative programming such as providing prepaid cell phones, delivering food to members, connecting members in homeless shelters to services, and addressing anxiety and depression among people being screened for COVID-19.

The Department also sent the RAEs a list of high-risk members to outreach. The RAEs developed engagement strategies for these high-risk members as well as outreached their members who rely on behavioral health services to maintain recovery and well-being. The RAEs collaborated with their behavioral health providers to proactively engage these members to develop safety plans; to make service accommodations, such as telemedicine, that maintain supports and services; and to monitor the well-being of their members.

The delivery model is shifting to rely more on providing services via telemedicine. Members and providers have gotten more proficient in using telemedicine and providers are reporting a dramatic decrease in no-show rates for behavioral health services as a result. Furthermore, members appreciate the convenience and some find that telemedicine is less intimidating than an in-person visit. Telemedicine has become an outstanding tool in our quest to sidestep the stigma of seeking mental health and substance use disorder support. For decades this stigma has inappropriately and dangerously impeded Coloradans from accessing available behavioral health support. Simply put, telemedicine enables a member to more privately engage in needed and valuable therapy.

Each phase of the pandemic has generated unique challenges that have required different responses from the health care system. As a result, we are still learning where gaps may be occurring along the continuum. That being said, we have heard anecdotally about challenges that arose when members began seeking inpatient behavioral health treatment again in the summer and early fall. Members may have delayed treatment for inpatient level of care so that when they finally accessed services they were displaying a higher level of acuity and complexity that required longer lengths of stay. The Department is partnering with the RAEs and other stakeholders to monitor and understand this situation in order to identify opportunities for intervention.

39. **[Sen. Moreno] How do the impacts of reduced substance use disorder treatment capacity (under COVID-19) affect reimbursements from the Department of Human Services and Health Care Policy & Financing? Please describe any funding that these departments have made available to providers to address this reduced capacity.**

RESPONSE

The Department of Human Services and the Department of Health Care Policy & Financing (Department) follow different state and federal rules and regulations regarding reimbursement policies. The Department has less flexibility than the Department of Human Services because they can fund providers and invest in infrastructure and capacity building. The Department is only allowed to pay for direct services to an enrolled member.

However, the substance use disorder benefit is operated through a managed care program administered by the Regional Accountable Entities. The managed care model provides the Regional Accountable Entities with some inherent flexibility in how they reimburse providers.

With the onset of COVID-19, the Department encouraged the Regional Accountable Entities to establish value-based payment arrangements with safety net behavioral health providers, such as the Community Mental Health Centers. Through value-based payments, the Regional Accountable Entities could promote providers in retaining the full continuum of essential behavioral health services throughout the pandemic while offsetting some losses associated with decreased utilization. To the extent Community Mental Health Centers provide services for substance use disorders, value-based payments have allowed them to be innovative in meeting members' health care needs.

Concurrently, the Department of Human Services' Office of Behavioral Health has implemented a number of policies to minimize the impact of COVID-19 on its providers, including:

- Amending all Managed Service Organization contracts to guarantee the full payout of the annual contract value and a steady cash flow.
- Allowing Managed Service Organizations to reimburse costs for an entire set of COVID-19-related expenses including: labor costs and premiums including retention bonuses and hazard pay for frontline staff, PPE, cleaning services and supplies, telehealth enabling technology, additional security for opioid treatment providers, and infection control training.
- Providing contractual budget flexibility in how Managed Service Organizations may shift funding between areas of their contracts to meet shifting needs related to COVID-19, i.e., underutilized funds in one program can be shifted to cover overutilization in another area, such as detox/withdrawal management to residential services.

40. [Sen. Rankin] How do we reconcile that Medicaid is an entitlement but the substance use disorder provider capacity does not exist? How are clients supposed to get the service?

RESPONSE

Starting Jan. 1, 2021, the Department will provide members with access to a full continuum of substance use disorder services, including residential, inpatient and withdrawal management services. The Department has collaborated with the Office of Behavioral Health, Managed Service Organizations, Regional Accountable

Entities, providers and advocates on the implementation of the new substance use disorder services. The Department is aware that there is a high demand for the new inpatient, residential and withdrawal management services, and that COVID-19 has increased that demand for services while at the same time challenging the capacity of providers to deliver these services. As with all Medicaid services, access to services is dependent on provider availability, even though it is an entitlement program. An entitlement program means the Department is responsible for paying for all covered services.

That being said, in an effort to meet increasing demand and better serve members, the Department and the Office of Behavioral Health have adopted the American Society of Addiction Medicine (ASAM) criteria to determine the most appropriate level of care for individuals requiring treatment for a substance use disorder. When using ASAM criteria, outpatient treatment is more often indicated for people than residential or inpatient treatment. The Regional Accountable Entities, and the Behavioral Health Organizations before them, have been administering a robust continuum of outpatient substance use disorder services for years, ranging from group therapies and peer support services to intensive outpatient services. If a particular level of care is not available for a member, the Regional Accountable Entity can leverage its continuum of outpatient and care coordination services to wrap around a member until the appropriate level of care becomes available.

The Department will continue collaboration with the RAEs and the Office of Behavioral Health to monitor the utilization of the benefit, troubleshoot problems that arise during implementation, build capacity for additional services where needed and improve care coordination for members with substance use disorders. As the RAEs implement the new services, they will pay particular attention to identifying where additional resources and providers may be needed. Once identified, they will work with the Department and the Office of Behavioral Health to thoughtfully develop additional capacity that meets Medicaid and quality requirements. Under the Hospital Transformation Program, there is also dedicated funding for hospitals in rural and frontier counties to invest in operational changes to better meet the needs of their communities, which can include expanding capacity for inpatient and residential services and making unused beds available for inpatient substance use disorder treatment.

As we move through the process of implementing this important benefit, the Department can also keep the Joint Budget Committee and General Assembly informed of critical updates. The Department will use the regular budget process if needed to account for changes in capacity.

41. **[Rep. McCluskie] How many providers are approved to provide the new substance use disorder benefit? Please describe the process to get enrolled as a substance use disorder provider and estimate both the administrative workload for the provider and the average time from the start of the process to approval. Given the capacity concerns, is there anything the Department can do to expedite the process and/or reduce the administrative burden on providers while protecting client safety?**

RESPONSE

The new Substance Use Disorder (SUD) benefit will allow Medicaid to reimburse providers for inpatient, residential and withdrawal management SUD services. To be eligible for reimbursement for the new services,

providers must be enrolled in Medicaid with their American Society of Addiction Medicine (ASAM) level of care license from the Office of Behavioral Health (OBH).

Currently, 30 providers are enrolled in Medicaid with the capabilities of providing inpatient and residential SUD services. These providers need to update their Medicaid provider enrollment record with their ASAM level of care. The following steps are required for a provider to update their provider enrollment record in the Medicaid Management Information System (MMIS):

- Ensure their National Provider Identifier (NPI) is updated.
- Submit a Provider Maintenance Request to add a Specialty Provider Type based on the provider's ASAM level of care.
- Upload their new Office of Behavioral Health ASAM level of care license

Many providers have started the process and have reported some technical difficulties, such as delays in receiving an NPI or problems with their OBH license. Once the Department identified providers were struggling, the Department put the following strategies in place to expedite the process and to support providers.

- All applications for SUD clinics have been expedited and, as of Monday, Dec. 14, all of them have been reviewed and assessed for next steps by our fiscal agent.
- The Department and our fiscal agent partners are pulling a daily list of any pending SUD clinic applications to monitor their progress, so the applications will continue to be prioritized.
- The Department is requesting a daily list of SUD clinic approvals to ensure the right applications are being processed.
- The Department has partnered with OBH, the Managed Service Organizations (MSOs) and private billing agencies to further identify problems and to outreach providers to move them through the application process.
- The Department has scheduled two Open Office Hours and invited providers to attend and have their questions answered.

A complete application should be approved in less than one week. Four providers have completed the process as of Dec. 18, 2020

The Department has also implemented value-based payments through the Hospital Transformation Program to encourage the expansion of inpatient substance use disorder treatment and services from our hospital partners.

42. **[Sen. Moreno] Compare the assumptions by the Department of Human Services and the Department of Health Care Policy & Financing about the number of people who will need room and board expenses for the substance use disorder benefit. Is the requested funding for the Department of Human Services sufficient to pay for the room and board expenses for Medicaid clients? What if the assumptions are incorrect? Will the capped appropriation for room and board in the Department of Human Services indirectly act as a limit on how many Medicaid**

clients can access the substance use disorder benefit, or do the departments have some other plan to move money around between services if utilization is higher than expected?

RESPONSE

The Department of Human Services' Office of Behavioral Health (OBH) and the Department of Health Care Policy & Financing (the Department) took different approaches to project the costs for substance use disorder treatment, including the number of people who will utilize the new Medicaid residential benefit and incur room and board costs. Room and board costs are eligible for Medicaid reimbursement in inpatient or institutional settings but are not eligible for Medicaid reimbursement in residential settings and would need to continue to be paid for by OBH. The utilization assumptions of the departments are aligned assuming OBH continues to pay the status quo room and board rate of $67 per day. Therefore, the requested funding for OBH is sufficient to pay for room and board expenses for Medicaid members.

OBH projects that 210 beds, or 75% of the 280 beds currently funded by OBH in residential facilities, will shift to Medicaid for the treatment costs and OBH will continue to pay room and board. This is based on historical utilization of the benefit for providers that contract with the Managed Service Organizations (MSOs). To meet its current budget target and not cut current services, OBH requested a reduction of $11.4 million in FY 2021-22 R-7, "Substance Use Treatment," in anticipation that the treatment costs for Medicaid-eligible individuals utilizing those beds would shift to Medicaid. OBH currently pays MSOs $67 per day for room and board, a price that has been flat for several years. OBH had considered higher rates for room and board (e.g., $100 per day) for those 280 beds due to concerns that the $67 per day rate is insufficient to maintain provider participation.

The Department is anticipating more providers will contract with the Regional Accountable Entities (RAEs) than are currently contracted with the MSOs, now that residential treatment is an entitlement benefit covered under Medicaid. The Department's actuaries are estimating that there will be 596 total beds available for Medicaid members; of this, 71 beds would be available in inpatient or institutional settings in which Medicaid will cover room and board. Of the remaining 525 beds, the Department's actuaries are estimating there will be 374 beds available for Medicaid members in residential facilities and 151 beds available in withdrawal management settings. This estimate considers all potential licensed beds in Colorado and is not limited to the current beds used in OBH contracts. It assumes about 30% of current Colorado residential bed capacity will be utilized by Medicaid members based on a capacity study completed by the Colorado Health Institute (CHI) as well as a memo from Health Management Associates (HMA) regarding Colorado's substance use disorder capacity. The Department will be re-evaluating the capitated rates for the RAEs for FY 2021-22 in the spring with more up-to-date information on provider enrollment, which may be slower than currently anticipated.

Room and board costs for the 151 beds projected in the withdrawal management settings are already covered within DHS-OBH's budget through separate line items. At a room and board rate of $67 per day, the OBH budget would be able to cover 368 total beds in residential facilities (210 currently funded beds plus 158 additional beds assuming higher utilization of Medicaid members). In many cases, the Medicaid rate

combined with the OBH room and board rate is on average slightly higher than the current rate accepted by most MSO providers.

If utilization of the SUD benefit were to exceed the Department's assumptions, it is possible that OBH funding for room and board could be inadequate. No budget shortfalls are anticipated, but both departments will closely monitor utilization and use the normal budget process to address potential issues.

If OBH were to increase room and board above current rates, it may not have enough funding for all 374 projected Medicaid beds in residential facilities. As the Department implements the Medicaid SUD benefit, it will gain information on provider participation and the sufficiency of the rates. The Department will use this information to assess whether future rate adjustments are warranted and could submit a related budget request.

43. **[Sen. Rankin] How will we know if administrative savings are achieved as a result of the behavioral health eligibility and claims system consolidation?**

RESPONSE

Governor Polis's Behavioral Health Task Force identified over 60 funding streams for publicly-funded behavioral health services. Identifying and billing the right funding stream impacts providers' time to bill the correct program and state agency. It also impacts access as individuals struggle to navigate the system or find the appropriate service to meet their unique needs. This decision is supported by a November 2016 Office of State Planning and Budgeting behavioral health funding study.[45] One of the primary recommendations was that the Office of Behavior Health (OBH) should work with the Department to significantly reduce or eliminate the payment of indigent client funding to Community Mental Health Centers (CMHCs) for individuals who are Medicaid eligible and enrolled. By consolidating eligibility and claims payments systems between OBH and the Department, it will help to eliminate these duplicative payments. This same report identified that the requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to members.

This request would reduce unnecessary burden on providers by consolidating eligibility for programs into a single structure using the Colorado Benefits Management System (CBMS), which will reduce fragmentation for members attempting to find resources for themselves or family members, and streamline billing and reimbursement for providers using the Department's billing system. Decreasing unnecessary administrative burden will not generate savings, but it can enable existing resources within the system to go further, enable state resources to be used more effectively, and potentially enable a greater percent of allocated resources to be spent on care (provider reimbursement) versus administration.

As a result of this effort, OBH and the Department will be able to report on cost, quality and outcomes for the behavioral health system. By leveraging the Department's existing systems and contractors, there are

[45] https://www.colorado.gov/cdhs/BHneeds2020

efficiencies to be gained instead of building, testing and rolling out all new systems to manage these behavioral health services. Consolidating data and enhanced analytics will allow for uniform reporting of the 60 funding streams that are supported with state funding as well. This is a significant step in improving insights to the pending Behavioral Health Administration in their quest to make continual, incremental improvements in Colorado's behavioral health system for years to come.

This consolidation Colorado's behavioral health program administration into the Department's administration structure enables the state to leverage the investments associated with our budgeted $950 million behavioral health spend to the betterment of much smaller programs that would face significant budget and technical challenges to implementing these improvements. This collaborative alignment of program administration also enables downstream benefits, like leveraging the RAE contracts or the same value-based reimbursements to align shared goals and interests across the industry, driving meaningful change to the betterment of prevention, health outcomes, system improvements, and affordability goals.

Maximizing the Department's administrative systems is just one of the many ways the Department is stepping up to be an active leader in the implementation and operations associated with the Behavioral Health Task Force Blueprint recommendations.

44. **[Sen. Rankin] Please respond to the JBC staff suggestion that maybe R23 Behavioral health eligibility and claims system consolidation should be phased or delayed to allow better analysis of the full scope of the work required. This seems like a great application of Agile. Is the Department using that software development methodology for this project? What are the things the Department would do first (the low hanging fruit)? Could the eligibility consolidation and the billing consolidation be separated into two projects? Provide a plan discussing these aspects of the project and process.**

RESPONSE

The implementation of the system changes will be a multiple phase project. The Department uses Agile, Waterfall, and a combination of the two system development lifecycles as needed. The eligibility consolidation and billing consolidation have been separate projects since they are implemented in separate systems. However, the implementation is integrated since the data must be exchanged between the systems. The high-level phases of the project include conducting an analysis of all of the eligibility requirements across programs for eligibility system (CBMS) changes, streamlined access for provider enrollment into the Department's claims processing system (MMIS), and developing and implementing requirements in the MMIS for benefits, providers, and services. For example, implementing the program eligibility within CBMS would be the first system implementation. This would allow providers to help determine if the patient is covered under Medicaid or another of the behavioral health programs. The high level requirements are known; however, a detailed project plan for each system that will be modified has not yet been developed.

45. **[Sen. Rankin] Please describe the involvement of the Joint Technology Committee and the Office of Information Technology with this project and the coordination of this project with the request from the Department of Human Services? What review has occurred to date, what is scheduled, and how has feedback received changed the planning?**

RESPONSE

As this project will leverage existing state systems, there was no capital request for a new system submitted to the Joint Technology Committee (JTC). The Governor's Office of Information Technology (OIT) will be engaged early to identify data conversion strategy and network and architecture strategy and development, as well as security reviews and approvals for data transfer and retention approval. Further, OIT will be involved in all system changes related to the Colorado Benefits Management System. The Department consulted with OIT prior to the request being released, and initiated project discussions with OIT starting in December 2020. The request was developed in collaboration with staff from the Office of Behavioral Health at the Department of Human Services. If requested by the JTC, the Department will provide updates if this budget request is approved.

OFFICE OF COMMUNITY LIVING

46. **[Rep. Herod] What is the Department doing to ensure that people continue to have access to needed long-term services and supports during the pandemic? How is the service delivery model changing and what pandemic-related service gaps are most concerning?**

RESPONSE

The Department took swift action at the beginning of the pandemic to ensure that to the extent possible, the safe delivery of services continued for members who need long-term services and supports. In total, the Department submitted for federal approval six amendments to our Home and Community-Based services (HCBS) waivers (Appendix K Emergency Preparedness and Response amendments, or "Appendix Ks") and five State Plan Amendments in order to provide the flexibility needed to continue to offer services while also adhering to current public health measures to ensure the health and safety of our members.

Through Colorado's Appendix Ks, the Department has temporarily expanded settings where many HCBS services may be provided and allowed that such services, when feasible, may be delivered through virtual means. The alternative settings could include:

- The participant's private home;
- A provider-owned, provider-controlled or extended-family home;
- Community center or designated community gathering center;
- Hotel/paid lodging;
- Newly rented room; or
- Other residential settings.

The ability to provide certain services virtually has been well received, and the Department is working with stakeholders to develop rule changes and additional waiver amendments to make some of those changes permanent. This effort is separate from the Department's current budget request R6 to add remote supports to HCBS programs, which would relate to a different set of services.

In addition to flexibilities allowed around the location and manner of delivery of services, the Department expanded the qualifications for who may provide certain services. For instance, adults with existing legal responsibility for a member were given permission to assist in a member's care to reduce the risk of exposure to COVID-19 that occurs when an outside provider comes into the member's home.

The Department has provided and continues to provide substantial financial support to our long-term services and supports providers throughout the COVID-19 public health emergency. This support includes, but is not limited to, the following actions:

- The Department issued $14,672,320 in supplemental payments on May 22, 2020, to nursing facilities to support compliance with state emergency guidance and reporting requirements to ensure the health, safety, and welfare of residents as well as to meet critical direct care staffing needs.
- The state obtained federal approval to utilize Civil Monetary Penalty Funding for the purchase of communication devices, plastic dividers, and tents/shelters to accommodate in-person and electronic communication with residents' family members. A total of $287,394 has been paid out to 120 nursing facilities through this grant thus far.
- Retainer payments were allowed for eligible provider types that were not able to remain open during the stay-at-home order. These payments were at the full reimbursement rate even though services were not rendered to a member. The Department authorized retainer payments for the following services: Adult Day Services (Elderly, Blind, and Disabled [EBD], Brain Injury [BI], Community Mental Health Supports [CMHS], and Spinal Cord Injury [SCI] waivers), Day Habilitation (Developmental Disabilities [DD] and Supported Living Services [SLS] waivers), Day Treatment [BI], Prevocational Services, and Supported Employment/ Supported Employment-Group (DD and SLS). These payments were critical to the ongoing operation of provider agencies that were not permitted to operate at any capacity. A total of $29,021,848 has been paid out through July 17, 2020.
- In order to support these providers and ensure compliance with all state emergency guidance and reporting requirements aimed at ensuring the health, safety, and welfare of Medicaid members, the Department received approval from CMS to temporarily increase all rates for residential settings by eight percent ($6,663,900 in total funds through June 30, 2020) and all personal care and homemaking services by four percent ($8,086,054 in total funds through June 30, 2020)

To protect those most at risk, the Department also had a key leadership role in the development and ongoing efforts of the Residential Care Strike Team. The role of this team has been to mitigate the spread of COVID-19 in residential care settings, including nursing facilities, assisted living residences, intermediate care facilities for individuals with intellectual or developmental disabilities, and group homes. The cross-agency team has focused its efforts on six key areas: enforcement and education; isolation and cohorting; testing; situational awareness; staffing; and health and well-being. Outlined below are key activities and accomplishments to date:

- Completed 1,478 infection control surveys across all 1,052 residential facilities in order to assess compliance and provide technical assistance and training.
- Reviewed isolation and prevention plans for all 1,000+ residential care settings;

    - Partnered with the federal Centers for Disease Control and Prevention (CDC) to provide infection prevention support;
    - Hired additional infection preventionists to specifically support these settings.
- Implemented system-wide surveillance and outbreak testing, completing approximately 90,000 tests per week across all settings.
- Added all residential care settings to the EMResource platform for insight into critical PPE, staffing, and bed shortages.
- Launched the ConnectToCareJobs website to connect residential care settings seeking to fill open positions with available job seekers.
- Collaborated with the Staff Shortage Fusion Center to distribute $1.3 million to support residential care settings experiencing critical staffing shortages; deployed teams of Colorado National Guard to provide hands-on support to those facilities in crisis.

The Department also made every effort to keep our stakeholders informed about policy and program changes. As part of these efforts, we released a total of 40 operational memos: 11 impacting case management agencies, seven affecting residential facilities and PACE providers, and 22 impacting our HCBS providers. And since March, the Department has hosted 63 webinars tailored to unique stakeholder groups, with a total of 11,110 attendees receiving updated information as the pandemic evolved. This new form of regular engagement received positive feedback from the community and has shaped how the Department intends to engage with stakeholders into the future, even beyond the pandemic.

Though the Department made significant efforts to ensure that services continued to be available to those who needed them, the provision of services in congregate or group settings was disrupted because of the increased infection risk associated with these types of programs. Those most affected include:

- Nursing facilities (9% decrease in paid claims in August 2020 compared to August 2019).
- Day habilitation (44% decrease in paid claims in August 2020 compared to August 2019).
- Supported employment (23% decrease in paid claims in August 2020 compared to August 2019).
- Adult day (21% decrease in paid claims in August 2020 compared to January 2020; comparison to August 2019 is complicated by a rate increase that went into effect in January 2020).
- Non-medical transportation (50% decrease in paid claims in August 2020 compared to August 2019).

Through work on the Strike Team and its ongoing engagement with stakeholders, the Department continues to seek and implement ways to restore these services as quickly as possible to those who need them. All of the most affected services and programs are being analyzed, and the Department is working on providing additional flexibilities and programmatic changes to increase utilization.

47. **[Rep. McCluskie] Please describe the intended purpose of the COVID-19-related retainer payments and enhanced rates. How was the money used by providers and did it achieve the intended objectives?**

RESPONSE

The Department received approval from the Centers for Medicare & Medicaid Services (CMS) to issue retainer payments (payments to providers at the full reimbursement rate, even though services were not rendered to a member) to eligible provider types that were not able to remain open during the stay-at-home order. The Department authorized retainer payments for the following services: Adult Day Services (available on the Elderly, Blind, and Disabled [EBD], Brain Injury [BI], Community Mental Health Supports [CMHS], and Spinal Cord Injury [SCI] waivers), Day Habilitation (available on the Developmental Disabilities [DD] and Supported Living Services [SLS] waivers), Day Treatment (BI), and Prevocational Services and Supported Employment/ Supported Employment-Group (DD and SLS).

The objective of retainer payments was to help eligible providers maintain operations, including the retention of their direct care workforce during the stay-at-home order. The goal was to ensure day program providers will be in place for members after the pandemic. The payments were critical to the ongoing viability of provider agencies that were not permitted to operate in any capacity during the stay-at-home order. Through these payments, provider agencies were able to maintain operations and retain staff until they were able and allowed to operate and serve members in a more limited capacity. In fact, 93.4% of providers who received retainer payments have rendered a service after receiving such payments (i.e., from Aug. 1 onward—note that for Sept. 1 onward, claims data is still being finalized). While the Department continues to hear from providers who are struggling during the public health emergency, it does appear that these providers were able to weather the toughest months and remain open following the stay-at-home order(s).

The Department issued retainer payments to day program providers from March 13, 2020, through July 17, 2020. They were discontinued because of a CMS policy that states retainer payments cannot be made for more than three consecutive periods of 30 days. The Department received guidance on June 30, 2020, that retainer payments were required to end by July 17, 2020. The Department publicly signed on to a letter written by the Colorado Congressional Delegation asking CMS to reconsider this policy.

The Department continues to meet with members, providers, and community partners to identify opportunities to develop day program policy and reimbursement in a way that incentivizes the safe continuation of services in a manner that also is financially viable for providers. Additionally, nursing facilities, intermediate care facilities for individuals with intellectual or developmental disabilities (ICF-IIDs), and Home and Community-Based Service (HCBS) residential and personal care providers have seen increased operational costs throughout the COVID-19 pandemic, including staffing, obtaining personal protective equipment (PPE), and testing for both residents and staff. In order to support these providers and ensure compliance with all state emergency guidance and reporting requirements aimed at ensuring the health, safety, and welfare of Medicaid members, the Department received approval from CMS to temporarily increase all rates for residential settings by eight percent and all personal care and homemaking services by four percent. The enhanced rates were approved from April 1, 2020, through June 30, 2020. The enhanced rates allowed providers most impacted by the COVID-19 illness to implement necessary infection control procedures and retain critical staffing during the initial days of the pandemic.

48. **[Rep. McCluskie] Was the request to reduce funding for nursing homes developed independent of the pandemic? How do current pandemic conditions inform the discussion of the adequacy of nursing home rates?**

RESPONSE

The Department developed the R-16 request independent of the pandemic in order to achieve parity across provider reimbursement methodologies. The purpose of this component of R-16 is to rationalize provider payment methodologies. Section 25.5-6-202, C.R.S. outlines a comprehensive methodology for the Department to set nursing facility rates. This methodology requires the Department to annually adjust nursing facility rates based on changes in provider costs. As a result, the state's reimbursement for nursing facilities historically increased by approximately 3.00% each year – i.e., by an amount generally equal to the statutory cap. Last session, the Joint Budget Committee introduced HB 20-1362, which limited the annual increase in the Department-paid per diem rates to nursing facilities to 2.00% for FY 2020-21 and FY 2021-22.

No other long-term care provider in the Medicaid program receives automatic rate increases, and other than nursing facilities, no other providers in the Medicaid program receive automatic rate increases as a result of state law. Other providers that receive automatic increases, such as pharmacies, receive these increases because of requirements in federal law. Revisions to rates for other providers are subject to annual appropriation by the General Assembly.

The request to remove the automatic, statutorily mandated rate increase of up to 2.00% for nursing facilities will hold nursing facility rates constant in FY 2021-22 and beyond. Implementing the Department's request will require a statutory change to amend section 25.5-6-202, C.R.S. to remove the automatic growth factor for nursing facility per diem rates in FY 2021-22 and ongoing. It is the Department's intent that any future nursing facility rate increases would be subject to annual appropriation by the General Assembly, in line with rate increases for other providers. This change maintains the ability for the JBC to initiate increases to nursing home rates and would consider such adjustments in parallel to all other provider reimbursement adjustments.

The Department will work with its contractor to complete a reimbursement system report that analyzes the current nursing facility reimbursement system and proposes recommendations for new methodologies. Preferred options will be those that incentivize quality outcomes, evolving reimbursement methodologies from volume or census-based payments toward quality-based payments. The Department will use those recommendations to engage stakeholders through a series of meetings to obtain their feedback as well as to obtain any additional ideas they may have. This work will begin in December 2020 and will include careful analysis of any statutory, state plan, and regulatory amendments that may be needed. The Department can commit to completing the development work by July 2021 and starting implementation as soon as the development work is complete.

In response to the pandemic, the Department and the federal government have provided, and continue to provide, substantial financial and material support to nursing facilities throughout the COVID-19 public health emergency. This support includes, but is not limited to, the following actions:

- The Department issued $14,672,320 in supplemental payments on May 22, 2020 to nursing facilities to support compliance with state emergency guidance and reporting requirements to ensure the health, safety, and welfare of residents as well as to meet critical direct care staffing needs.

- The U.S. Department of Health and Human Services has issued payments from the federal Provider Relief Fund, including:
    1. May 2020 - assistance payment of $50,000/facility plus $2500/bed, for a total of $63 million for Colorado nursing homes;
    2. August 2020 - assistance payment totaling $32 million for Colorado nursing homes;
    3. October 2020 – COVID-19 incentive: $2,716,825 in payments made to Colorado nursing homes enrolled as Medicaid providers; and
    4. December 2020 COVID-19 incentive- $7,565,172 in payments made to Colorado nursing homes enrolled as Medicaid providers.
- It is anticipated that there will be three additional incentive payments issued from the federal Provider Relief Fund in 2021.
- The Department also built a job search platform, ConnecttoCareJobs.com, to assist providers in need of staffing support to connect with job seekers with related skills during the pandemic. Additionally, in collaboration with the Unified Command Center's Staff Shortage Fusion Center, $1.3 million in funding has been earmarked to support Colorado residential care facilities experiencing staffing shortages. Finally, the Colorado National Guard and clinical staff from the Alternative Care Site Shock Team have provided direct staffing support at no cost to providers.
- The State has partnered with Curative, a national leader in COVID-19 testing, to assist facilities in meeting new testing requirements outlined in Public Health Order 20-20. Through Curative, the state is providing test kits to all residential care facilities, including nursing facilities, at no cost. The kits are being used for at least weekly surveillance testing of all staff and residents who have left the building. Curative is also providing testing supplies for facilities who are testing in response to an outbreak.
- The State Emergency Operations Center has coordinated delivery of supplemental Personal Protective Equipment (PPE) to facilities at no cost since March 2020. In June 2020, the federal government began sending additional PPE to facilities.
- The state obtained federal approval to utilize Civil Monetary Penalty Funding for the purchase of communication devices, plastic dividers, and tents/shelters to accommodate in-person and electronic communication with residents' family members. A total of $287,394 has been paid out to 120 nursing facilities through this grant thus far.

While R-16 is independent of the pandemic and the right long-term policy change, the Department is indeed concerned about the pandemic's impact on the financial condition of nursing homes, assisted living facilities and our congregant settings who care for some of our most vulnerable members. Staffing shortages, increasing compliance costs, and the intensity and constant vigilance necessary to prevent COVID-19 infection and spread among adults 65 and older and other members at higher risk has created enormous challenges for our nursing home partners. This population is most vulnerable to adverse outcomes from the disease, with residents in long-term care facilities across the country accounting for 40% of all COVID-19 deaths, despite them accounting for just 0.6% of the total population in the United States.[46] And, among those

[46] Chidambaram, P., Garfield, R., & Neuman, T. (2020). COVID-19 has claimed the lives of 100,000 long-term care residents and staff. Kaiser Family Foundation. https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/.

residents who have had COVID-19, the death rate is approximately 20% compared to 3% in the general population.[47,48] Unfortunately, as Colorado has seen an increase in the number of COVID-19 cases, there has been a corresponding and startling increase in the number of outbreaks in long-term care facilities. This disproportional impact of the disease on the residents within long-term care settings has significantly affected those who care for them most directly. In the last two weeks, 323 residential care facilities have reported a critical staff shortage. These facilities reported a need for over 1,000 clinical and front-line staff to meet the current care and services required by their residents.[49] These staff shortages, coupled with the increased demands of sustaining a business in the time of COVID-19, have put immense pressure on our Medicaid providers, threatening their long-term viability.

The Department will continue to work with the community, the Joint Budget Committee, and the General Assembly to identify additional opportunities to ensure the viability of these critical providers. The Department remains dedicated to ensuring the health and safety of nursing facilities and residents during, and after, the COVID-19 public health emergency. The Department looks forward to discussing a broader and longstanding set of reimbursement policies with stakeholders.

49. [Rep. Ransom] If enrollment is capped for the Program for All-inclusive Care for the Elderly (PACE), what are the alternatives for clients? How do people access services and are there regional variations in access to alternatives?

RESPONSE

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community. An individual may have either Medicare or Medicaid, or both, to join PACE. PACE is only available in some states. To qualify for PACE, a person must: be 55 or older; live in the service area of a PACE Organization; meet nursing-home level of care; and be able to live safely in the community with help from PACE. To demonstrate that an individual can live safely in the community, the PACE program performs an assessment to verify that the individual does not require 24-hour skilled care. Accordingly, individuals enrolling into the PACE program may meet nursing facility level of care, but only require Home and Community-Based Services (HCBS). Furthermore, the Grade of Membership (GOM) model proposed and funded by the largest PACE organization in Colorado, and subsequently removed by SB 19-209, found that the people being served by PACE at entry are healthier than those presupposed by the current rate methodology, which is weighted more toward individuals requiring 24-hour skilled nursing care. In addition, the majority of individuals who disenroll from the PACE program enroll into an HCBS waiver program.

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[47] Centers for Medicare and Medicaid Services (CMS). (2020). COVID-19 nursing home data. https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

[48] Yi, S. H., See, I., Kent, A. G., Vlachos, N., Whitworth, C., Xu, K., Gouin, K. A., Zhang, S., Slifka, K. J., Sauer, A. G., Kutty, P. K., Perz, J. F., Stone, N. D., & Stuckey, M. J. ((2020). Characterization of COVID-19 in assisted living facilities- 39 states, October 2020. *Weekly, 69*(46), 1730-1735.

[49] Data retrieved from EM Resource on 12/21/2020 for the following dates: 12/3/2020/12/17/2020. EM Resources is a tool used for required reporting by nursing facilities, assisted living residences, group homes, and intermediate care facilities.

If the PACE Program enrollments reach the identified maximum, PACE organizations may only enroll individuals to replace those who have passed away or disenrolled. Individuals seeking PACE enrollment will need to be placed on a waiting list and may access services such as medical, dental, behavioral health, and home health through the Medicaid State Plan and HCBS such as homemaker, adult day, and personal care through an HCBS waiver in which they can be enrolled by their local Single Entry Point (SEP) agency. Because Medicaid State Plan services and HCBS are available in all current PACE service areas within Colorado and care plans are developed by SEP case managers to meet the needs of the client (in a manner similar to PACE), there are no anticipated issues with individuals' accessing alternative long-term care services absent immediate enrollment in PACE.

50. [Sen. Moreno] How do the outcomes for participants in PACE compare to the outcomes for people participating in alternatives?

RESPONSE

Per Mathematica Policy Research (Evaluating PACE: A Review of the Literature, January 2014[50]), "[e]vidence on the effect of PACE on the utilization of expensive acute and long-term care services is mixed--studies with the strongest design find PACE enrollees have fewer inpatient hospitalizations than their fee-for-service counterparts, but they appear to have higher rates of nursing home admission. None of the studies, however, differentiate between post-acute and long-term nursing home stays."

PACE is a fully capitated program, whereas other long-term care programs are fee-for-service. The differences between these service delivery models create barriers for direct comparisons. As of July 2019, PACE providers have been submitting encounter data. To ensure accuracy of the data, the Department is altering its system to adjudicate PACE encounter data. This change will ensure that encounter data is submitted per the Department's business rules and conformity requirements. The Department will be able to analyze the value of the PACE program and compare outcomes between PACE and other long-term care programs. Further, the Department will analyze utilization trends with performance metrics to better understand member outcomes as compared to other long-term care programs. While the Department is unable to directly compare PACE outcomes to alternative long-term care programs, the Department has implemented measures to ensure the health, safety, and welfare of PACE members and identify quality of care concerns, such as compliance investigations, technical advisory visits, involuntary disenrollment reviews, and restructuring quality data submission to include best practices. Currently, as part of PACE oversight, the Department captures member health metrics such as hospitalizations, home care visits, falls, injuries, emergency department visits, and behavioral health screenings. The Department determines the average of each metric and identifies whether the PACE organization is above or below the average. If below, the Department requests a quality improvement plan or a corrective action plan as necessary to address any issues.

51. [Sen. Moreno] Does PACE save money over the long term?

[50] https://aspe.hhs.gov/basic-report/evaluating-pace-review-literature

RESPONSE

PACE is a fully capitated program that incorporates Medicare and Medicaid payments for the needs of participating members. In exchange for a fixed capitated payment per participating member, PACE provides a continuum of acute and long-term care services, including hospital and nursing-facility care, and bears full financial risk for these services. This integration of services in the PACE model allows for the care of members with multiple conditions to be managed by a single organization. Historically, the Department was unable to quantify the true cost of care for an individual in the PACE program because of the lack of data. As of July 2019, PACE providers now submit encounter data, which will need at least two years of data runout before it is usable for cost saving analyses. The Department is altering its system to adjudicate PACE encounter data which will ensure that data is submitted per the Department's business rules and conformity requirements. As we begin to collect appropriate encounter data that shows the unique experience of each PACE member, along with understanding how these services are being delivered, the Department will be able to better understand the cost of PACE compared to other programs. It is imperative that PACE Organizations submit accurate data and cost to verify the value of the program.

Based on currently available data, it is not clear whether the PACE program provides cost savings. The Grade of Membership (GOM) model proposed and funded by the largest PACE organization, and subsequently removed by SB 19-209, found that the people being served by PACE at entry are healthier than those presupposed by the current rate methodology, which is weighted more toward individuals requiring 24-hour skilled nursing care. Newly enrolled members are younger and incur lower costs on average outside of PACE. The average annual cost of a PACE enrollee is about $51,000, compared to the average cost of a member age 65 on the Elderly, Blind, and Disabled waiver of about $27,000. Also, PACE expenditures have increased by 63.4% over the past four years (FY 2016-17 to FY 2019-20) from $131 million to $214 million, with 42.3% of the increase due to caseload. In order to achieve cost savings for the PACE program, a member must remain with the program for their health care life.

Put simply, as the member ages within the PACE program and requires skilled care, the Department may see a cost savings depending on their total cost of care. However, disenrollment data shows that almost half of PACE members who disenroll into an alternative long-term care setting transfer into a higher-cost service such as skilled nursing care or hospice. This immediately increases costs to the Department. While the other half disenroll into Home and Community-Based Services (HCBS), the capitation paid to PACE members is higher than these services, thus resulting in the Department overspending during the time these members were enrolled with a PACE organization.

52. [Sen. Rankin] What are the client satisfaction results for PACE and alternatives?

RESPONSE

Because of the nature of the program, the Department cannot compare client satisfaction of PACE to alternatives; the Department has instituted mechanisms to track and ensure client satisfaction within the PACE program. Because PACE is a fully capitated program, whereas other long-term care programs are fee-for-service, the delivery of services are inherently different.

Under federal regulations, a PACE organization must survey, on an ongoing basis, participants and their caregivers to determine satisfaction with the services furnished and the outcomes achieved. The Centers for Medicare & Medicaid Services (CMS) expects the PACE organization to use this information to identify opportunities to improve services as well as caregiver and participant satisfaction. Although CMS does not require the use of a specific survey tool in measuring participant and family satisfaction, the Department has required PACE providers to use a uniform survey tool to better compare satisfaction between each provider as of July 2019. The Department also requires that PACE organizations develop a uniform exit survey to better understand the reasons for disenrolling from the PACE program. The Department collects this data annually and requires the provider to develop and submit quality improvement initiatives for identified client issues. From the Department's initial analysis, members have overall been satisfied with the PACE program. Although it has provided the Department key areas which need improvement, such as communication. Because these requirements are new, and the pandemic has created hurdles in collection, the Department expects to have even better data within the next year.

53. **[Rep. Herod] Discuss the potential cost shifting that could occur, for example to behavioral health services, as a result of the transition to remote supports and a commensurate decrease in human contact and increase in social isolation. Please discuss any lessons learned from Ohio and whether it resulted in increased depression.**

RESPONSE

The Department does not anticipate increases in behavioral health challenges, nor does it anticipate cost-shifting in connection with the implementation of remote supports. As with all Home and Community-Based Services (HCBS), the remote support delivery method will be authorized only when there is an assessed need and the member chooses the service to meet the identified need.

The use of remote supports will not replace or eliminate human interaction. As described in response to JBC Question #61, the most common remote support delivery option is real-time interaction between the member and support staff using a method of communication decided upon by the member (examples: real-time video chat or a phone call via a landline). The services most likely to be used through remote supports are homemaker and/or personal care services (when hands-on support is not needed). This voluntary service option gives the Department the opportunity to offer the right service at the right time to our members.

White Paper: Use of Remote Support in Ohio and Emerging Technologies on the Horizon[51] discusses the impact of remote supports on behaviors as well as isolation. One compelling example describes the decrease in challenging behaviors when an individual was provided with remote support instead of 24-hour in-person staffing (p. 17). For some, remote supports significantly increase independence and reduce reliance on in-person staffing and their associated patterns. Additionally, Ohio uses a video[52] to highlight the importance of being given an alternative to group activities or group living situations. The members and their families

[51] https://nisonger.osu.edu/wp-content/uploads/2017/02/White-Paper-Use-of-Remote-Support-in-Ohio-and-Emerging-Technologies-on-the-Horizon.pdf
[52] https://nisonger.osu.edu/adult/resources/technology-project/remote-supports/

express the positive impact on the member's quality of life by having the option to choose a less intrusive and more flexible service delivery method, that also emphasizes the member's autonomy.

The potential for isolation is a valid concern. As we look to engage with members, families, and other stakeholders on the development of the remote supports service, the risk of isolation will be reviewed. As noted in the white paper referenced above, dignity of risk is also to be considered. Ensuring a member can live their life in a way that encourages independence will undoubtedly entail some risk. The Department strives to find balance and ensure that there is support available to members that will increase their independence while at the same time, through careful assessment and person-centered planning, will address areas of risk and ensure health, safety, and welfare.

As with any HCBS waiver service, the choice to utilize a service, such as remote supports, is voluntary. The Department will use future stakeholder engagement on the development of the remote services benefit in waivers, to consider the role of case management in identifying through an assessment, those members who are experiencing (or at risk of experiencing) increased depression and/or behavioral health needs, as well as identifying the role of an HCBS waiver service in alleviating or causing such impacts.

54. [Sen. Moreno] What is the source/nature of the projected savings from remote supports?

RESPONSE

The projected savings come from the lower rate for remote support services versus in-person services. Remote support rates are about one-third of the rate for in-person services because a remote support worker is able to provide services for multiple members during one shift, as they do not need to do other tasks like driving to a person's house. States that have implemented remote supports have seen members elect to switch some of their personal care and homemaker services from in-person delivery to remote delivery. Since the remote option has a lower rate, this results in cost savings. The savings estimated by the Department are based on the real-world experiences observed in a similar effort undertaken by Ohio's Medicaid program.

The Department also believes that members on the Brain Injury (BI) waiver with lower acuity scores could replace the residential Supportive Living Program (SLP) placements and remain in their own residence if remote supports were available. The Department believes it is possible that a member could avoid the residential service if a remote support provider were able to provide remote verbal cues while in their home. Current per diem rates for SLP range from $197 to $369, which is significantly higher than the proposed $8.56 hourly rate for remote supports. The Department projects that this potential shift in utilization will result in additional cost savings.

55. [Sen. Rankin] Regarding remote supports, how does the Department plan to work around broadband access issues in rural areas? What input has the Department received about the proposal from rural areas?

RESPONSE

The Governor's Office of eHealth Innovation (OeHI) has developed a telehealth and broadband initiative to develop and support approaches that lead to increased adoption of telehealth, and reliable and affordable broadband access for health organizations and consumers. OeHI is currently exploring how to expand broadband access to support rural connectivity to health information exchanges and telemedicine. The Department plans to work with OeHI along with other agencies to support the expansion of broadband access across all regions of Colorado. Additionally, as seen in other states, remote supports have been successful in rural areas where finding a regular direct care worker in sparsely populated areas may be more difficult. Remote services can alleviate the provider shortage experienced in some rural areas by giving our providers the opportunity to service more members with effective and quality care, eliminating the need for excess travel time and freeing up direct support providers to care for those members who do require hands-on assistance for homemaker and personal care services.

The Department strives to collect and consider feedback from stakeholders across the state when implementing a policy change, including from our rural communities. As the Department pursues service development for remote supports, a stakeholder engagement plan will be implemented to ensure a diverse representation of stakeholders is involved in developing this service.

56. **[Sen. Rankin] What is the specific technology the Department proposes implementing for remote supports? Is it limited to communications technology, or would it involve more sophisticated technology that can be used to monitor health-related data, such as smart watches?**

RESPONSE

Remote support is an emerging service model that combines technology and direct care to support people with disabilities and thereby may reduce the need for in-person services. This model is not intended to eliminate all in-person services, but rather to allow for certain personal care and homemaker tasks to be completed with support using technology, if that meets the member's needs and is what the member chooses. Examples of remote supports include technology for cooking safely, overnight support, medication adherence, fall detection and wandering prevention. The service is designed for members who need reminders and supervision but not physical assistance. Remote supports respect an individual's right to privacy and promote their independence while still providing access to support professionals for tasks that may not require on-site staff. The technology used is specific to each person's identified and assessed needs and preferences. This can include two-way communication systems as well as home-based sensors and monitors.

Two-way video calling may be used to assist a member with their morning routine, for example. When the member wakes up, they may have a video check-in on a tablet computer with their provider. The direct care professional can discuss the member's agenda for the day, note the weather as it relates to the member's clothing choice, and prompt the member to shower and brush their teeth. The member has full control to turn on/off video based on their privacy preference and comfort level. They may prefer video prompts for some activities and audio-only prompts for other activities.

A speaker may be used in the bathroom so that the direct support professional can provide real-time prompting and reminders for an activity like showering, while respecting the member's privacy and independence.

If the member does not need real-time prompting for a task like meal prep, then sensors may be a helpful tool. Sensors on the stove could alert the direct care professional that a burner has been left on, for example. This staff person would then check in with the member and provide a reminder to shut off the stove.

Through remote supports, members have access to the support needed to remain safe in their home while also retaining a sense of independence and privacy by not having a direct care professional in their home with them at all times. This is especially beneficial for overnight hours. Members using similar supports in Ohio and Missouri reported an increased feeling of safety.

Remote supports are a way to leverage existing technology to reduce the number of in-home visits while still providing members with the care they need. In the examples given above, the member may experience the remote support as less intrusive or invasive than having a staff person physically inside their home. By using remote supports a member may have more control over their daily routine because they are not scheduling their day around provider's schedules, but members will have access to an on-call provider. Additionally, remote services can alleviate the provider shortage experienced in some rural areas by giving our providers the opportunity to service more members with effective and quality care, eliminating the need for excess travel time and freeing up direct support providers to care for those members who do require hands on assistance for homemaker and personal care services.

Members interested in using remote supports will be assessed to determine whether remote supports would be appropriate based on their individual skills and needs. The technology used would be very specific to each person's needs and preferences, while respecting their privacy and comfort levels as they relate to personal care and homemaker tasks. Remote supports will not replace all in-person supports but through thoughtful planning, can be used to increase member's independence and autonomy. This technology would not include smart watches or other assistive technology required for medical monitoring or otherwise covered by existing long-term home health benefits.

For additional information and insights from people currently utilizing similar remote supports in Ohio, please review this short video: https://nisonger.osu.edu/adult/resources/technology-project/remote-supports/.

57. **[Rep. Ransom] Is the remote supports request limited to personal care and homemaker services, or would it apply to individuals with higher needs, including medical care?**

RESPONSE

Yes, remote supports will be limited to personal care and homemaker services, when hands-on care is not required and will not include medical or skilled care.

58. **[Sen. Hansen] Please provide an update on the implementation of electronic visit verification. How is it being applied to telehealth services? Please describe advocate and provider concerns**

about the application of electronic visit verification to telehealth services and respond to those concerns. Would electronic visit verification apply to the proposed remote supports, and if so, how?

RESPONSE

The Electronic Visit Verification (EVV) program has been implemented in Colorado. EVV is a technology used to verify that home or community-based service visits occur and is required by federal law (42 U.S.C. § 1396b(l)). The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smartphone or tablet, a toll-free telephone number, or a web-based portal. The state EVV solution and data aggregator have been operational since Oct. 1, 2019, and the use of EVV was mandated by Colorado Code of Regulation 10 CCR 2505-10 8.001 effective Aug. 3, 2020. The Department continues to reach out to providers to increase EVV utilization.

EVV is required for select services provided in the home and community. Telehealth is considered a method for the delivery of care. If EVV is required for a service, as outlined in the service code inclusion list, then EVV would also be required if those services are provided via telehealth. Accordingly, the EVV requirement will apply to the proposed remote supports benefit.

The public health emergency (PHE) has changed the landscape of service delivery. Existing telehealth services are being utilized at a higher than usual rate, and many services that were previously only provided in person are now permitted to be delivered through virtual methods. Providers are learning how to operationalize telehealth services within both EVV requirements and under the PHE.

The primary concern around EVV and telehealth is from providers who are new to using EVV. For example, a number of facility-based clinicians expanded their service delivery to include telehealth during the PHE. These providers are required to follow EVV rules and operationalize an EVV system for a small subset of their business. Because facility-based clinicians have not previously billed for services covered by the EVV requirements, they were not familiar with these requirements. However, outpatient therapies can occur in the community and in the home, and in this respect are similar to therapy offered through the home health benefit. The Department has reached out to providers who are newly billing for telehealth services and provided information about the EVV mandate. EVV technology is available at no cost to providers, and multiple support pathways exist to assist these providers in implementing and using EVV. Stakeholders with specific questions or concerns are encouraged to contact the Department at evv@state.co.us for direct support. The Department has been holding monthly meetings with stakeholders affected by EVV to hear and resolve questions and concerns since September 2017, and it expects these meetings to continue through 2021.

59. **[Sen. Moreno] Please provide information about the reporting requirements related to local minimum wage increases. Where are the dollars going and how have providers utilized the additional funding?**

RESPONSE

The minimum wage pass-through for nursing facilities did contain a funding allocation attached to HB 19-1210. The Department gained approval from CMS and worked with stakeholders to identify information requirements necessary to calculate the supplemental payment related to minimum wage increases. The application for funding is expected to be available in January 2021, and payments are expected in March 2021.

Regarding oversight of other rate increases intended to be passed through to Direct Care Workers (DCWs), the Department is currently in the process of receiving SB 19-238 data. SB 19-238 states that "[o]n and after July 1, 2020, the hourly minimum wage for direct care workers providing personal care services, homemaker services, and in-home support services is $12.41 per hour." To date, 174 of the roughly 400 providers that provide these services have accessed the wage pass-through reporting tool to register and begin reporting. Preliminary data collected by the Department indicates that home care agencies/providers are utilizing the additional funding to increase DCW wages, distribute bonuses, and increase employer-paid payroll taxes. Year 1 of this bill (July 1, 2019, through June 30, 2020) has a reporting deadline of Dec. 31, 2020. The Department anticipates more providers will complete and submit reporting by the upcoming deadline. The Department will ensure compliance and oversight starting in January 2021 once the Year 1 reporting deadline has expired. The minimum wage increase requirement takes place in Year 2 (July 1, 2020 – June 30, 2020), so the Department will not have insight into how increased funding was used or maintained in Year 2 until Dec. 31, 2021. As required by the statute, 85% of the increase allocated for the City and County of Denver will be passed to the Direct Care Worker providing Personal Care and Homemaking services.

The Department is monitoring continuing developments that impact the LTSS direct care workforce, including the ongoing challenges associated with the pandemic and the possibility of additional localities raising their minimum wage requirements. The independent actions of localities to independently increase the minimum wage create significant fiscal and operational challenges that are often misunderstood by local governments. For example, the Department can increase payment rates only if greater appropriations are approved by the General Assembly and only if variable billing practices are approved by the federal Centers for Medicare and Medicaid Services (CMS).

60. **[Rep. McCluskie and Sen. Rankin] Please explain the amounts people with disabilities pay to "buy in" to Medicaid and how the amounts are determined. Is it on a sliding scale?**

RESPONSE

There are two programs for people with disabilities that require monthly premiums to "buy in" to Medicaid: the Health First Colorado Buy-In Program for Working Adults with Disabilities, and the Health First Colorado Buy-In Program for Children with Disabilities. These two programs are targeted to special populations that are specifically authorized by CMS through federal law. The premium amounts for both

programs are determined on a sliding scale based on their income. The premium amounts fluctuate if the member's or family's income fluctuates as well, meaning they may pay more or less on the next billing cycle depending on reported income changes.

The premium sliding scale is based on a one-person household for the Health First Colorado Buy-In Program for Working Adults with Disabilities. This means that eligibility and premiums are determined based on the member's income only, without regard to other members who may be part of the household. The premium amounts were determined by the Centers for Medicare and Medicaid Services (CMS). CMS regulations limit premium amounts to a maximum of 7.5% of the individual's income. Premiums range from $0 per month up to no more than $200 per month. Below is the income chart and premium guide for 2020:

Buy-In Program for Working Adults with Disabilities Monthly Income After Income Adjustments					
Income amount	$0 - $426	$427 - $1,415	$1,416- $2,127	$2,128 - $3,190	$3,191 - $4,785
Federal Poverty Level (FPL)	0% - 40%	41% - 133%	134% - 200%	201% - 300%	301% - 450%
Monthly Premium	**$0**	**$25**	**$90**	**$130**	**$200**

NOTE: This chart is based on 2020 federal poverty level (FPL) guidelines.

The premium sliding scale for the Health First Colorado Buy-In Program for Children With Disabilities is based on the family size. One monthly premium is charged for the household, regardless of how many children may potentially be eligible for the program. These premium amounts were determined according to CMS regulations with a maximum of 5% of a family's income for families with income up to 200% of the federal poverty level (FPL) and 7.5% of a family's income for families with FPL above 200% and up to 300% FPL. Premiums range from $0 per month up to no more than $120 per month. Below is the income chart and premium guide for 2020:

Family Size	**Buy-In Program for Children with Disabilities Monthly Income After Income Adjustments**			
1	0 – $1,415	$1,416– $1,968	$1,969– $2,659	$2,660– $3,190
2	0 – $1,911	$1,912– $2,658	$2,659– $3,592	$3,593– $4,310
3	0 – $2,408	$2,409– $3,349	$3,350– $4,525	$4,526– $5,430
4	0 – $2,904	$2,905– $4,040	$4,041– $5,459	$5,460– $6,550
5	0 – $3,401	$3,402– $4,730	$4,731– $6,392	$6,393– $7,670
6	0 – $3,897	$3,898– $5,421	$5,422– $7,325	$7,326– $8,790
7	0 – $4,394	$4,395– $6,112	$6,113– $8,259	$8,260– $9,910
8	0 – $4,890	$4,891– $6,802	$6,803– $9,192	$9,193– $11,030
Federal Poverty Level (FPL)	**0% - 133%**	**134% - 185%**	**186% - 250%**	**251% - 300%**
Monthly Premium	**$0**	**$70**	**$90**	**$120**

NOTE: This chart is based on 2020 federal poverty level (FPL) guidelines.

61. **[Rep. McCluskie] Are there lessons learned from the "buy-in" program for people with disabilities that could inform a broader buy in program that gives more people access to affordable health care?**

RESPONSE

Health First Colorado Buy-In Program for Working Adults with Disabilities, and the Health First Colorado Buy-In Program for Children with Disabilities are for people with disabilities who may have higher income levels, but pay monthly premiums to receive Medicaid benefits. The premiums partially offset the cost of coverage. The programs are financed, in part, by federal matching funds.

There are some lessons that the Department has learned from the buy-in programs for people with disabilities. These include providing members sufficient time to plan for payment of premiums. It is best to have a consistent scheduled due date for premiums (such as the 15th of every month). Due to the potential for late payments or overpayments, it is critical to have a robust tracking mechanism for premiums and a clear way of communicating these amounts to members. Payment systems should also have the ability to manage a variety of scenarios encountered such as ability to make partial payments, overpayments, schedule payments, and manage various forms of payments (such as credit/debit cards, checks, and in-person cash payments). Streamlining and providing clarity around payment of premiums reduces the potential of members losing coverage based on premiums due.

Another critical lesson we have learned is the importance of having a consolidated group to provide support and answer questions for members regarding the program and premiums. This group also is responsible for all aspects of the premiums including researching missing payments, potential refund of payments, and other scenarios.

The training and program awareness are important to ensure people understand the program and access affordable health care. The Department has brochures available to help explain the program to potential applicants, maintains updated information on the website and works with community partners to provide information to both future applicants and current members.

These lessons may be applicable to a broader buy-in program, depending on how it is structured. In addition, the Department is covering an added 162,000 members (across all programs, not just the buy-in programs) since March with all operational metrics achieving targets. Given this performance and lessons learned, the Department stands ready to respond to health care policy or operational directives from the General Assembly to further meet the access, affordability or coverage needs of Coloradans during this economic downturn or in the future, including Medicaid Buy-In or other evolving solutions.

62. **[Sen. Rankin] Please provide an update on consolidating the waivers and implementing the new assessment tool. What is the plan and what is the time frame?**

RESPONSE

Update on Waiver Consolidation
HB 15-1318 required the Department consolidate the two Home and Community-Based Services (HCBS) waivers serving adults with intellectual and developmental disabilities.

The actuarial findings resulting from the work to implement HB 15-1318 revealed a significant cost to implement the redesigned consolidated waiver. 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 experience for members receiving services.

There has been significant stakeholder engagement to inform policy options to redesign the services across Colorado's wavier programs. The next step in moving this important work forward is to build upon the completed work and 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. Key progress to redesign services over the past year includes:

- Launching a supportive employment pilot program aimed at incentivizing waiver providers to increase quality outcomes for members and at a cost savings for the state.
- Creating a new telehealth service delivery option that allows for virtual delivery of services.
- Expanding and making improvements to day services that have led to a more customizable and streamlined approach benefiting both members and providers.

Update on the new Long-Term Services and Supports Assessment Tool
SB 16-192, "Assessment Tool Intellectual and Developmental Disabilities," appropriated funding over five fiscal years for the Department to develop a single assessment tool to be used with all HCBS populations.

Implementation of the single assessment tool includes three distinct projects:

1. Development of a single new assessment and person-centered support plan for long-term services and supports (LTSS) programs;
2. Implementation of a new care and case management IT system to house the new assessment and person-centered support plan and all case management business requirements; and
3. Development of the person-centered budget algorithm (PCBA) based on the new assessment.

These three projects are interdependent and sequential. The new assessment and person-centered support plan must be final in order to incorporate it into the new care and case management IT system. Once implemented in the care and case management system, the new assessment and person-centered support plan can be rolled out and used with members seeking or receiving LTSS. The new assessment needs to be rolled out before final development of the PCBA, as more assessments are needed to gather sufficient data to finalize and validate the PCBA.

New Assessment and Person-Centered Support Plan

From 2016 through 2019, the Department worked with a contractor and stakeholders to develop a new level of care (LOC) screen and a new assessment and person-centered support plan for all individuals seeking or receiving long-term services and supports. The Department designed the new assessment and support planning processes to be person-centered, facilitate greater coordination of services, and be equally applicable to adults and children with disabilities. Between March 2019 and May 2020, the Department piloted the new assessment and person-centered support plan with case managers in three phases: level of care, support plan, and time study. Based on the pilot and stakeholder feedback, the Department has finalized the new tools to be incorporated into the care and case management system. The implementation of the new assessment and person-centered support plan is on track and scheduled to begin in July 2021.

New Care and Case Management System

The new LOC screen, assessment and person-centered support plan will be supported through automation with the implementation of a new care and case management IT system. Along with the new assessment tools, other case management functions that currently exist across several IT systems will also be consolidated into the new care and case management system. The new system will help streamline processes and increase efficiency for case managers and members. The new system is scheduled to go live in July 2021.

Person-Centered Budget Algorithm

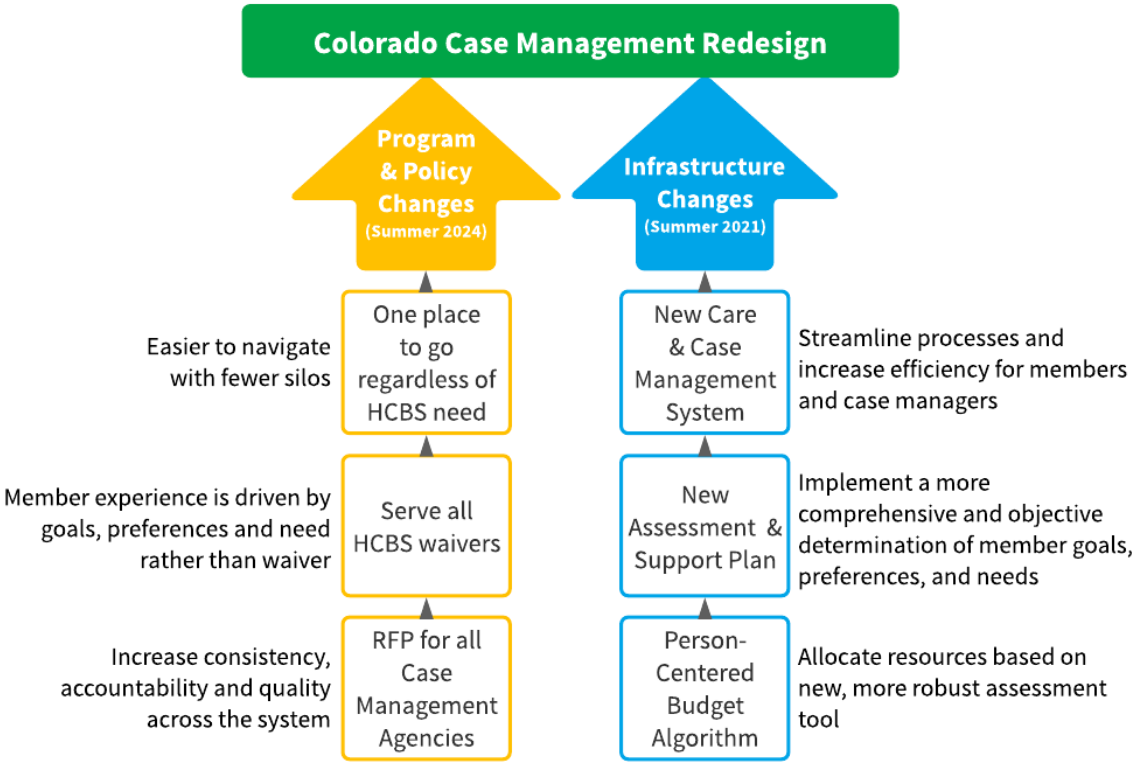
The Department is also developing a person-centered budget algorithm (PCBA) to provide a more objective and equitable way to allocate resources. The PCBA will provide a budget range to be used with each member seeking or receiving HCBS during the person-centered planning process. The PCBA will utilize information within the new assessment to determine support needs for all individuals on HCBS waivers. The PCBA is being developed using information derived entirely from the new assessment and person-centered support plan and will not be based on any previous tools used by the Department. Because the Department has not begun using the new assessment tools, we have a very limited data set to develop the PCBA with confidence.

So far, there has been extensive stakeholder engagement to obtain input on the development of the PCBA through the Technical Advisory Group (TAG) established for this purpose, the Clinical Hypothetical Study panel, and statewide meetings conducted from September through December 2020. While the Department and its contractor continue to make progress with stakeholders on developing the PCBA, it is clear that more data from the new assessment and person-centered support plan—particularly data from in-person assessments that have been put on hold during the pandemic—is needed to validate and finalize the PCBA.

The Department intends to implement the new assessment and person-centered support plan within the new care and case management system beginning in July 2021. Final PCBA development and implementation is dependent on a robust and reliable data set from the new assessment and stakeholder feedback. Due to the limited number of completed assessments, the Department proposes to delay the implementation timeline of July 2021 for the PCBA to complete additional assessments. To adjust funding for this delay and complete the project, the Department has submitted a supplemental budget request for roll-forward authority for existing appropriations.

Once the PCBA is finalized, it will be incorporated into the new care and case management system and implemented as part of the assessment and person-centered support planning process.

The three major initiatives outlined above fit together as part of a larger effort to redesign case management in Colorado.



63. **[Sen. Crowder] Given the legislature's demonstrated interest in reducing the waitlist for services for people with intellectual and developmental disabilities, why are measures to reduce the waitlist not a higher priority in the Governor's request?**

RESPONSE

Ensuring people with intellectual and developmental disabilities have access to the services they need when they need them is a top priority in the Governor's budget. This is reflected in both the R-8 budget request for Supported Living Services Flexibility and the prioritization of just over $17 million total funds to continue authorizations for enrollment into the HCBS- Developmental Disabilities (DD) waiver for people who are most in need. The Department, with the support of the General Assembly, has successfully eliminated the waiting list for three of the five programs targeted to people with intellectual and developmental disabilities. Enrollment in these five programs since FY 2013-14 has grown by just under 50%, which is 6,096 people who now have access to services as of November 2020. During the same time period, the waiting list for HCBS-DD has grown by 130% from 1,454 to 3,355, despite a 41% growth in enrollment in HCBS-DD from 4,848 to 6,859. The Department has previously provided the budget estimate for what it would cost to achieve the full elimination of the HCBS-DD waiver waiting list over a period of 6 years. By year six, the total funds fiscal impact is projected just over $315 million.

To better meet the needs of people waiting for the HCBS-DD waiver the Department has put forward the R8 budget request for Supported Living Services Flexibility. This request is designed to address individuals who are receiving HCBS-SLS waiver services and are nearing their service unit cap or Support Level Authorization Limit (SPAL) and are in a situation where accessing additional services would require an emergency enrollment into the HCBS-DD waiver. By decreasing the disparity between the resources available and the services needed by higher-needs members on HCBS-SLS, the Department could mitigate the need for HCBS-DD waiver services. For example, in FY 2019-20, 137 members on the HCBS-SLS waiver received a reserved capacity ("emergency") enrollment into the HCBS-DD waiver. If some of them had remained on the HCBS-SLS waiver because of expanded flexibility, the HCBS-DD enrollments could have gone to others on the HCBS-DD waitlist.

The Department is expecting to authorize 411 reserved capacity enrollments during FY 2021-22. The estimated cost of authorizing these reserved capacity enrollments is just over $17 million total funds, and is included in the Department's R-5 budget request. In addition to the 411, the Department will continue to authorize enrollments when spots become available from churn.

In addition to the efforts described above effective July 1, 2020, if the Colorado General Assembly authorizes a one-time appropriation in the future for new enrollments into the HCBS-DD waiver, the new enrollments funded will be allocated to community centered board (CCB) service areas on a per capita basis proportional to their population. This change from the historical approach of statewide enrollments was made after conducting stakeholder engagement and completing a review of feedback received. This was also part of the Department's work with the rural providers to identify solutions for rural sustainability. Providing enrollment authorizations on a per capita basis will ensure that most catchment areas of the state will receive an enrollment authorization if the General Assembly authorizes any future one-time appropriation for enrollment purposes. This change in the authorization process will contribute to rural stabilization and assist in offering timely access to services and supports that are needed by individuals in all areas of the state. This process will be used only if authorized enrollments are appropriated by the General Assembly for new enrollments into the HCBS-DD waiver and is not applicable to enrollment authorizations made through reserved capacity or churn.

64. [Sen. Rankin] Some of the people impacted by R8 Supported living services flexibility might be on the wait list for residential services. Please discuss the interaction between supported living services and residential services and how to balance funding between the programs to most efficiently and effectively meet client needs?

RESPONSE

The Department's R8 budget request, Supported Living Services Program Flexibility, is a cost-effective approach that will allow members to get the right level of services in a cost-effective manner. The request will allow individuals who are receiving HCBS-SLS waiver services to request additional funding. This would be limited to particular services when the member is nearing their service unit cap or SPAL or are in a situation where accessing additional services would require an emergency enrollment into the HCBS-DD waiver. This new policy will prevent or delay the need for enrollment into the HCBS-DD waiver and allow

members to receive the most appropriate level of services to meet their needs. Conversely, this policy will also better ensure that enrollments on HCBS-DD are available to individuals who require that higher level of care and supervision.

As of November 2020, 2,209 out of 4,972 members who are enrolled in the HCBS-Supported Living Services (SLS) waiver are also on the HCBS-Developmental Disabilities (DD) waiver waiting list. As of November 30, 2020, there were 3,355 individuals on the waiting list for the HCBS-DD waiver. Not all of these individuals are in need of immediate residential services. Since May 2018, the Department has offered 1,490 individuals on the HCBS-DD waiting list enrollments into the HCBS-DD waiver, and 387 have declined enrollment, stating that their service needs are being met through other waivers or alternative means, resulting in a 26% declination rate. Additionally, 21% of individuals who are on the HCBS-DD waiver with a status of As Soon As Available (ASAA), indicating they would enroll into the HCBS-DD waiver as soon as a resource is available, have chosen to not receive any Medicaid services while they are waiting.

The primary difference between the HCBS SLS and DD waivers is the availability of 24/7 residential services. The average cost per person in the SLS waiver is forecasted to be just under $16,000 in FY 2020-21, whereas the average cost per person in the DD waiver is projected to be $77,000 in FY 2020-21. The purpose of the R8 request is to close the resource gap between the two waiver programs and thereby drive down the need for the HCBS-DD waiver. When reviewing emergency enrollment requests for the HCBS-DD waiver, an estimated 10% of requests state that the emergency situation could be resolved if the individual had access to additional HCBS-SLS services, such as day program, respite, or behavioral services. However, because of an individual's existing Service Plan Authorization Limit (SPAL) on the HCBS-SLS waiver, an emergency enrollment into the HCBS-DD waiver, which does not have a SPAL, often must be requested. In these cases, the identified need of the member is additional services and supports rather than residential services.

65. **[Sen. Rankin] Some advocates and providers, particularly in rural communities, have expressed concerns about the proposed consolidation of appropriations for the Community Centered Boards and single entry points in R14 Technical adjustments. Please summarize and respond to these concerns.**

RESPONSE

Last year the Department heard from stakeholders who were confused about the purpose of this request. After explaining that consolidating the Single Entry Point (SEP) and Community Centered Board (CCB) appropriations has no impact on funding allocations or payment methodology, additional questions or concerns have not been raised to the Department. The goal of consolidating these budget line items for case management is to reduce administrative burden while allowing the Department to more effectively manage and track funding, increasing transparency.

Currently, the Department's funding for case management is spread among four separate appropriations, including a larger administrative line item for utilization review, Medical Services Premiums, Targeted Case Management, and the Eligibility Determination and Waiting List Management line items. This makes it difficult to determine how much was spent overall. By combining the funding into one line item, the

Committee and other stakeholders would be able to track how much was appropriated and spent in total on case management activities and services by all contracted and enrolled case management agencies each year.

COLORADO
Department of Health Care Policy & Financing

COVID-19 Stimulus from various sources for Colorado Hospitals

*HRSA attestation is on the System level, see the table below

			Provider Relief Fund from CARES ($100b)/ PPPHCE ($75b)			PPP-HCE Act	CARES Act	CARES and PPP-HCE Acts	Stafford Act	CPSRA Act	
			General & Others	Targeted Distribution	Uninsured Distribution						
		*	Total Reported	High-Impact Payment Reported	Uninsured Reimbursement	Small Business Loans	HRSA Supplemental Grant	Small Grants	FEMA Disaster	Hosp Prepare Program	
Date updated:			12/01/2020	09/01/2020	11/27/2020	Finalized	Finalized	Finalized	12/11/2020	05/29/2020	
Hospital	System	*	HRSA Attestation	High-Impact Payments	Attestation	Average of High/Low Range	SHIP Payment	Telehealth & Expanded Testing	Disaster Relief	HPP	Estimated Total
Animas Surgical Hospital			$ 4,382,927				$ 84,317			$ 7,230	$ 4,474,474
Arkansas Valley Regional Medical Center			$ 4,665,143			$ 3,500,000	$ 84,317			$ 7,230	$ 8,256,690
Aspen Valley Hospital			$ 6,934,356			$ 7,500,000	$ 84,317			$ 7,230	$ 14,525,903
Avista Adventist Hospital	Centura Health Adventist	*								$ 7,230	$ 7,230
Banner Fort Collins Medical Center	Banner Health		?		$ 7,160					$ 7,230	$ 14,390
Boulder Community Health			$ 12,091,839		$ 146,438			$ 638,842	$ 869,909.55	$ 7,230	$ 13,735,987
Castle Rock Adventist Hospital	Centura Health Adventist	*		$ 1,500,000						$ 7,230	$ 1,507,230
Children's Hospital Colorado	Children's Hospital Colorado		$ 51,523,985		$ 11,763			$ 807,090		$ 7,230	$ 52,350,068
Colorado Canyons Hospital and Medical Center			$ 5,188,303				$ 84,317			$ 7,230	$ 5,279,850
Colorado Plains Medical Center			$ 5,197,538	$ 1,650,000	$ 90,884		$ 84,317			$ 7,230	$ 7,014,211
Community Hospital			$ 9,495,063		$ 20,040					$ 7,230	$ 9,520,427
Delta County Memorial Hospital			$ 6,417,086				$ 84,317			$ 7,230	$ 6,508,633
Denver Health Medical Center	Denver Health and Hospital Authority		$ 61,979,862	$ 30,578,940	$ 2,614,518			$ 2,739,964		$ 7,230	$ 97,160,337
East Morgan County Hospital	Banner Health		$ 4,518,227	$ 1,950,000	$ 46,376		$ 84,317			$ 7,230	$ 6,600,510
Estes Park Health			$ 5,370,002		$ 3,734	$ 3,500,000	$ 84,317			$ 7,230	$ 8,964,705
Good Samaritan Medical Center	SCL Health		$ 6,232,232	$ 6,800,000	$ 15,634					$ 7,230	$ 13,054,941
Grand River Hospital District			$ 6,744,087	$ 500,000	$ 101,158		$ 84,317			$ 7,230	$ 7,269,942
Gunnison Valley Health			$ 5,009,795	$ 2,200,000		$ 3,500,000	$ 84,317			$ 7,230	$ 10,801,342
Haxtun Hospital District			$ 3,440,896			$ 675,000	$ 84,317			$ 7,230	$ 4,207,443
Heart of the Rockies Regional Medical Center			$ 6,342,302				$ 84,317			$ 7,230	$ 6,433,849
Keefe Memorial Health Service District			$ 2,936,009			$ 675,000	$ 84,317			$ 7,230	$ 3,702,556
Kit Carson County Health Service District			$ 4,149,999			$ 1,500,000	$ 84,317			$ 7,230	$ 5,741,546
Lincoln Community Hospital			$ 4,115,163			$ 1,500,000	$ 84,317			$ 7,230	$ 5,706,710
Littleton Adventist Hospital	Centura Health Adventist	*		$ 5,450,000						$ 7,230	$ 5,457,230
Longmont United Hospital	Centura Health CHI		$ 9,225,731		$ 73,997					$ 7,230	$ 9,268,841
Lutheran Medical Center	SCL Health		$ 9,507,160	$ 10,150,000	$ 295,502			$ 730,008		$ 7,230	$ 20,651,009
McKee Medical Center	Banner Health		$ 2,737,692		$ 71,257					$ 7,230	$ 2,803,814
Medical Center of the Rockies	UCHealth		$ 11,352,209	$ 6,000,000						$ 7,230	$ 17,359,439
Melissa Memorial Hospital			$ 3,832,057			$ 1,500,000	$ 84,317			$ 7,230	$ 5,423,604
Memorial Hospital Central	UCHealth		$ 18,368,339		$ 906,450					$ 7,230	$ 19,041,110
Memorial Regional Health			$ 5,510,830			$ 3,500,000	$ 84,317			$ 7,230	$ 9,102,377
Mercy Regional Medical Center	Centura Health CHI	*								$ 7,230	$ 7,230
Middle Park Medical Center - Kremmling			$ 4,386,549			$ 3,500,000	$ 84,317			$ 7,230	$ 7,978,096
Montrose Memorial Hospital			$ 7,701,229	$ 1,850,000	$ 141,669					$ 7,230	$ 9,625,675
Mt. San Rafael Hospital			$ 4,422,188			$ 3,500,000	$ 84,317			$ 7,230	$ 8,013,735
National Jewish Health			$ 3,682,508							$ 7,230	$ 3,689,738
North Colorado Medical Center	Banner Health		$ 7,547,777	$ 18,771,658	$ 922,508					$ 7,230	$ 27,199,059
North Suburban Medical Center	HealthONE	*		$ 7,200,000						$ 7,230	$ 7,207,230
OrthoColorado Hospital	Centura Health CHI		$ 1,889,360							$ 7,230	$ 1,896,590
Pagosa Springs Medical Center			$ 5,043,353			$ 3,500,000	$ 84,317			$ 7,230	$ 8,634,900
Parker Adventist Hospital	Centura Health Adventist	*		$ 6,000,000						$ 7,230	$ 6,007,230
Parkview Medical Center			$ 13,623,114		$ 76,317					$ 7,230	$ 13,706,386
Penrose-St. Francis Health Services	Centura Health CHI	*								$ 7,230	$ 7,230
Pikes Peak Regional Hospital	UCHealth		$ 3,950,648		$ 11,243		$ 84,317			$ 7,230	$ 4,053,401
Pioneers Medical Center			$ 4,419,351			$ 1,500,000	$ 84,317			$ 7,230	$ 5,957,398
Platte Valley Medical Center	SCL Health		$ 7,831,124	$ 3,850,000	$ 118,307					$ 7,230	$ 11,769,372
Porter Adventist Hospital	Centura Health Adventist	*		$ 5,000,000						$ 7,230	$ 5,007,230
Poudre Valley Hospital	UCHealth		$ 13,620,861		$ 303,798					$ 7,230	$ 13,861,116
Presbyterian/St. Luke's Medical Center	HealthONE	*								$ 7,230	$ 7,230
Prowers Medical Center			$ 4,305,310			$ 3,500,000	$ 84,317			$ 7,230	$ 7,896,857
Rangely District Hospital			$ 3,866,865			$ 1,500,000	$ 84,317			$ 7,230	$ 5,458,412
Rio Grande Hospital			$ 3,924,015				$ 84,317			$ 7,230	$ 4,015,562
Rose Medical Center	HealthONE	*		$ 7,950,000	$ 4,120,894					$ 7,230	$ 11,416,570
San Luis Valley Health Conejos County Hospital	San Luis Valley	*			$ 56,845		$ 84,317			$ 7,230	$ 147,591
San Luis Valley Health Regional Medical Center	San Luis Valley	*					$ 84,317			$ 7,230	$ 92,830
Sedgwick County Health Center			$ 3,754,550			$ 675,000	$ 84,317			$ 7,230	$ 4,464,697
Sky Ridge Medical Center	HealthONE	*								$ 7,230	$ 7,230
Southeast Colorado Hospital District			$ 4,071,609			$ 3,500,000	$ 84,317			$ 7,230	$ 7,571,956
Southwest Health System, Inc.			$ 5,546,589			$ 7,500,000	$ 84,317			$ 7,230	$ 13,138,136
Spanish Peaks Regional Health Center			$ 4,748,862			$ 7,500,000	$ 84,317			$ 7,230	$ 12,322,926
St. Anthony Hospital	Centura Health CHI	*		$ 6,900,000						$ 7,230	$ 6,907,230
St. Anthony North Health Campus	Centura Health CHI	*		$ 5,400,000						$ 7,230	$ 5,407,230
St. Anthony Summit Medical Center	Centura Health CHI	*		$ 1,500,000			$ 84,317			$ 7,230	$ 1,591,547
St. Joseph Hospital	SCL Health		$ 11,596,046	$ 17,471,816	$ 877,807					$ 7,230	$ 29,930,790
St. Mary-Corwin Medical Center	Centura Health CHI	*								$ 7,230	$ 7,230
St. Mary's Hospital & Medical Center, Inc.	SCL Health		$ 13,848,406		$ 104,212					$ 7,230	$ 13,957,255
St. Thomas More Hospital	Centura Health CHI	*					$ 84,317			$ 7,230	$ 91,547
St. Vincent General Hospital District			$ 3,466,406		$ 32,728	$ 675,000	$ 84,317	$ 2,796		$ 7,230	$ 4,263,869
Sterling Regional MedCenter	Banner Health		$ 5,272,551	$ 900,000	$ 38,307		$ 84,317			$ 7,230	$ 6,298,331
Swedish Medical Center	HealthONE	*		$ 9,900,000						$ 7,230	$ 9,907,230
The Medical Center of Aurora	HealthONE	*		$ 24,119,702						$ 7,230	$ 24,126,932
UCHealth Broomfield Hospital	UCHealth		$ 5,457,789		$ 9,529					$ 7,230	$ 5,473,563
UCHealth Grandview Hospital	UCHealth		$ 5,714,357		$ 6,887					$ 7,230	$ 5,727,585
UCHealth Greeley	UCHealth		$ 2,049,972		$ 337,248					$ 7,230	$ 2,382,237
UCHealth Highlands Ranch	UCHealth		$ 1,986,964		$ 69,651					$ 7,230	$ 2,049,393
UCHealth Longs Peak Hospital	UCHealth		$ 6,827,999	$ 3,000,000	$ 357,071					$ 7,230	$ 10,046,977
University of Colorado Hospital	UCHealth		$ 42,662,940	$ 54,104,940	$ 2,926,283			$ 998,250		$ 7,230	$ 100,344,879
Vail Health Hospital			$ 11,542,132	$ 1,750,000	$ 363,704				$ 238,507.82	$ 7,230	$ 13,872,046
Valley View Hospital			$ 12,639,237		$ 111,129					$ 7,230	$ 12,741,022
Weisbrod Memorial County Hospital			$ 3,132,915			$ 675,000	$ 84,317			$ 7,230	$ 3,899,462
Wray Community District Hospital			$ 3,953,069			$ 1,500,000	$ 84,317			$ 7,230	$ 5,544,616
Yampa Valley Medical Center	UCHealth		$ 12,254,391		$ 23,712		$ 84,317			$ 7,230	$ 12,367,016
Yuma District Hospital			$ 3,963,313			$ 1,500,000	$ 84,317			$ 7,230	$ 5,554,860
System-Level Attestations	San Luis Valley	*	$ 10,219,596								$ 10,219,596
System-Level Attestations	HealthONE	*	$ 51,860,418								$ 51,860,418
System-Level Attestations	Centura Health CHI	*	$ 69,176,569		$ 525,280						$ 69,488,780
System-Level Attestations	Centura Health Adventist	*	$ 43,763,218								$ 43,763,218
	LTAC/Rehab Hospitals	*	$ 6,408,882	$ 750,000	$ 19,279	$ -	$ -	$ -	$ -	$ 79,530	$ 7,041,986
Sum			$713,401,863	$243,197,056	$15,959,319	$67,875,000	$3,288,363	$5,916,950	$1,108,417	$679,620	$1,051,426,589

COVID-19 Stimulus from various sources for Colorado Hospitals

By Type		HRSA Attestation‡	High-Impact Payment	Uninsured Reimbursement	PPP Loan Average	SHIP Payment	Telehealth/ Expanded testing	Disaster Relief	HPP	Estimated Total†
Critical Access		$145,932,357	$4,650,000	$252,085	$67,875,000	$2,698,144	$2,796	$0	$231,360	$221,244,644
General		$509,536,639	$237,797,056	$15,676,193	$0	$590,219	$5,107,064	$1,108,417	$361,500	$767,338,158
Children		$51,523,985	$0	$11,763	$0	$0	$807,090	$0	$7,230	$52,350,068
Long Term Care, Psychiatric, Rehab Hospitals	(not broken out individually)	$6,408,882	$750,000	$19,279	$0	$0	$0	$0	$79,530	$7,041,986
Sum		$713,401,863	$243,197,056	$15,959,319	$67,875,000	$3,288,363	$5,916,950	$1,108,417	$679,620	$1,051,426,589

By System		HRSA Attestation‡	High-Impact Payment	Uninsured Reimbursement	PPP Loan Average	SHIP Payment	Telehealth/ Expanded testing	Disaster Relief	CHA HPP	Estimated Total†
Banner Health		$20,076,247	$21,621,658	$1,085,608	$0	$168,634	$0	$0	$36,150	$42,916,104
Centura Health Adventist	*	$43,763,218	$17,950,000	$0	$0	$0	$0	$0	$36,150	$61,749,368
Centura Health CHI	*	$80,291,660	$13,800,000	$599,277	$0	$168,634	$0	$0	$65,070	$94,673,455
Children's Hospital Colorado		$51,523,985	$0	$11,763	$0	$0	$807,090	$0	$7,230	$52,350,068
Denver Health and Hospital Authority		$61,979,862	$30,578,940	$2,614,518	$0	$0	$2,739,964	$0	$7,230	$97,160,337
HealthONE	*	$51,860,418	$49,169,702	$4,120,894	$0	$0	$0	$0	$50,610	$104,540,070
San Luis Valley	*	$10,219,596	$0	$56,845	$0	$168,634	$0	$0	$14,460	$10,460,017
SCL Health		$49,014,967	$38,271,816	$1,411,461	$0	$0	$730,008	$0	$36,150	$89,363,367
UCHealth		$124,246,469	$63,104,940	$4,951,872	$0	$168,634	$998,250	$0	$79,530	$192,706,716
Independent		$220,425,440	$8,700,000	$1,107,082	$67,875,000	$2,613,827	$641,638	$1,108,417	$347,040	$302,055,354
Sum		$713,401,863	$243,197,056	$15,959,319	$67,875,000	$3,288,363	$5,916,950	$1,108,417	$679,620	$1,051,426,589

†RHC's affiliated with hospitals have their payments lumped with the hospital

‡Some hospitals have included High-Impact Payments in their General Attestation, those numbers have been adjusted to prevent double counts

Health Care Policy & Financing JBC Hearing

EDO, BH & OCL Budget Lines

Kim Bimestefer, Executive Director
Tracy Johnson, Medicaid Director
Bonnie Silva, Office of Community Living Director

January 7, 2021

Health Care Policy & Financing Organizational Structure

COVID-19 Updates Data through 1/03/2021

National:
Cases: 20,666,746
Deaths: 351,682

Colorado:

Cases: 341,250

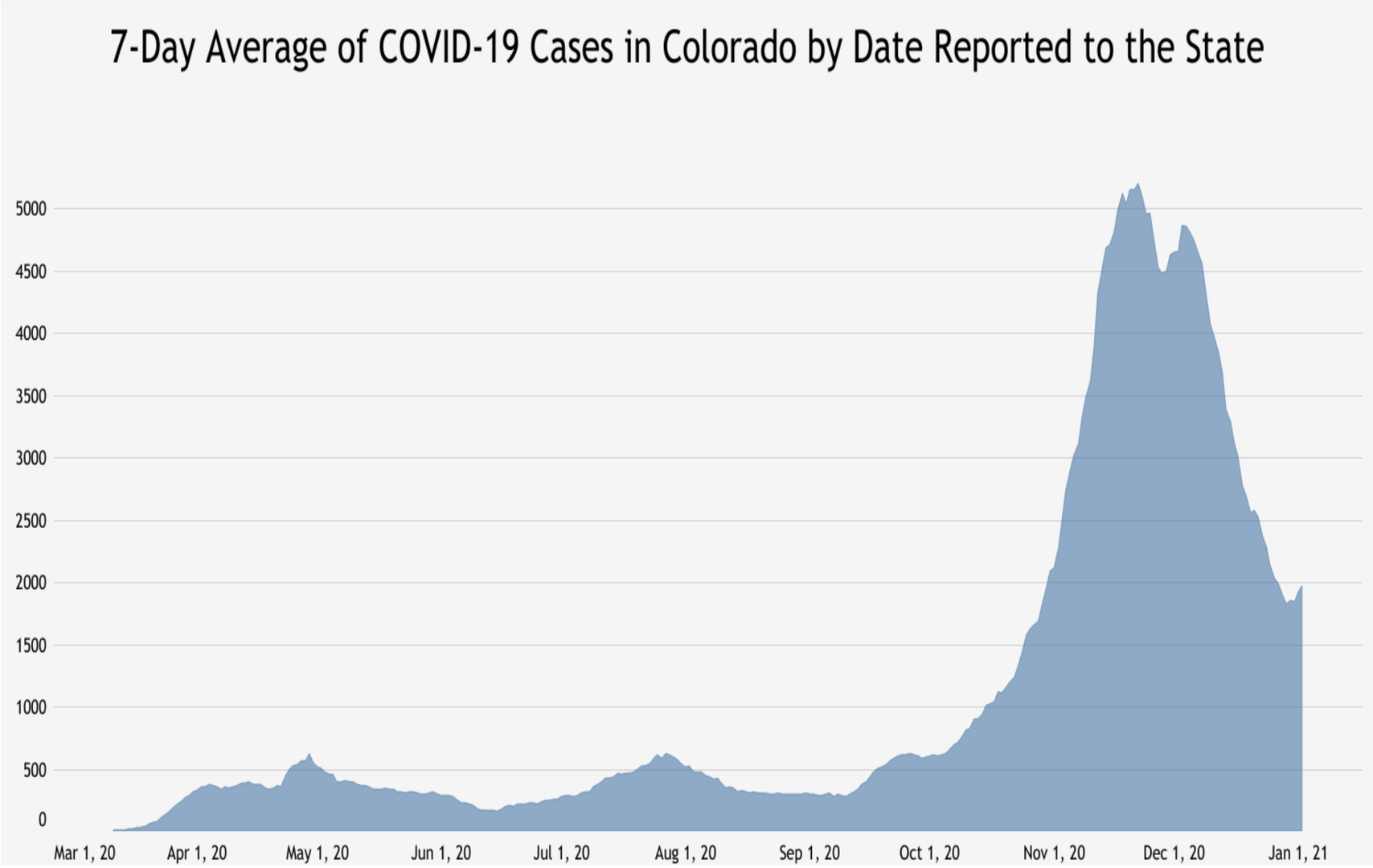
Deaths Due to COVID19: 3,907

Deaths Among Cases: 4,434

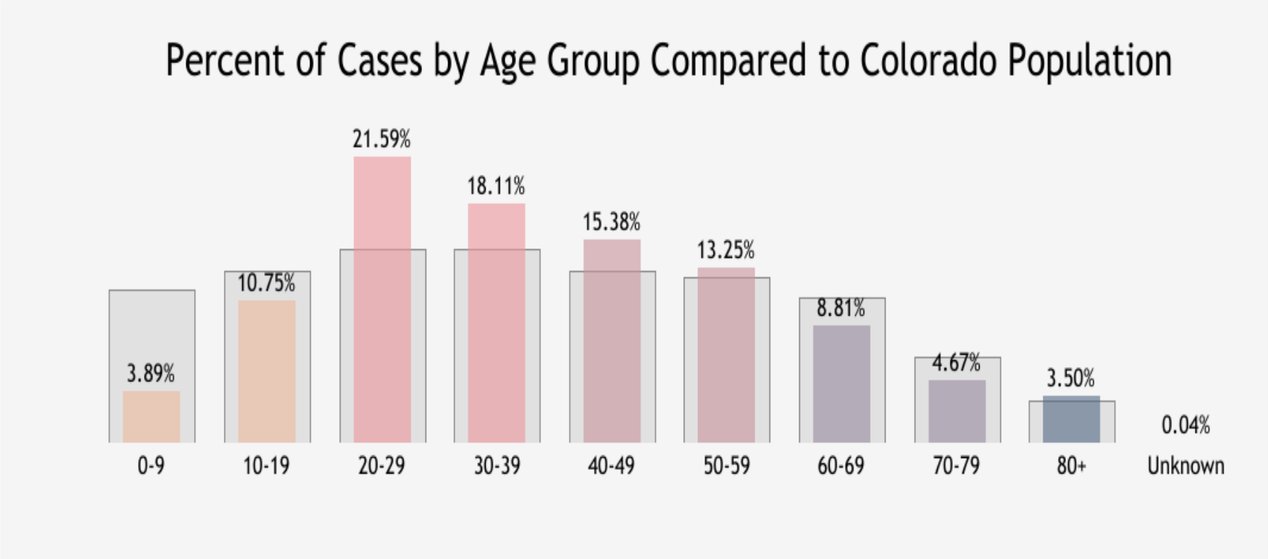
Contagious Est:1 in 57 & improving

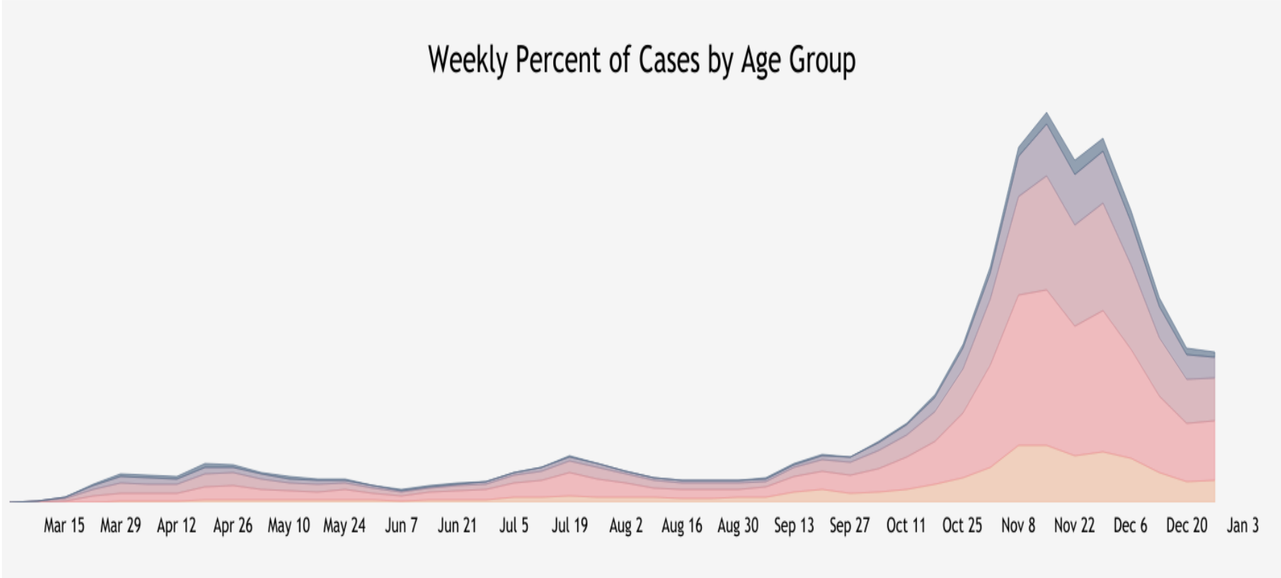
CO Hospital Stats

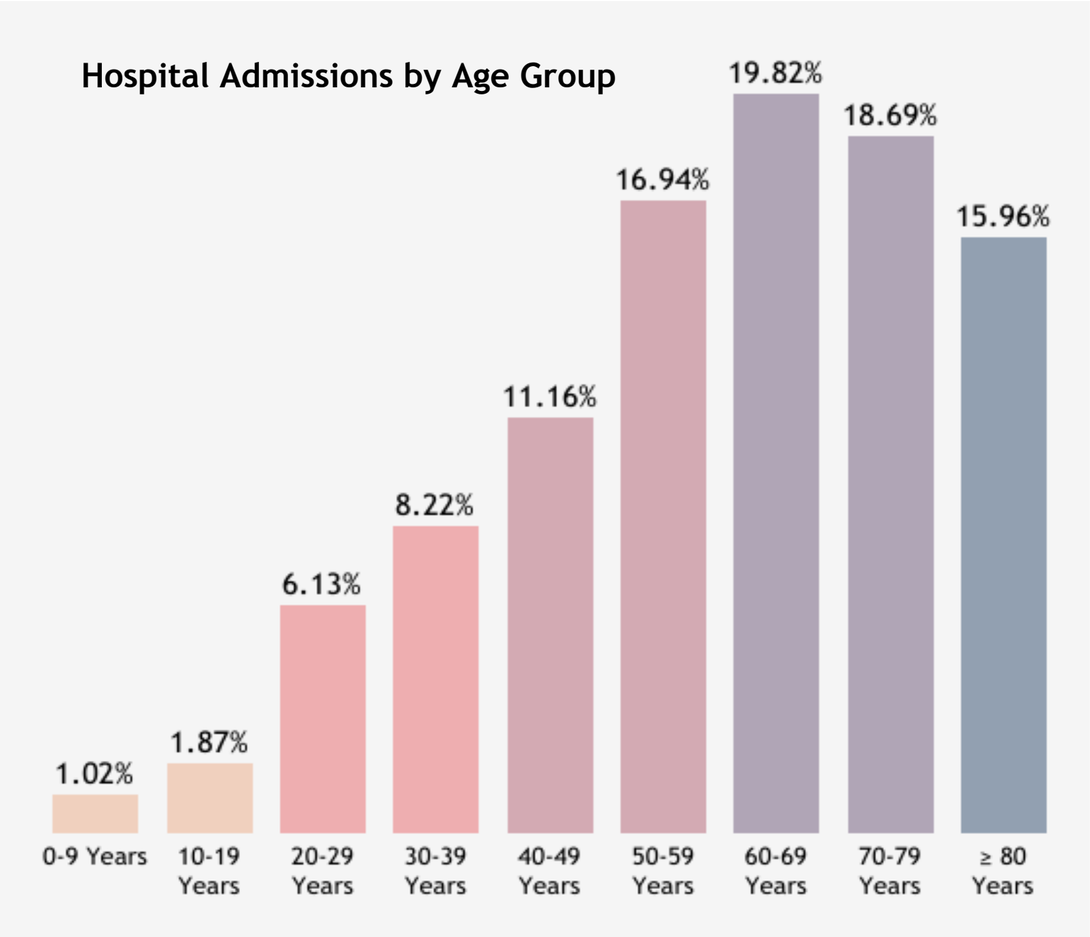
- 37% of adult ventilators in use
- 63% of ICU beds in use



OLDER POPULATIONS ARE INCREASINGLY AFFECTED – COLORADO DATA. CLOSE PATTERNS BTW 40-64 AND 65+ CATEGORIES







Source: Colorado Department of Public Health & Environment: **Covid19.colorado.gov**

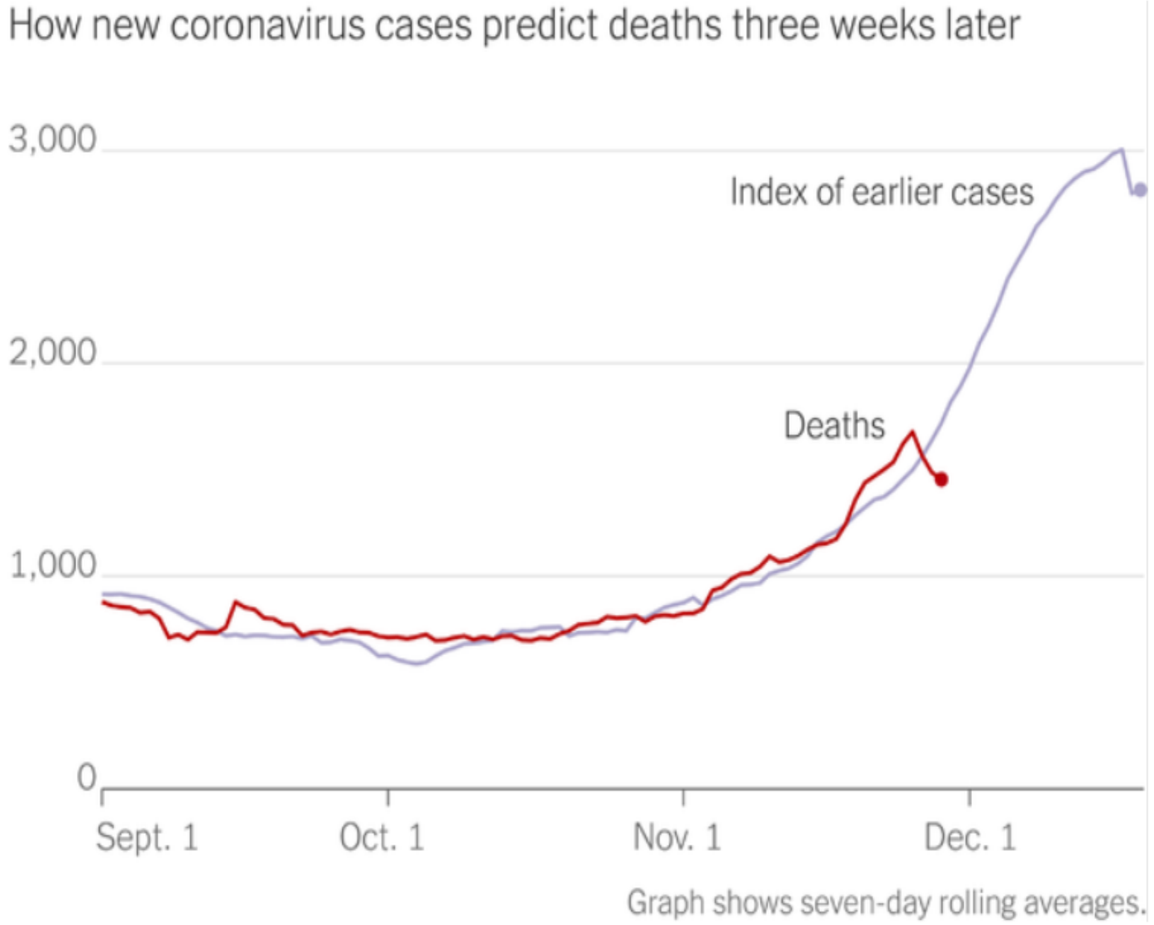
Impact of Age on Hospitalizations and Deaths - CDC

	Hospitalization[1]	Death[2]
0-4 years	4x lower	9x lower
5-17 years	9x lower	16x lower
18-29 years	Comparison Group	Comparison Group
30-39 years	2x higher	4x higher
40-49 years	3x higher	10x higher
50-64 years	4x higher	30x higher
65-74 years	5x higher	90x higher
75-84 years	8x higher	220x higher
85+ years	13x higher	630x higher

Source: CDC Website, Jan 5, 2021. Rate ratios compared to 18-29 year olds

Coronavirus & Death – Nationally

- Relationship between confirmed new coronavirus cases and deaths has held steady this fall.
- Track the # of new cases to predict # of deaths 3 weeks later. Every 100 new cases in the U.S. has led to an average of ~ 1.7 deaths, with that 3-week lag.
- Chart shows the relationship — daily deaths compared w/ index equal to 1.7% of newly diagnosed cases from 3 weeks earlier. The two lines have risen almost in tandem for the past 3 mo.



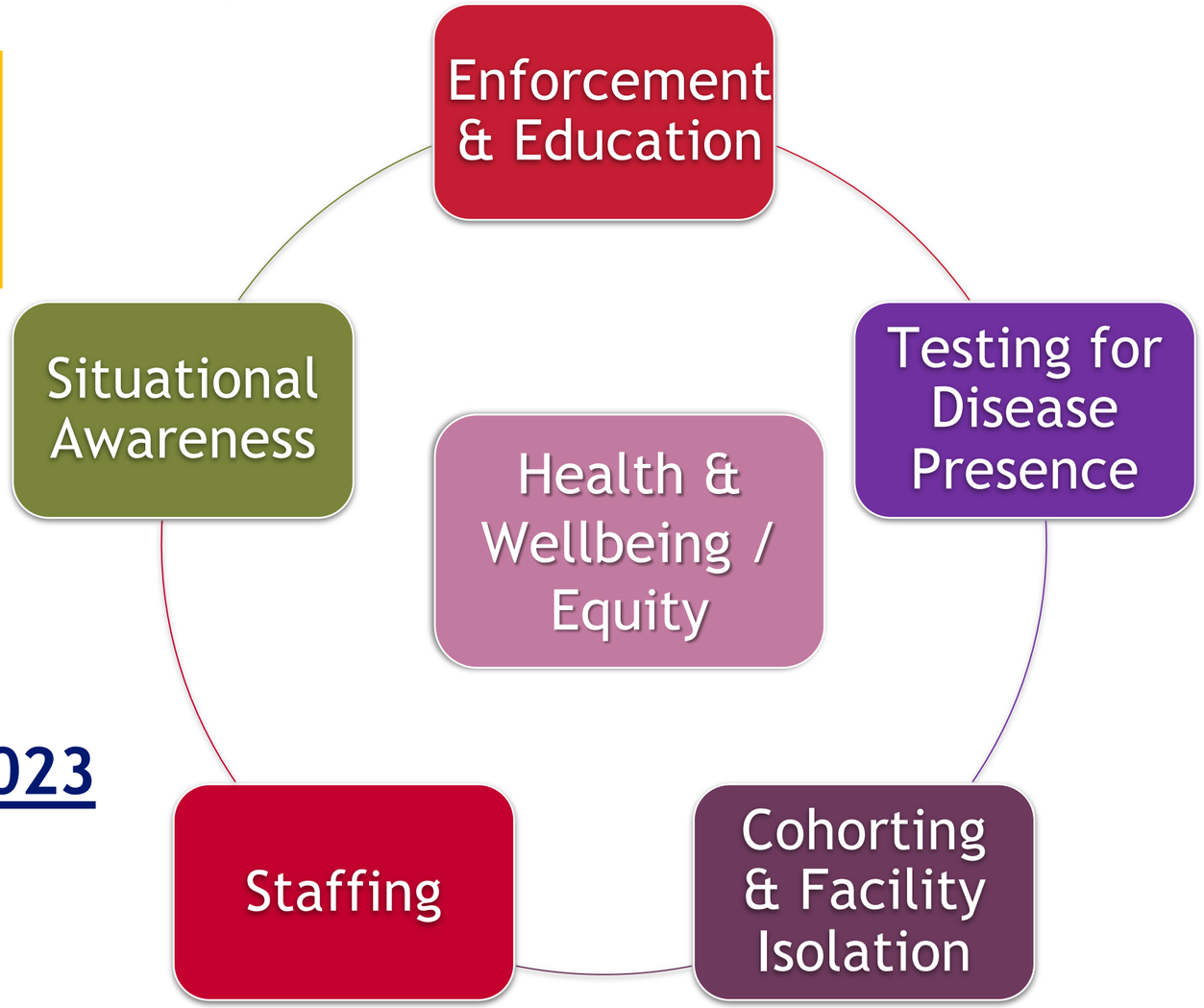
By The New York Times | Sources: State and local health agencies and hospitals

Protecting Our Most Vulnerable Through a Residential Strike Force

Recognized by AARP as a national model

Importance of this work is clear.

Over 40% of COVID deaths are in nursing homes, other residential care settings. Through 1/1/21, **519** residential care facilities have had an outbreak, **10,023** residents and **7,846** staff have tested positive for COVID-19. Tragically **1,729** residents have passed away.



(1) Residential Care Strike Force (2) The American Association of Retired Persons. Governor Polis Nov. 2020 Press Release.

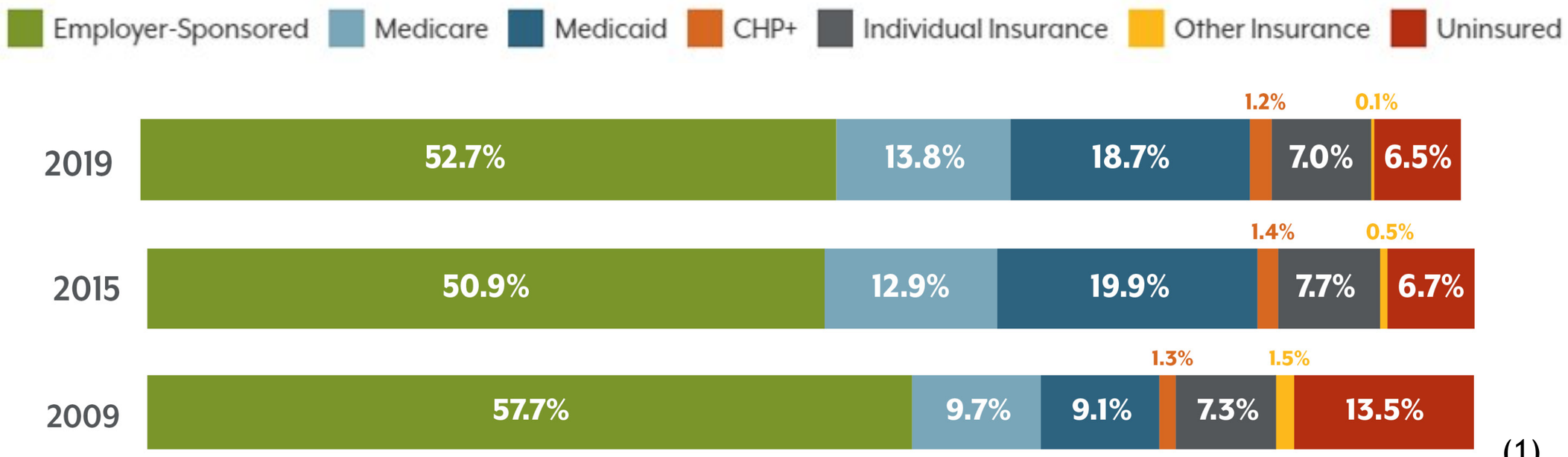
Collaboration with providers and other stakeholders to reach Coloradans

1. **Socially distance.** Wear your mask. Wash your hands
2. **Interacting with households**
3. **Customizable messaging** including emerging **vaccine outreach.**
4. > 120 **operational memos** and 100 **stakeholder meetings**

Holiday stay safe Step-Up Campaign: covid19.colorado.gov/social-media-graphics

Exposure Notifications (contact tracing) to Your Phone: addyourphone.com

How Coloradans Are Getting Covered



(1)

- Dec 2020, 1.42M (24.2%) of Coloradans in Medicaid, CHP+ (2)
- Sept 2020, Medicare covers 16.1%, 941k+. **Public Plans > 40%.**
- Uninsured rate is rising. Uncertainty in employer coverage
- **Renewed focus on Affordability – Coloradans, Employers, State**
- **Increased collaboration and Dept and Health Cabinet leadership**

(1) Colorado Health Institute, February 2020 (2) Official HCPF data, October 2020

Health Care Affordability

Health care spending in the US is 17.7% of GDP ($3.6T).

Colorado budget for HCPF, CDPHE & CDHS = $4.2B GF (36%).

Affordability measures help State, Employers, Coloradans.

Evolving Medicaid Member Health & Cost Control

3 Programs: Maternal Supports, Diabetes and Complex Case Management

Improving consistency between RAEs on:

- programs and their features/components
- components when programs are delegated to PCMPs
- member experience, health improvement and savings results

Sample Components: Member identification, risk stratification, culturally competent specialized care teams, facilitates access to appropriate resources and community programs, evidence-based initiatives.

SB18-266: THANK YOU. Dept has exceeded $5M savings promised with SB18-266 and built foundation enabling more/better trend controls.

Maximize & Drive Innovation

- **Telemedicine** improves access for:
    - Specialty Care
    - Behavioral Care (battles stigma)
    - Rural and geographically isolated areas
    - Access for Individuals with Disabilities & Seniors
    - Individuals without reliable transportations

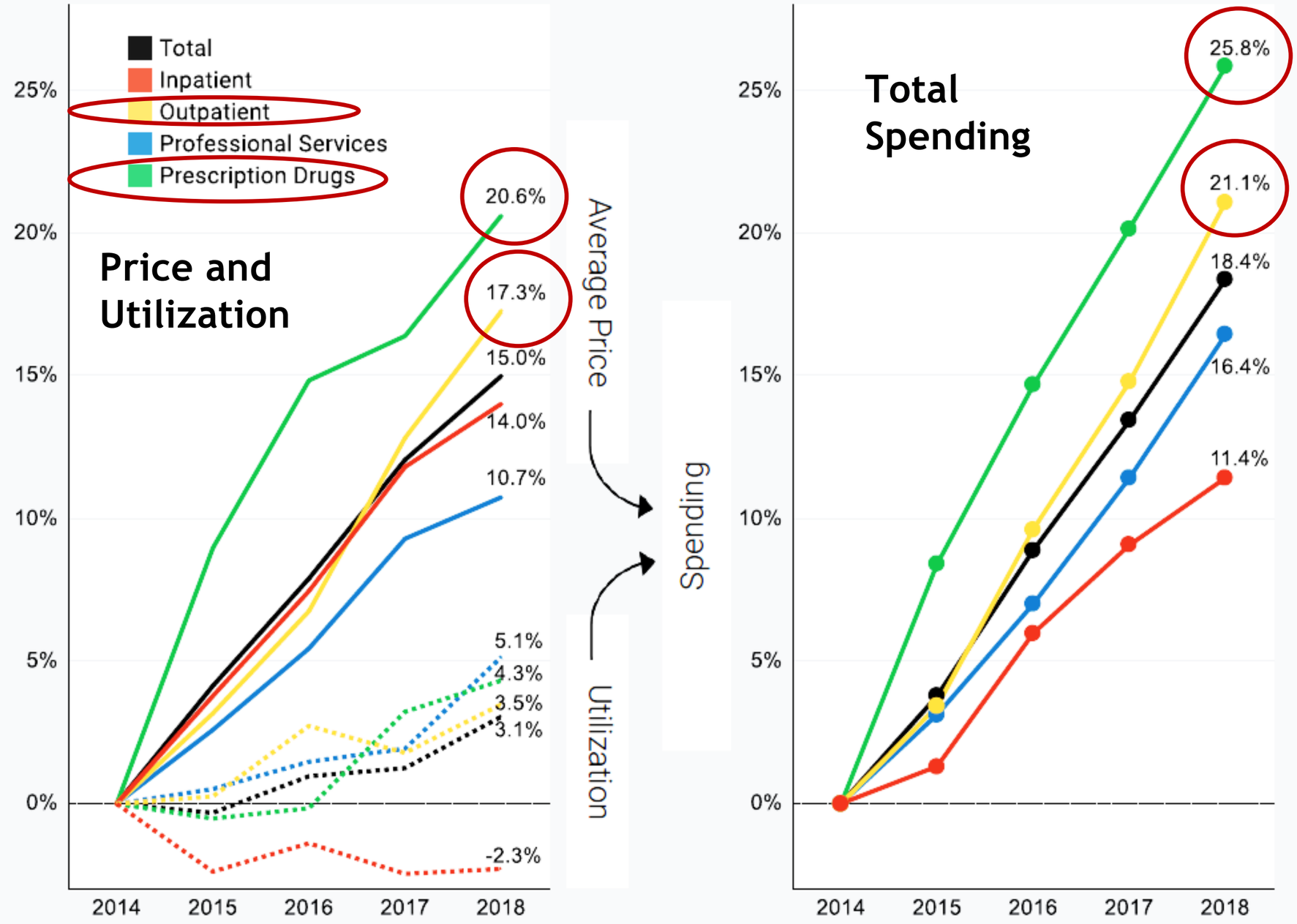
- **Prescriber Tool**: Gives docs insights into costs between therapy options, by patient

- **Alternative Payment Methodologies**

Leveraging HCPF to control costs for all Coloradans

Rx and Hospital are top opportunities

Figure 4: Cumulative Change in Spending per Person, Utilization, and Average Price by Service Category



(1) Health Care Cost Institute, 2020

Partnership with Lt. Gov Primavera, Office of Saving People Money on Health Care and the Health Cabinet

1. **Reduce pharmacy costs**

2. **Reduce costs** in the large **employer insurance market**, focusing especially on opportunities from the "New Normal in Health Care" evolving response to COVID-19

3. Implement the **Behavioral Health Task Force** recommendations

Federal Monitoring and Response

Supreme Court ACA Hearing decision likely May or June.
Just some of the potential ACA impact:

- $2B+ for Medicaid expansion up to 138% FPL covering 462k in CO
- Exchanges, fed subsidies up to 400% FPL, 123k of 167k in CO
- Up to age 26 and employer-sponsored coverage mandates
- Consumer protections
- Reinsurance funding

Cautiously optimistic on outcome based on Justice's questions.
39 states & DC have passed Medicaid expansion.

Strategic response to ACA ruling and **Biden overall healthcare agenda.**

(1) Kaiser Family Foundation 2020 Issue Brief

2020 Focus on Equity Diversity Inclusion (EDI)

June:
Created, Distributed Juneteenth awareness seminar for state employees.

Led LGBTQ preparation. Engaged public discussions on ACA & Supreme Court hearings.

Completed interview with Cleo Parker Robinson. Video & facilitation guide released Dec 2020 for state agencies.

Hired EDI Officer

JULY AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER

Hosted listening sessions on racial equity

Established EDI Committee

Identified priorities

Draft EDI plan & equity framework

Involved more than 80 staff in 5 EDI subcommittees

2021 Focus

Begin EDI Trainings

Finalize EDI Pan

Launch EDI assessment

Begin work on
EDI assessment

Begin work on equity lens

Pilot equity lens

Complete EDI Trainings

JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE

MLK Day

Black History

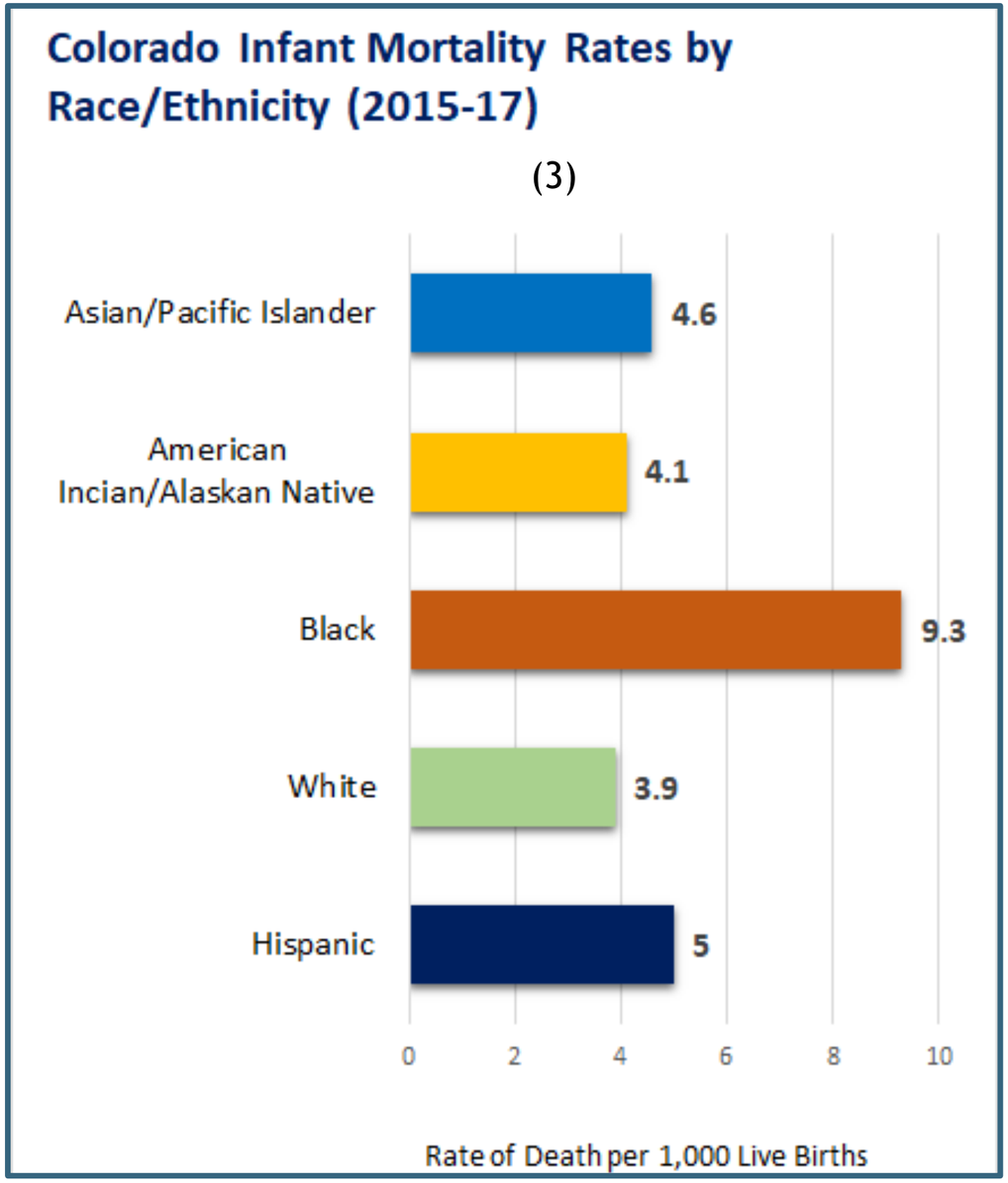
Minority Health

LGBTQ+ Pride
Juneteenth

Women's History
Cesar E. Chavez Day

AAPI Heritage
Older Americans

Opportunity: Health Equity for People of Color



"**Hispanic residents are about 20% more likely than white residents to die** of treatable conditions. There's no one explanation for the disparity in deaths, experts say."
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In Colorado:

- **Hispanic people** are 22% of the pop and 38% of COVID cases and hospitalizations.
- **Black people** are almost 5% of the pop, nearly 10% of COVID hosp., 7% of deaths.
- **White people** are 68% of the population but only 38% of COVID cases. (2)

(1) Wingerter, Denver Post, October 2020 (2) CDPHE data, 2020 (3) March of Dimes, Peristats, 2020

Accomplishments and Critical Project Work

- Enrolled > 175,000 members since March. Exceeded customer service standards
- Executed over 20 emergency waivers, rules, and State Plan Amendments to improve access and to reduce provider administrative burden
- Co-chaired the COVID-19 Residential Care Strike Team and launched the ConnectToCare jobs site
- Expanded telemedicine policy to support safe access to care
- Supported the development of alternative care sites
- Collaborated with CDHS, Counties and Medical Assistance sites to double PEAK online applications and improve CBMS eligibility system performance
- Launched “We’re Here for You, Colorado” campaign to connect Coloradans to coverage

Accomplishments and Critical Project Work

- Implementing Hospital Transformation program to drive affordability and developed the Rural Support Fund - $12M annually to rural hospitals starting in Fall 2021
- 1st & 2nd Rx Cost Control solutions report; hosting 1-12-21 Affordability Summit
- Implemented Substance Use Disorder (SUD) benefit- residential, inpatient care
- Implemented ClaimsXten to prevent inappropriate claims payments
- Co-chairing CBMS management and launched the Consolidated Return Mail Center to improve eligibility accuracy and County support
- Re-designed the Health First Colorado mobile app, which increased usage and consumer satisfaction
- Transitioned HCPF workforce to a virtual operating model
- Kicked-off HCPF Equity, Diversity and Inclusion to support "*A Colorado for All*"

HCPF Budget Overview

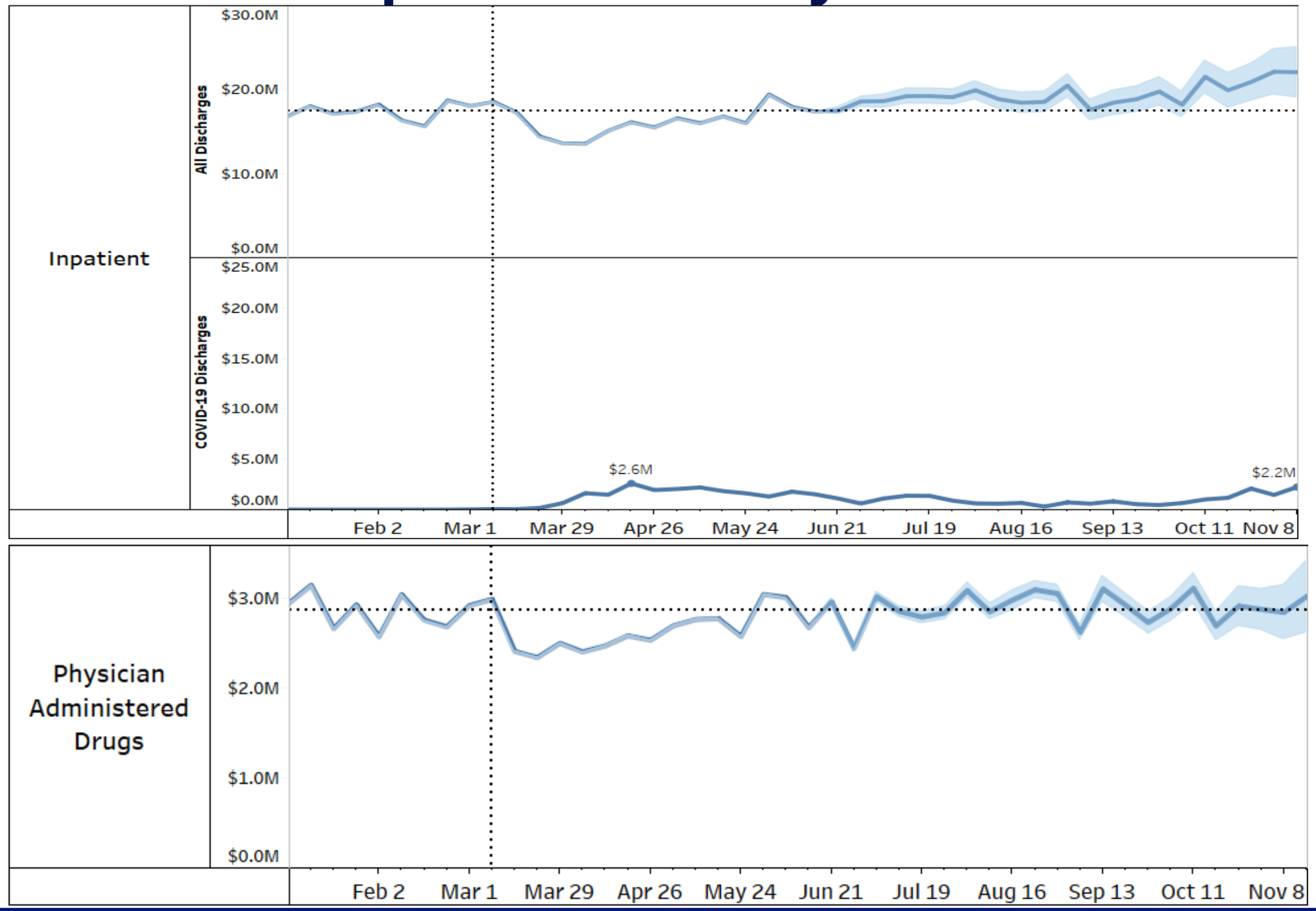
		Total Funds	General Fund	FTE
FY 2020-21	**Appropriation**	**$12,034 M**	**$3,185 M**	**556.7**
FY 2021-22	Base Adjustments	$150 M	$215 M	1.0
	Caseload Requests	$297 M	$248 M	0.0
	Decision Items	$20 M	$10 M	14.5
	Budget Reductions	($165 M)	($146 M)	0.0
FY 2021-22	**Budget Request**	**$12,336 M**	**$3,511 M**	**572.2**
	Year-over-year Change	*$302 M*	*$327 M*	*15.5*
	Percent Change	*2.5%*	*10.3%*	*2.8%*

FY 2021-22 Budget Requests

Budget Requests
R6 Remote Supports for HCBS Programs
R7 Nurse Advice Line
R8 Supported Living Services Flexibility
R9 Patient Access and Rule Compliance
R10 Covert Contractor Resources to FTE
R11 Medicaid Funding for Connect for Health
R12 ARRA-HITECH Funding Transition
R13 Funding for Family Medicine Residency Programs
R14 Technical Adjustments
R23 Behavioral Health Claims and Eligibility Processing
R24 Addressing Health Care Disparities

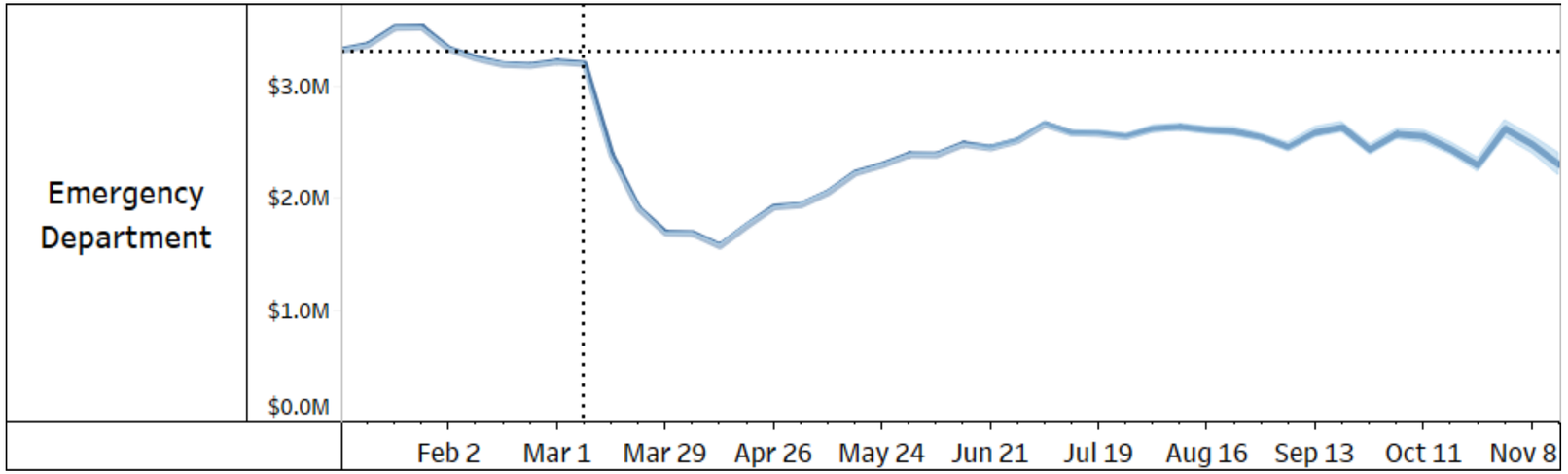
COVID-19 & Economic Downturn Impacts Questions 1-15

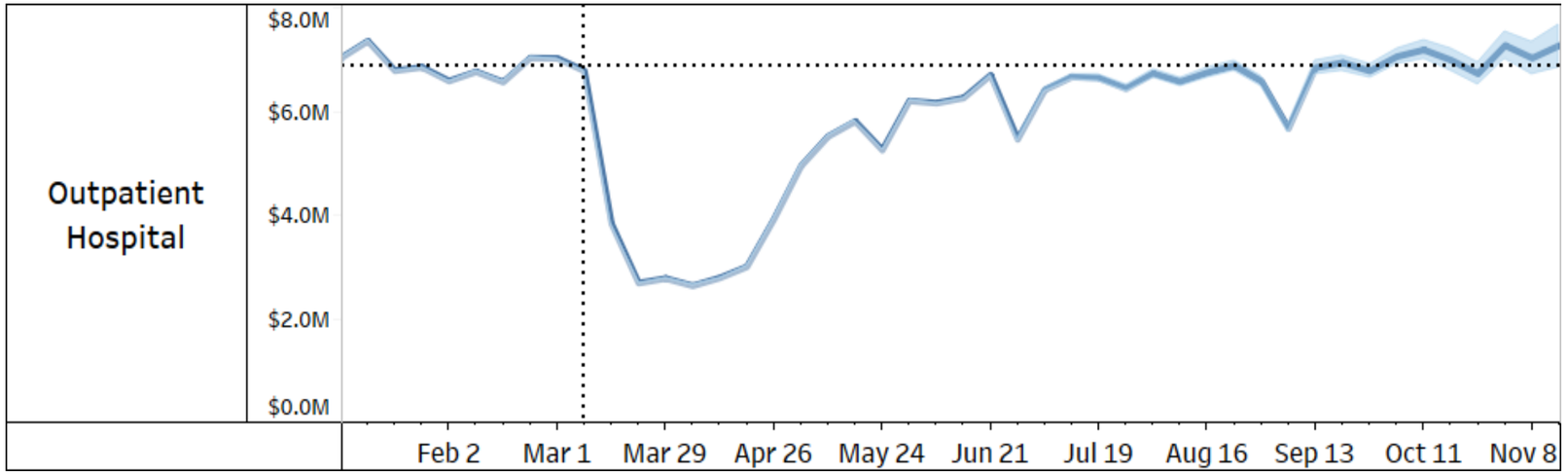
Questions 1-2: COVID's Impact on Utilization Inpatient & Physician Administered Rx



- Blue line is incurred weekly service utilization trends IBNR adjusted through 10/24
- Blue shading is the range of uncertainty in the IBNR estimates
- Vertical dotted line is the last week prior to social distancing
- Horizontal dotted line is the weekly average paid before social distancing
- Inpatient does NOT include interim billing where the Member has not yet been discharged

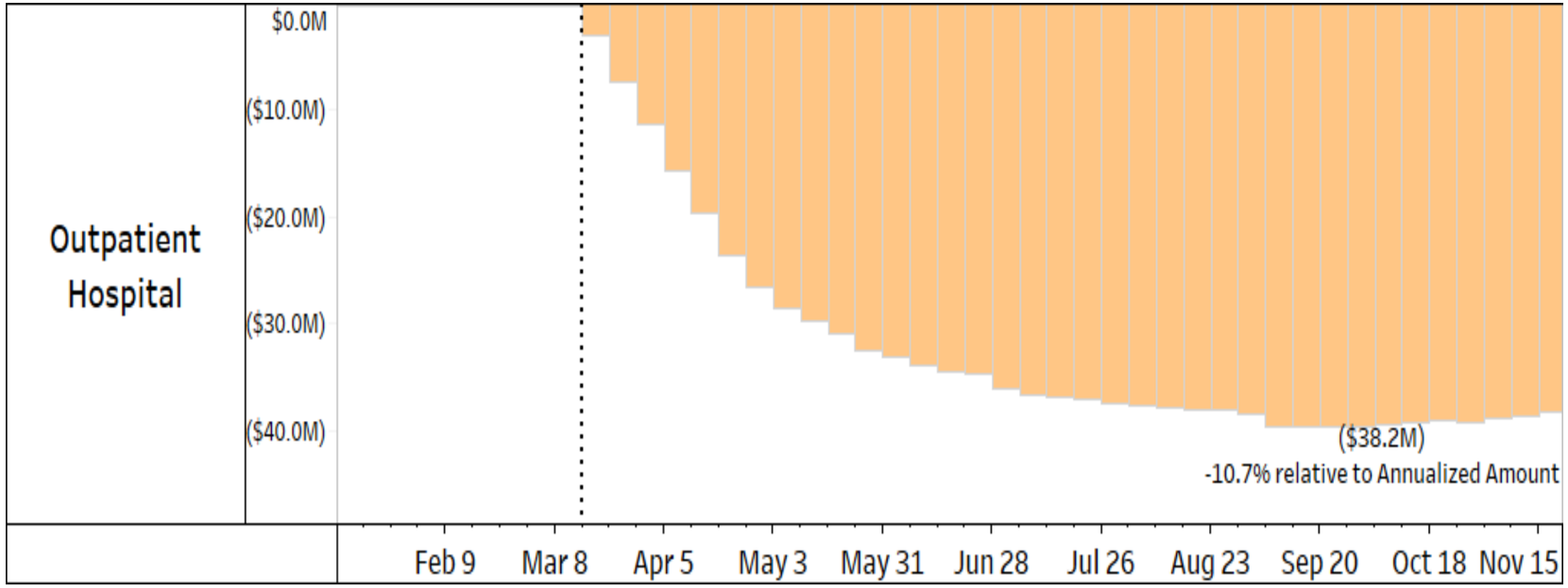
Outpatient Hospital & Emergency Room





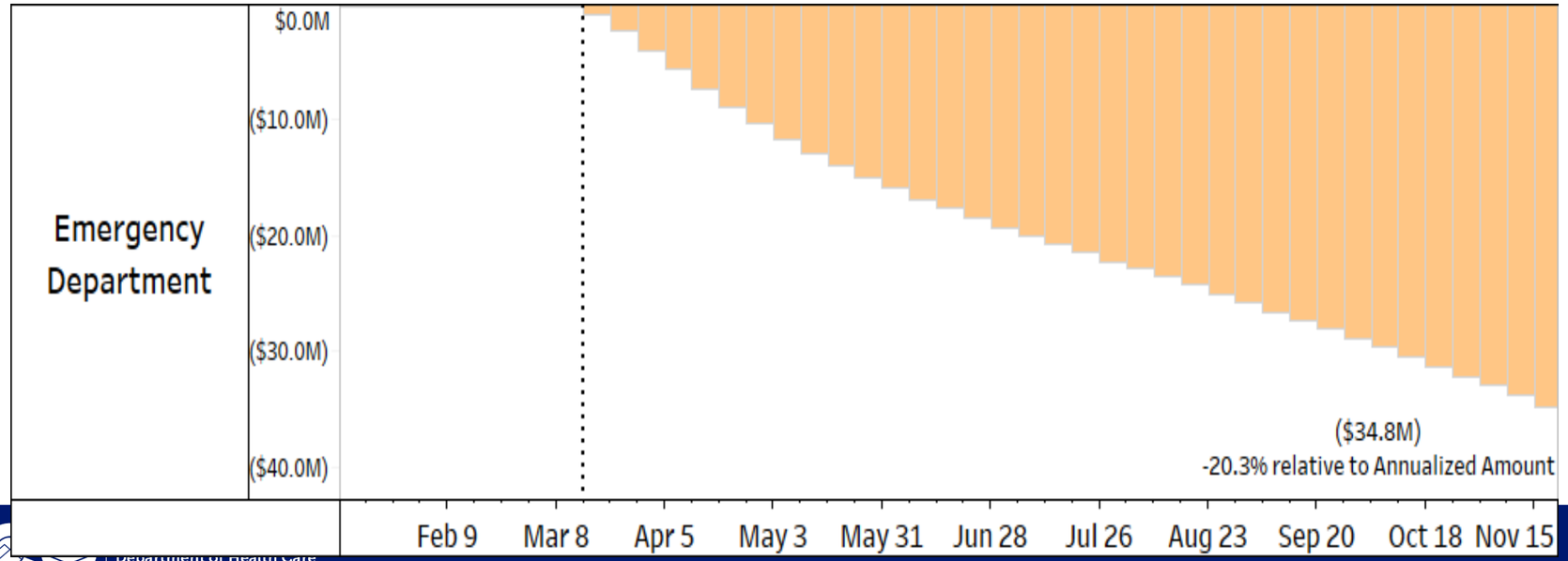
- Blue line is incurred weekly service utilization trends IBNR adjusted through 10/31
- Blue shading is the range of uncertainty in the IBNR estimates
- Vertical dotted line is the last week prior to social distancing
- Horizontal dotted line is the weekly average paid before social distancing

Outpatient Hospital & Emergency Room



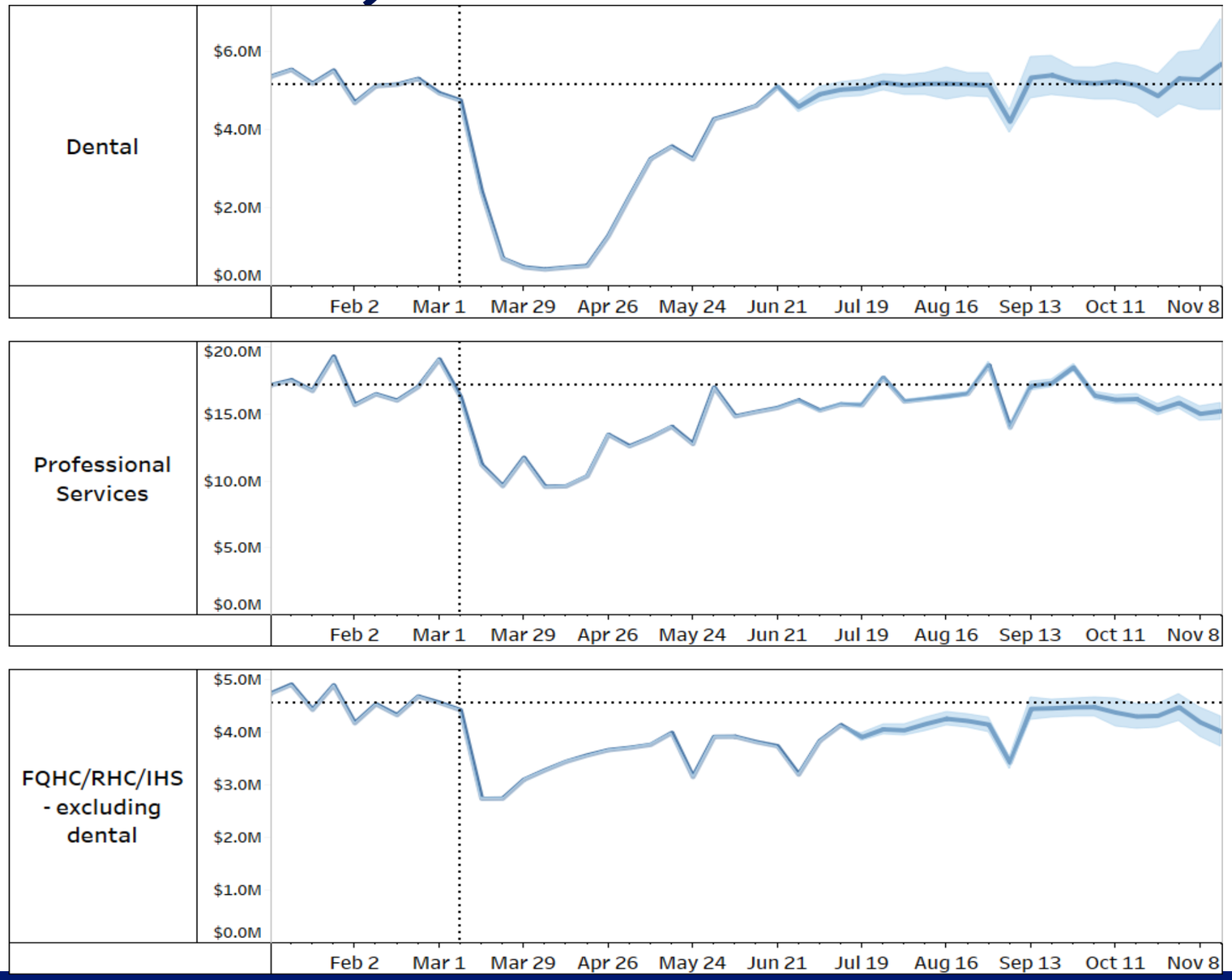
Each bar = 1 wk of cummulative gap to prior Medicaid rev

Annualized - Down 10.7%

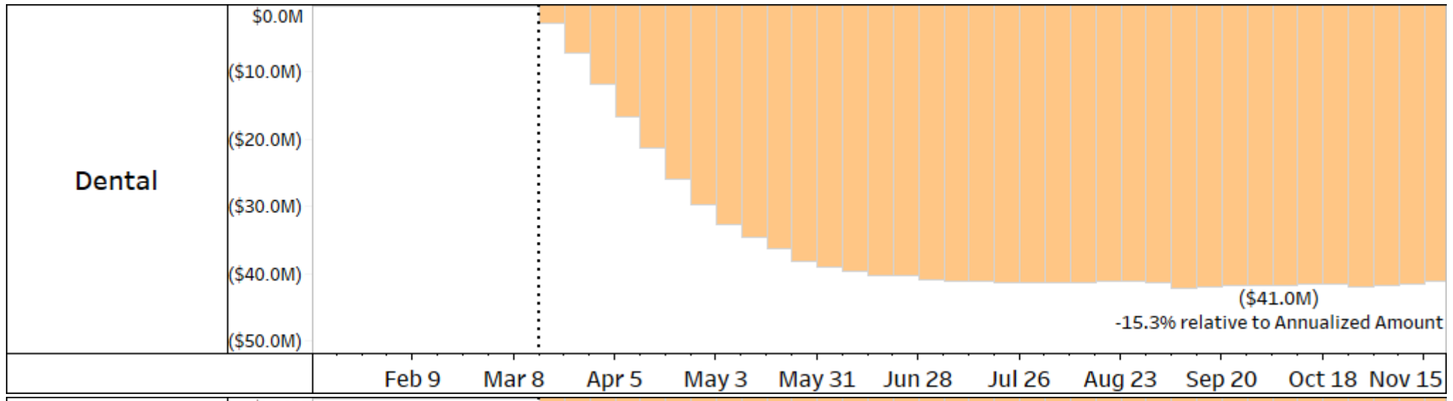


Annualized - Down 20.3%

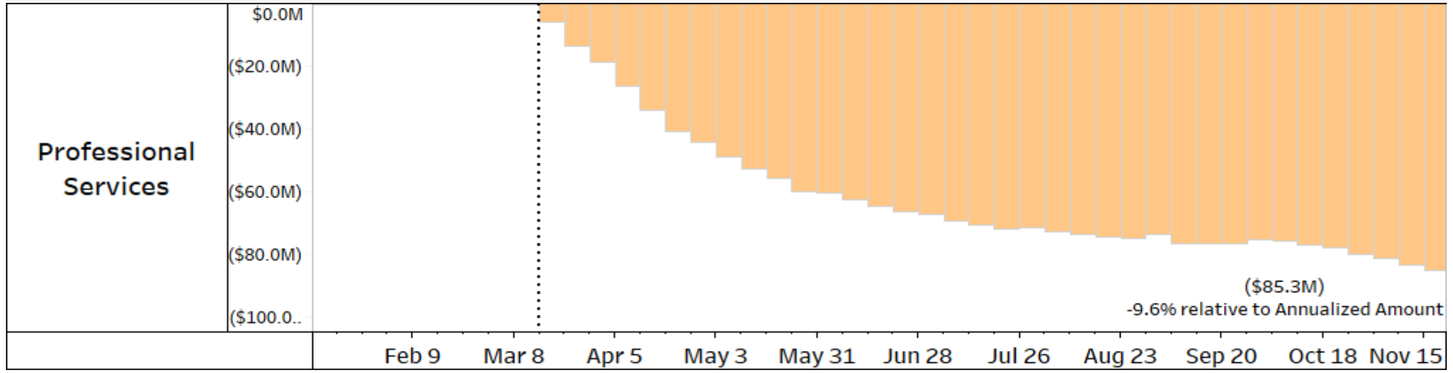
Dental, Prof. Services & Clinics



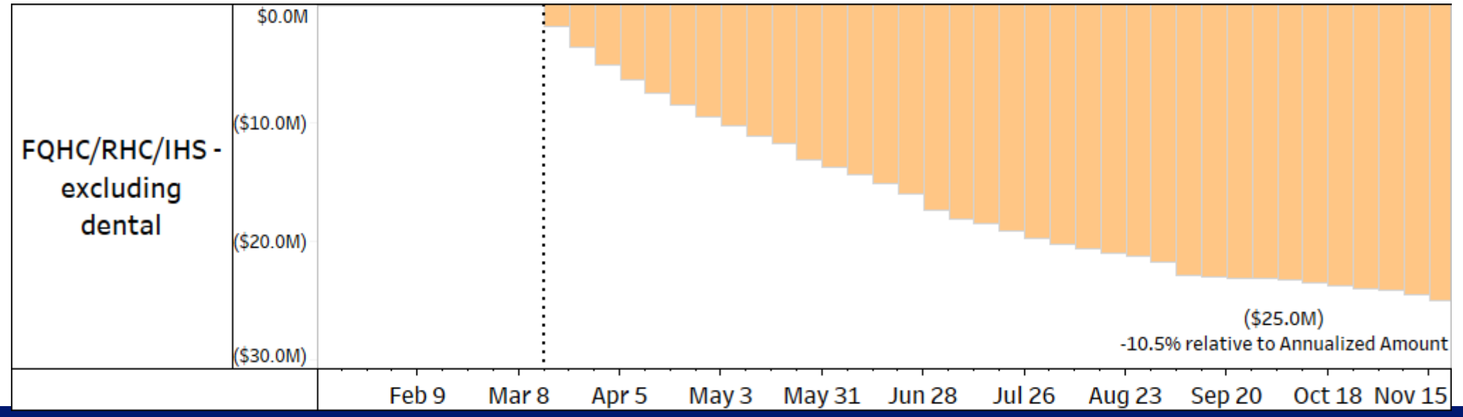
Dental, Prof. Services, Clinics



Annualized - Down 15.3%



Annualized - Down 9.6%



Annualized - Down 10.5%

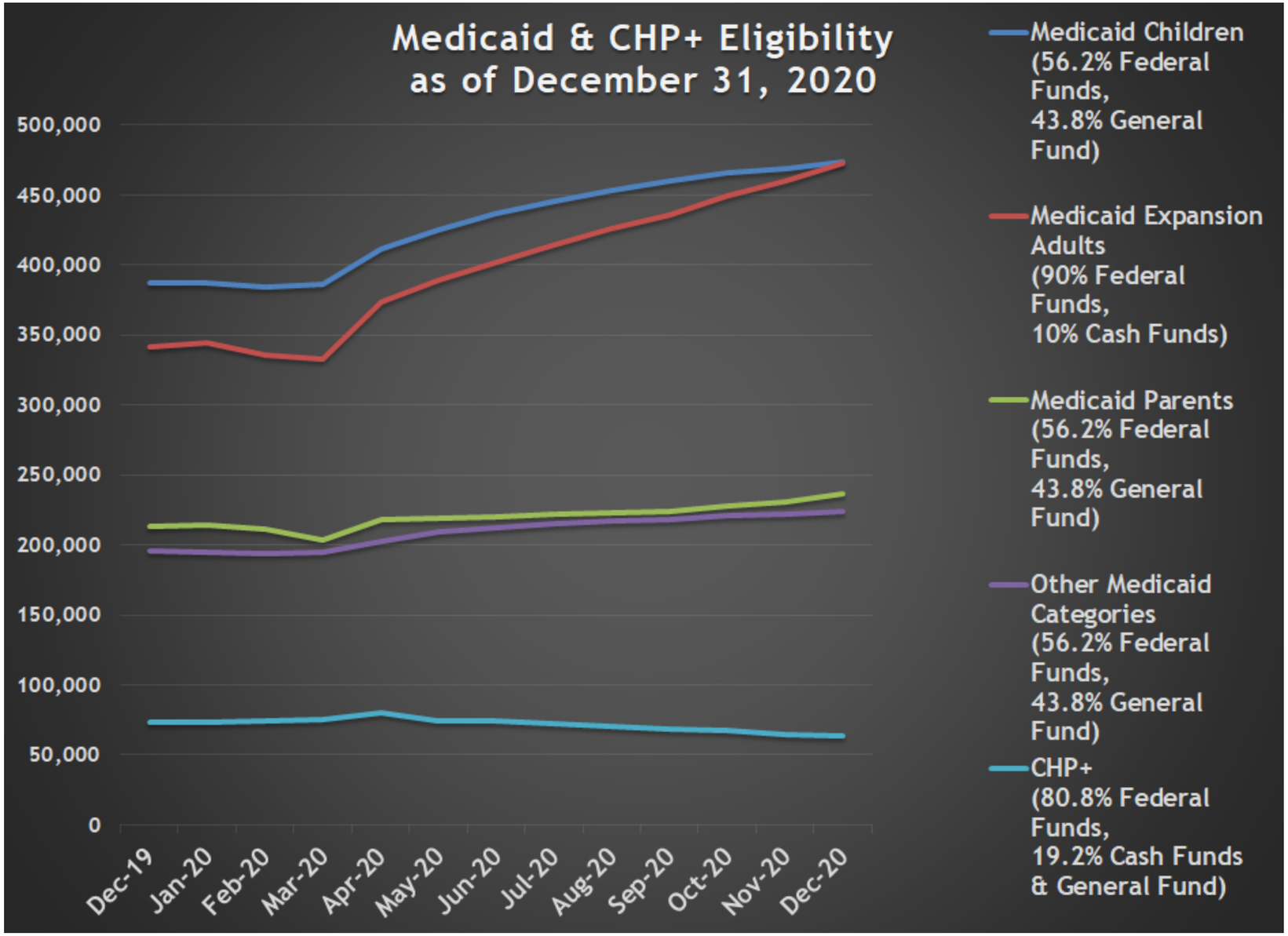
Questions 3-4: COVID-19's Impact on Enrollment

Enrollment Growth Since March 2020:

Adults & Expansion Adults = 61% of growth.

Children ~30% of growth.

Adults 65+ & Adults with Disabilities make up 5% of growth. 2nd fastest state for seniors growth.



(1) Colorado Department of Health Care Policy & Financing 2020 data.

Question 6: Medical Assistance thru 12/29/20, Up 175k+

	New Members 2020	Disenrolled Members 2020	Continuous Coverage	Total Enrollment (MA) 2020
January	35,113	38,004		1,262,929
February	27,197	33,565		1,256,561
March	33,607	40,635		1,249,533
April	42,397	4,600	37,608	1,287,330
May	26,434	6,868	34,661	1,306,896
June	28,052	6,211	24,809	1,328,737
July	26,905	6,158	28,029	1,349,484
August	27,121	6,338	33,153	1,370,267
September	25,475	6,429	24,120	1,389,313
October	22,024	6,325	35,020	1,405,012
November	21,982	7,231	28,233	1,419,763
December	14,861	6,544	22,769	1,428,080
January	2,438	6,413	41,297	1,424,105
Total			309,699	

61,676 members are also locked-into a higher benefit category, such as Medicaid versus CHP+.

Q7: Stimulus Funding for Providers

Provider Type	%	Provider Relief Fund	Pending Stimulus
Hospitals	55.8%	$926,048,095	$147M
Government	17.5%	$291,026,977	
Other/Not Tagged*	17.0%	$281,842,535	
FQHCs	3.1%	$50,864,252	
Nursing Homes/SNFs	1.6%	$25,797,065	
Universities	1.4%	$22,500,430	
Medical Groups	1.1%	$18,765,430	
Hospices	0.8%	$14,055,468	
Schools	0.8%	$12,950,189	
Mental Health	0.6%	$10,100,151	
Native	0.2%	$4,097,180	
Medical Equipment	0.1%	$1,123,254	
	100%	$1,659,171,025	

*Many amounts too small to be attributed manually

With PPP and FEMA, $1.042B to Colorado hospitals to date

HHS Press Release:

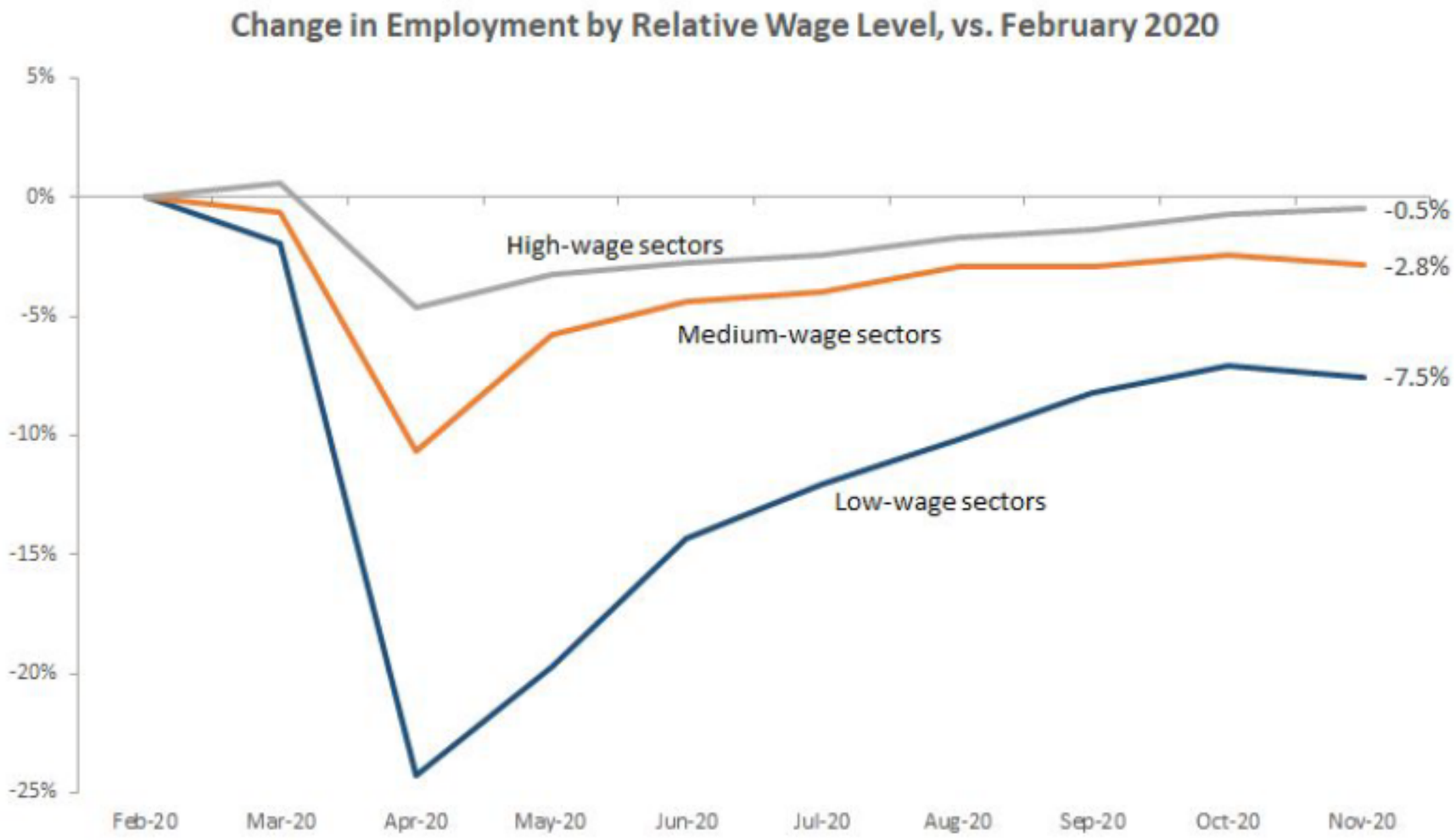
"HRSA...will distribute $24.5B to over 70k providers. Up from the $20B originally planned, the addition of another $4.5B is being used to satisfy close to 90% of each applicant's reported lost revenues and net change in expenses caused by the coronavirus pandemic in the first half of 2020. Payment distribution started [12/16] and will continue through Jan 2021... Funding will distribute to providers up to 88% of their reported losses. It is worth noting that over 35,000 applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88% of reported losses." Colorado providers will receive $147 million.

Questions 8-9: Pandemic's Impact on Health Insurance Landscape

672,000 Coloradans Received Unemployment Insurance March-Oct (22% of 2019 workforce); Now = 253,333 on UI.

Unemployment Rate in Colorado:

Feb: 2.5%
Mar: 5.2%
Apr: 12.2%
May: 10.2%
Jun: 10.6%
Jul: 7.4%
Aug: 6.7%
Sep: 6.4%
Oct: 6.4%
Nov: 6.4%



(1) Colorado Department of Labor and Employment. (2) Office of State Planning and Budget, November 2020.

CDLE-HCPF Survey: Where are you getting your health insurance coverage?

	July 31 (5,000+ respondents)	Nov 9 (857 respondents)
Employer extended health care benefits	8.97%	3.07%
Employer's COBRA option	4.73%	1.30%
Spouse's health insurance	15.94%	4.01%
Under age 26, on my parent's health insurance	2.18%	2.13%
Coverage through Connect for Health Colorado	10.70%	7.91%
Health First Colorado	22.47%	18.65%
Child Health Plan *Plus*	.21%	.24%
Have coverage, but not through any of above	15.47%	4.96%
*Medicare or Medicare Advantage	N/A	11.81%
*Veterans Administration (VA) or TRICARE	N/A	1.06%
I don't have health insurance coverage	19.33%	44.86%

* Medicare, VA and TRICARE were included in "have health care coverage but not any of the above" in the July survey.

If you are currently uninsured, or anticipate being uninsured, do you plan to:

	July 31 (5,000+ respondents)	Nov 9 (857 respondents)
Purchase coverage through Connect for Health Colorado	8.92%	8.89%
Purchase coverage directly from a health insurance company	2.70%	.81%
Apply for coverage w/Health First Colorado (Medicaid)	20.0%	35.85%
Apply for coverage w/Child Health Plan *Plus* (CHP+)	.99%	1.08%
Get covered through my spouse's health insurance	1.71%	.27%
Under 26, get covered through my parent's health insurance	0.09%	.27%
Get covered, but not through any of the above	4.95%	4.04%
Other	14.50%	8.36%
Go without health insurance coverage	46.13%	40.43%

Why are you planning to go without coverage?

I can’t afford the monthly premiums: **82.63%**

I can’t afford the copayments, coinsurance or other out-of-pocket costs: **40.12%**

I don’t think I will be out of work – and therefore without health care coverage – for that long: **3.56%**

I do not think I need health insurance: **4.79%**

Commission on Family Medicine Funding Questions 16-17

Hospitals
Questions 18-23

Health System Affordability Measures

- **UCH:** closed/repurposed 8 freestanding EDs; invested in consumer price transparency tools

- **Children's**: 40-70% decrease in unnecessary treatments/scans; focused on social determinants of health to reduce ED use

- **SCL**: divested 3 freestanding EDs in Denver; in Grand Junction, lowered MRI/CT imaging prices by up to 70%; working on Centers of Excellence approach in Grand Junction (1)

(1) Self report by hospitals (2020)

Health System Affordability Measures

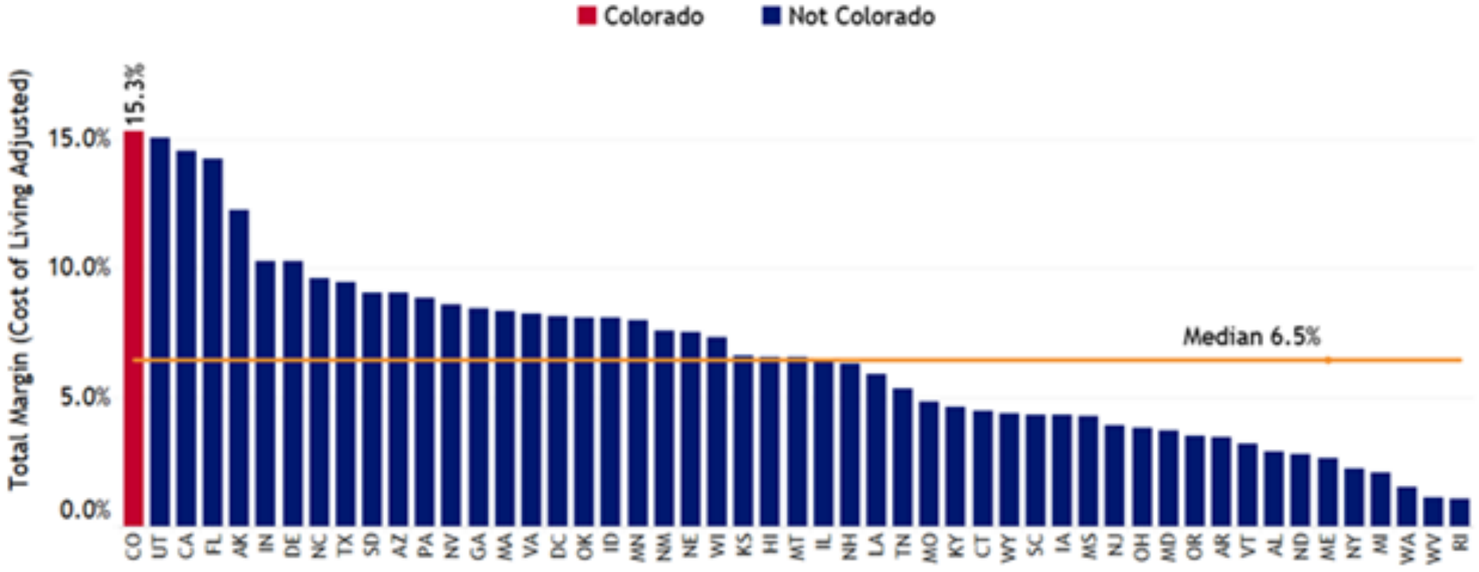
- **Centura:** partnered with Peak Health Alliance and Southwest Health Alliance Partnership, resulting in lower cost prices to seven counties; 50-60% off charges for self-pay consumers

- **Banner**: supported patients following discharge to avoid readmissions; 24-hour call line to triage patients to the right level of care

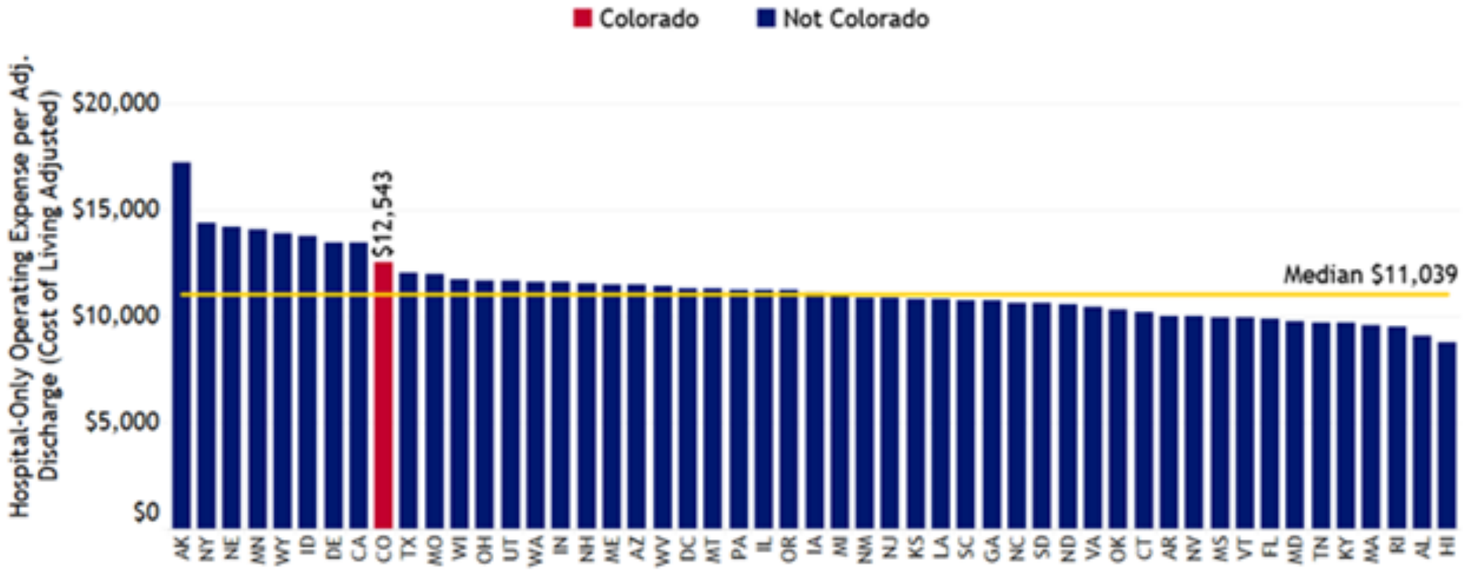
- **Vail Health**: significant decreases in rates to local marketplace exchange carrier and sm grp market carrier; provided four large self-insured employers with rate reductions; reduced imaging, lab and physician prices (1)

(1) Self report by hospitals (2020)

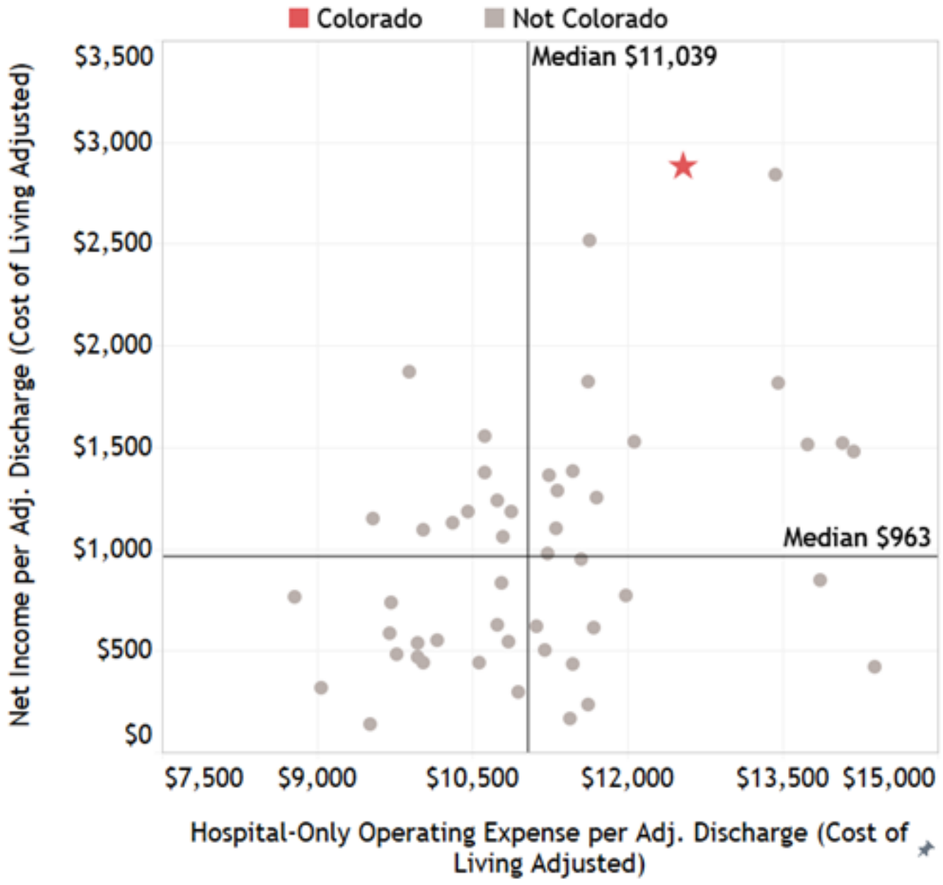
2018 Colorado and U.S. State Cost and the District of Columbia of Living-adjusted Hospital-Only Operating Expense per Adjusted Discharge



2018 Colorado and U.S. States and the District of Columbia Total Margin



2018 State Comparison of Cost and Net Income



Rural vs Urban Divide

Critical Access Hospitals*†

- Patient services margin is -5.4% compared to +9.8% for urban hospitals
- Average number of inpatients per night is less than 8 compared to more than 160 for urban hospitals
- 80% of patient revenue is from outpatient care compared to 50% for all other hospitals

*25 or fewer beds, rural areas, 35 miles from nearest hospital
†Data from 2018 hospital Medicare Cost Reports

Hospital Transformation Program (HTP) Timeline

Apr 2021

- Hospital Application due with public input

May 2021

- HCPF and consultant review applications, request revisions if necessary
- Complete applications with HCPF recommendations to Oversight Committee

Jun 2021

- Oversight Committee completes reviews, sends to HCPF

Jul 2021

- Additional application revisions and review, if needed
- Presentation to CHASE Board
- Final application review period ends and applications published

Aug - Nov 2021

- Implementation plan process

Dec - Mar 2021

- Project ramp-up and planning

Apr 2022

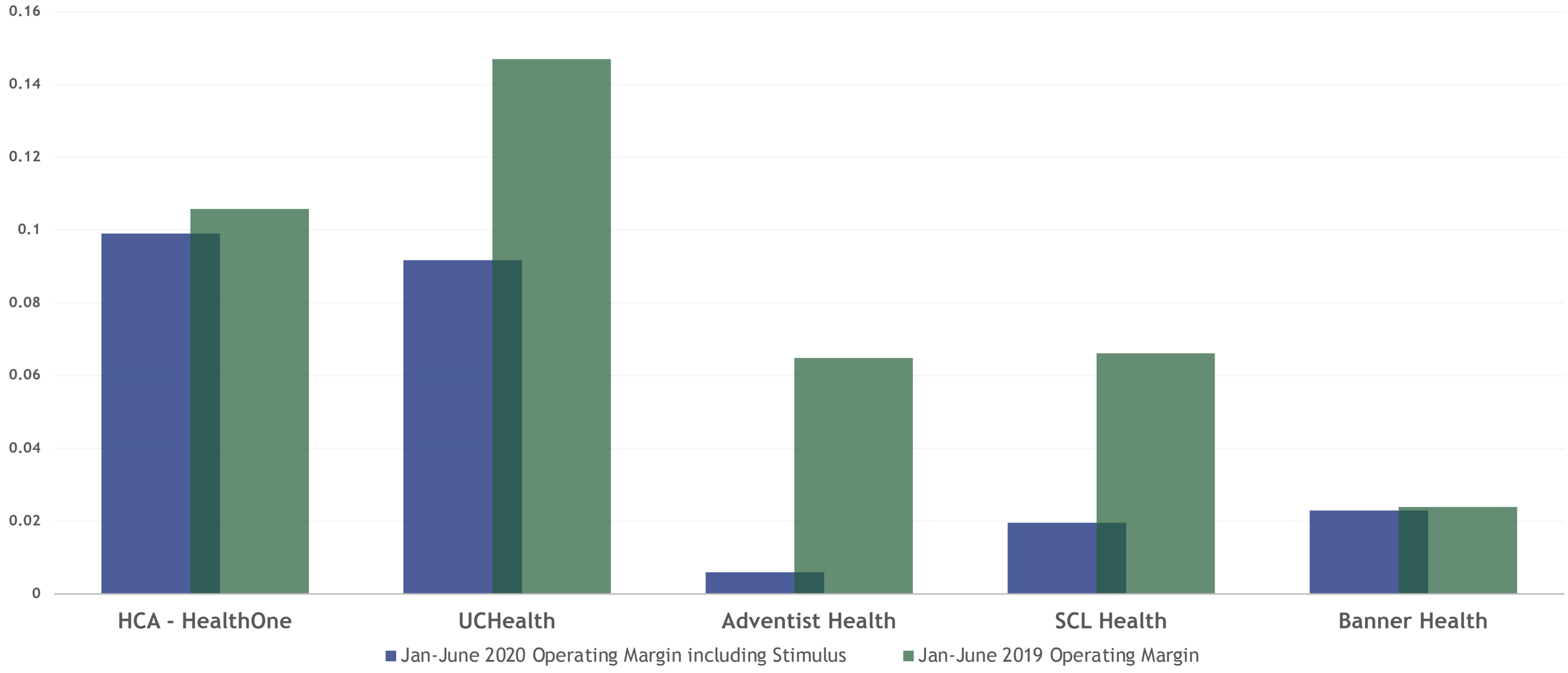
- HTP activity begins

Jul 2022

- First activity reporting for prior quarter

Question 18: COVID-19 & Hospital Finances

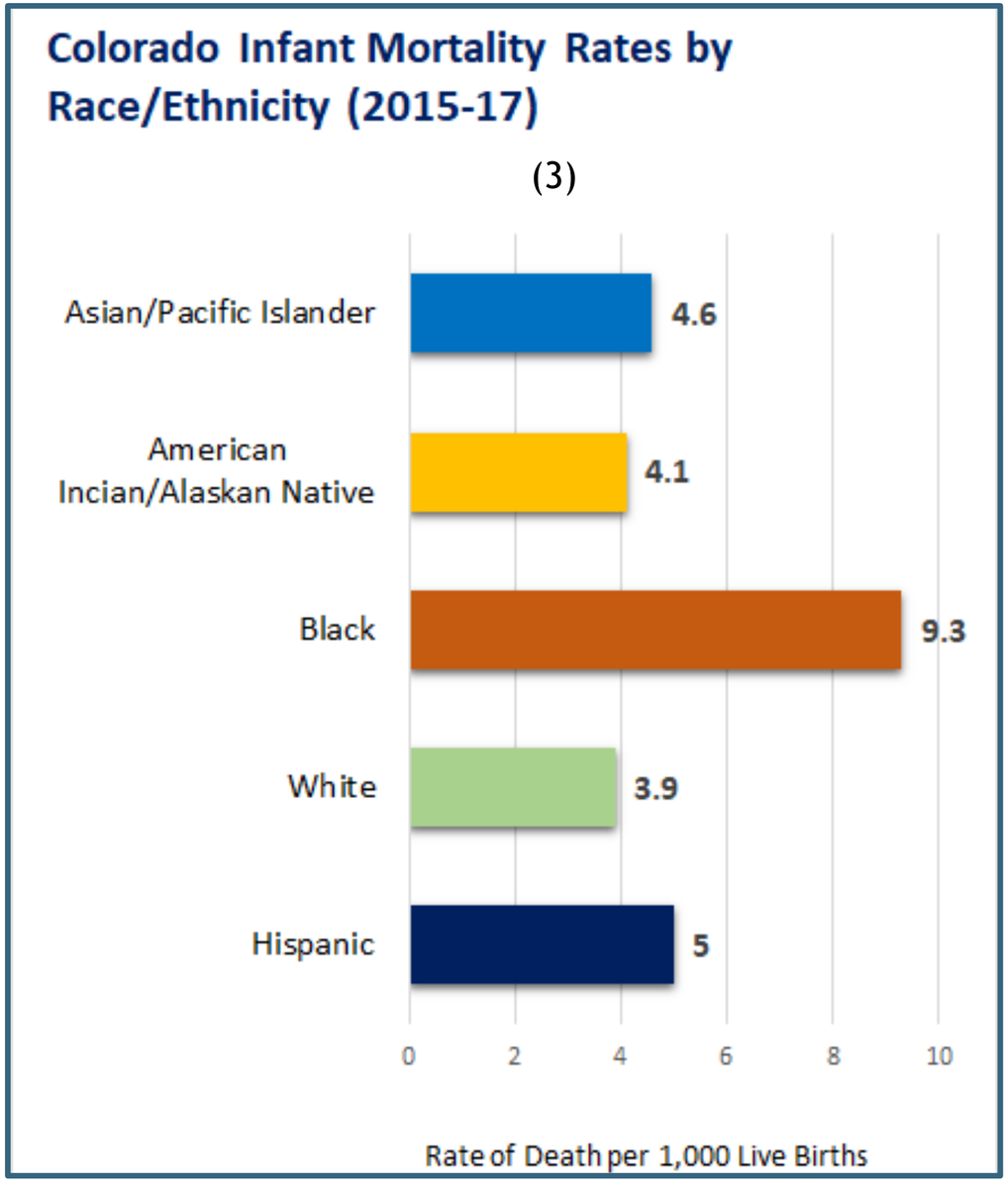
Operating Margin Jan-June 2019 and 2020



Source: *Municipal Securities Rulemaking Board::EMMA*. (n.d.). EMMA Municipal Securities Documents. Retrieved Oct-Dec 2020, from https://emma.msrb.org/

Budget Request & General Questions 24-30

Opportunity: Health Equity for People of Color



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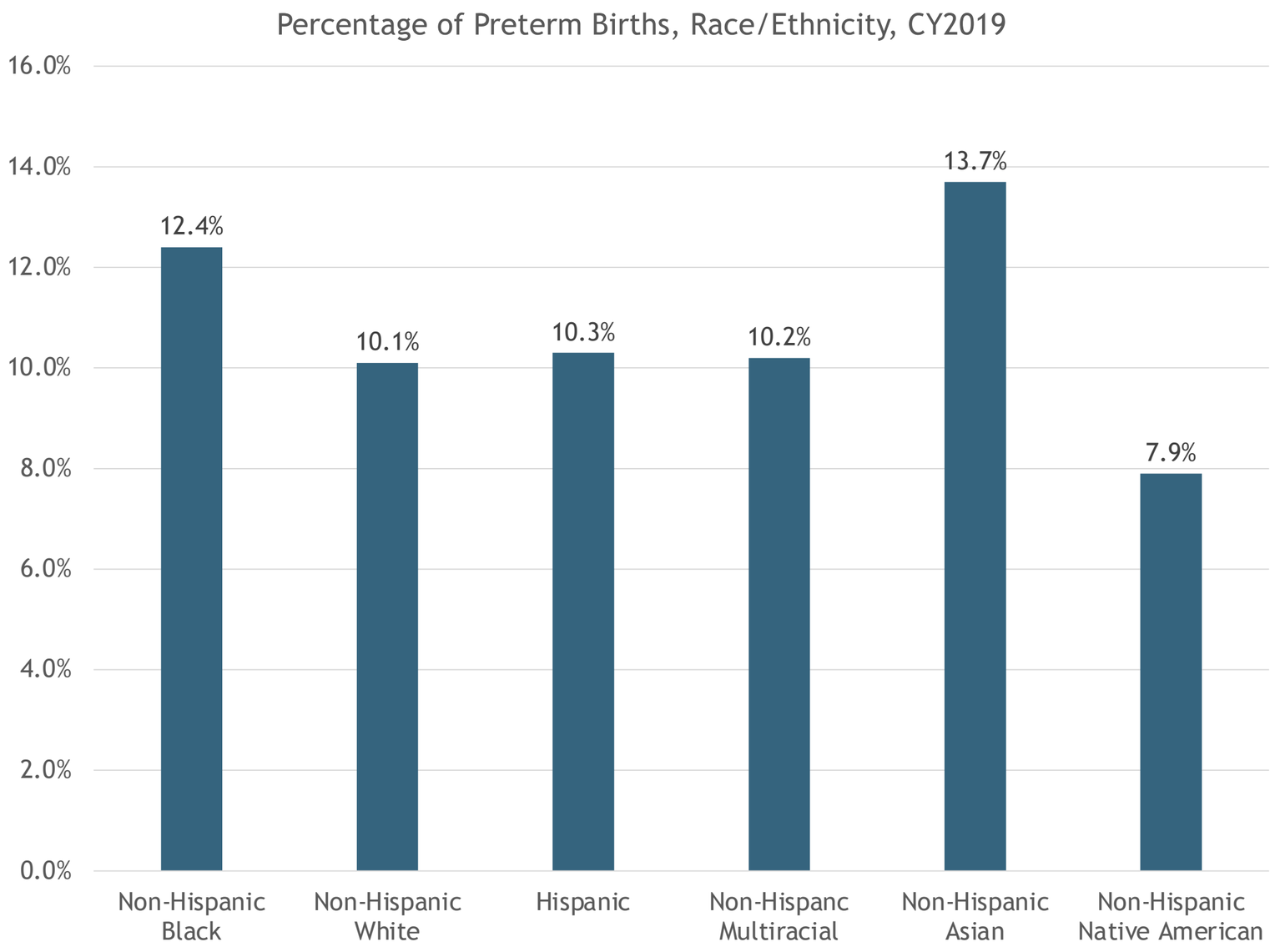
(1) Wingerter, Denver Post, October 2020 (2) CDPHE data, 2020 (3) March of Dimes, Peristats, 2020

Why focus on Maternity Disparities?



- ✓ **Health First Colorado responsible for 40-45% of CO births**
- ✓ **Colorado ranks 29th nationally for maternal mortality rates**
- ✓ **Pronounced race/ethnicity disparities in maternal and child outcomes**

Dept Maternity Initiatives with Equity Focus

- **Accountable Care Collaborative**
  - Program: Maternity Condition Management, Nurse Family Partnership, Prenatal Plus, Special Connections
  - Metrics: Prenatal Care KPI & Maternity Dashboard to illustrate areas of opportunity and performance by RAE, provider, community

- **Hospital Quality Incentive Program**
  - Program: Demographic data collection reqs for EHR, staff training
  - Metrics: Reduce disparities in maternal patient safety (2021), hospital-wide (2022)

- **Maternity Bundle**
  - Program: Maternity Advisory Committee (members w lived experience)
  - Metrics: Disparities in service provision (gate before pay-out)

Provider Rates Questions 31-36

Question 31: Payment to Cost Ratios

Year	Medicare	Colorado Medicaid	Insurance	CICP/Self Pay/Other	Overall
CY 2009	0.78	0.54	1.55	0.52	1.05
CY 2010	0.76	0.74	1.49	0.72	1.06
CY 2011	0.77	0.76	1.54	0.65	1.07
CY 2012	0.74	0.79	1.54	0.67	1.07
CY 2013	0.66	0.8	1.52	0.84	1.05
CY 2014	0.71	0.72	1.59	0.93	1.07
CY 2015	0.72	0.75	1.58	1.11	1.08
CY 2016	0.71	0.71	1.64	1.08	1.09
CY 2017	0.72	0.72	1.66	0.85	1.07
CY 2018	0.70	0.77	1.70	0.88	1.09

Year	Medicare	Colorado Medicaid	Insurance	Self-Pay	CICP/ Other	Overall
CY 2019	0.72	0.75	1.85	0.26	0.71	1.07

Medicaid Provider Rate Review Advisory Committee Background

Purpose

- Department is responsible for conducting an analysis of the access, service, quality, and utilization of each service subject to a provider rate review and shall compare the rates paid with available benchmarks, including Medicare rates and other states' Medicaid rates. The Department uses qualitative and quantitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services.

The rate review process operates on a five-year schedule

- Each year, certain services are reviewed.
- The work for each 'year' lasts about 18 months due to overlap.

MPRRAC Timeline

- July-September: Interdepartmental collaboration
- September-February: Conduct Rate Comparison and Access to Care Analyses
- February-March: Data presented to MPRRAC
- February-April: Write and refine Analysis Report
- May 1st: Analysis Report Due
- May-June: Department Develops Working Recommendations
- June-September: Present to MPRRAC and Collect Feedback
- September-October: Write Recommendation Report
- November 1st: Recommendation Report Due
- November: Out-of-Cycle Review Requests considered by MPRRAC
- December 1st: Out-of-Cycle Review Requests due to Department

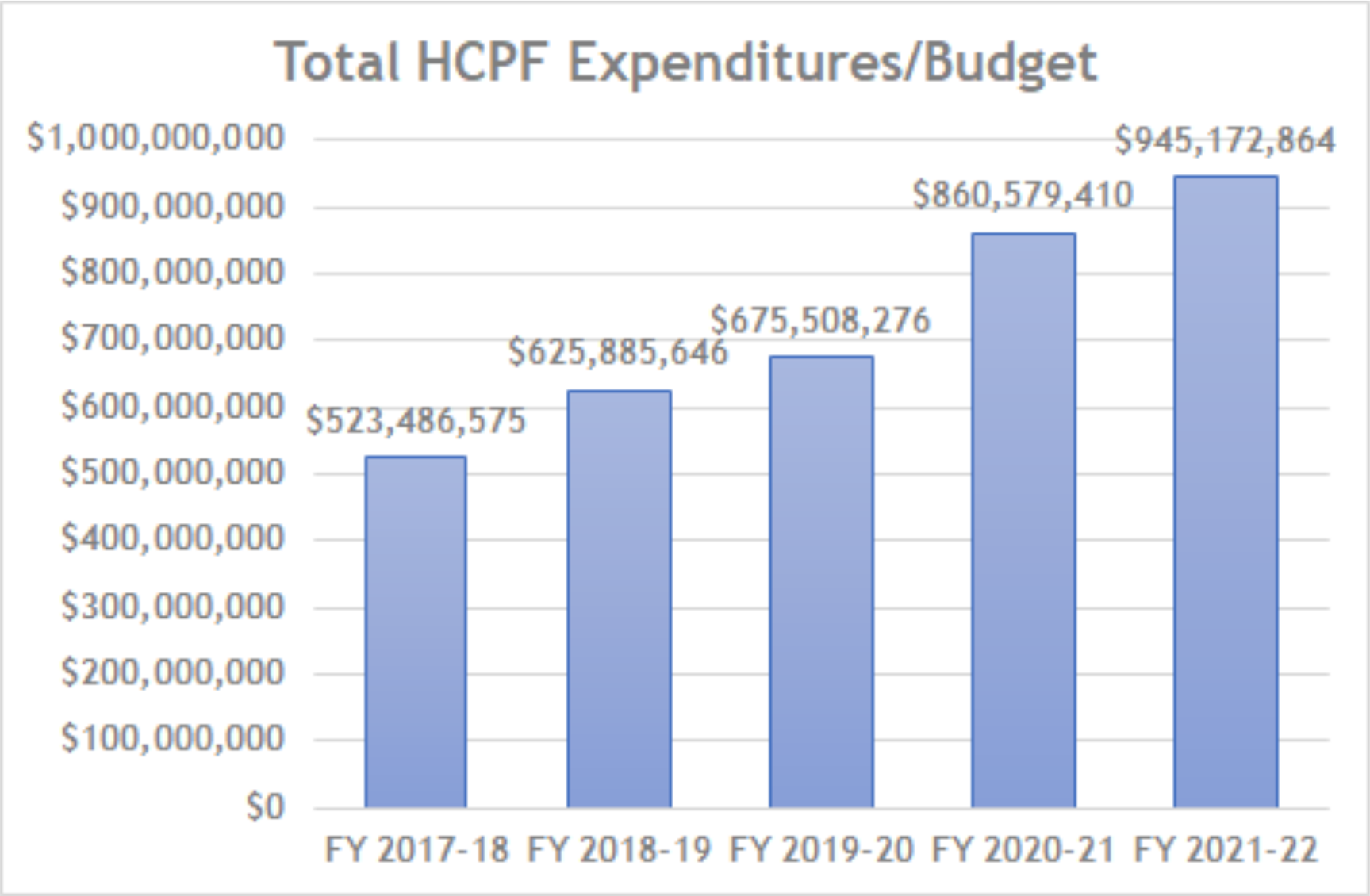
Health Care Policy & Financing JBC Hearing

Behavioral Health

Kim Bimestefer, Executive Director
Tracy Johnson, Medicaid Director

January 7, 2021

Outcome: Increased BH Investment



- Medicaid is increasing investment in BH
- Increased need, utilization, and cost due to COVID-19

COVID is fueling Behavioral Health challenges New SUD Benefit, eff 1/1/2021

- Colorado is #45 in US for **both** alcohol related deaths and suicide rate (1)
- 15.3% of Coloradans reported poor mental health in 2019, up from 11.8% in 2017 (2)
- US: in 2018, about 10.3M abused opioids. 47k Americans died - 130 people per day. (3)

- **Thank You:** New SUD Benefit completes continuum
- COVID impact: 128 drug overdose deaths May 2020 versus 73 in 2019 (4)
- Only 20% of those with an OUD receive treatment. (2)

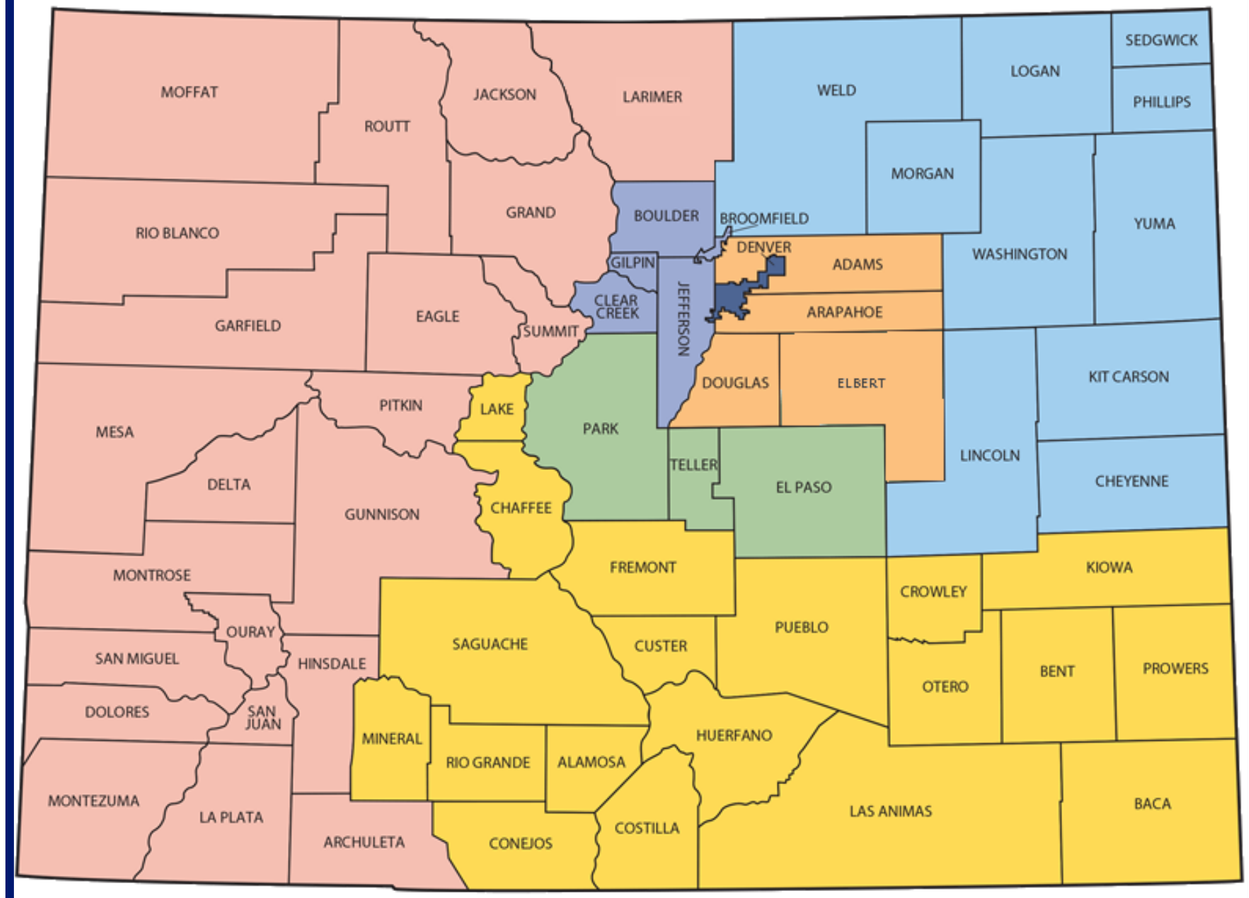
(1) Commonwealth Report, 2020 (2) Colorado Health Institute, Colorado Health Access Survey 2020 (3) CDC 2020 (4) CDPHE 2020

Improving Behavioral Health Outcomes

- **Expanding Access to Treatment:** Jan 2021, Medicaid covers Residential Substance Abuse treatment
- **Prevention:** Prescriber Tool includes OpiSafe
- **System Reform: Behavioral Health Task Force**
  - Improve access, quality, efficiency, navigation
  - New Behavioral Health Administration (BHA) addresses a fragmented system, merging 75 non-Medicaid programs
  - Stimulus to centralize BH eligibility, claims payment, reporting

Behavioral Health Questions 37-45

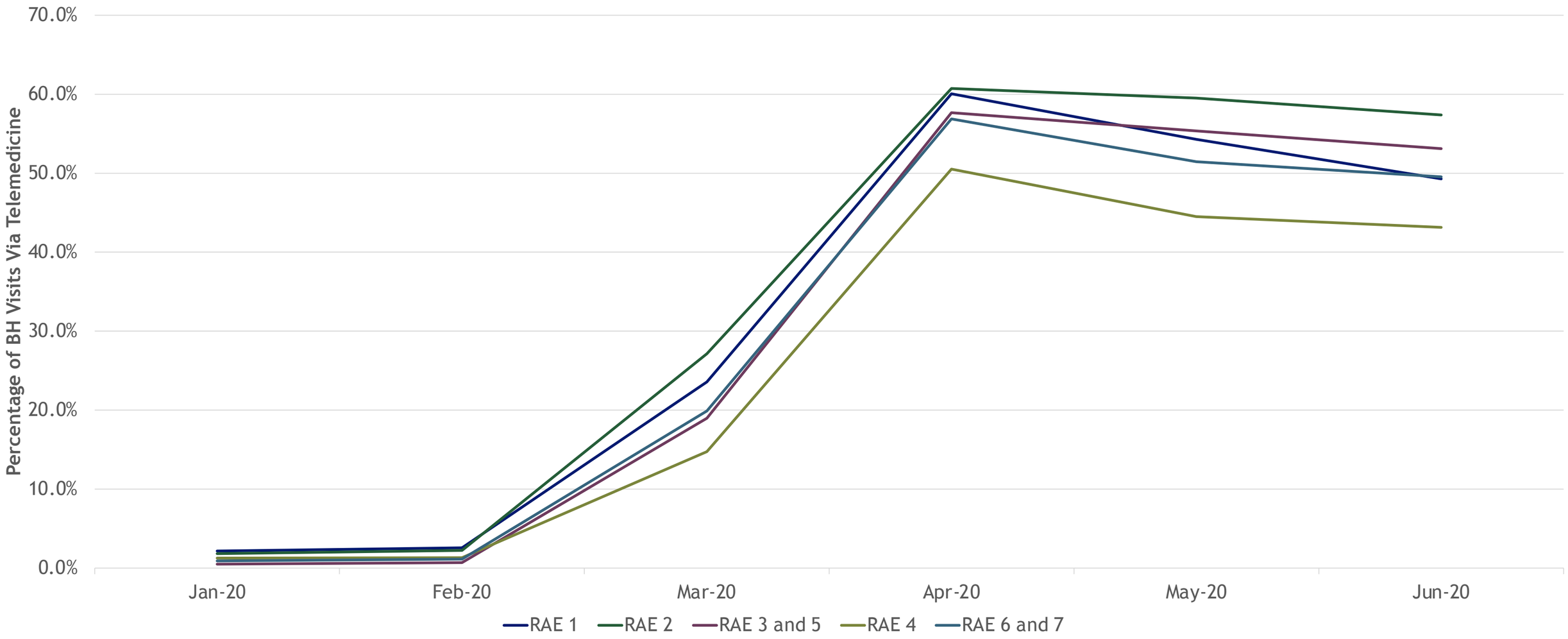
Regional Accountable Entity



RAE Payment Model

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

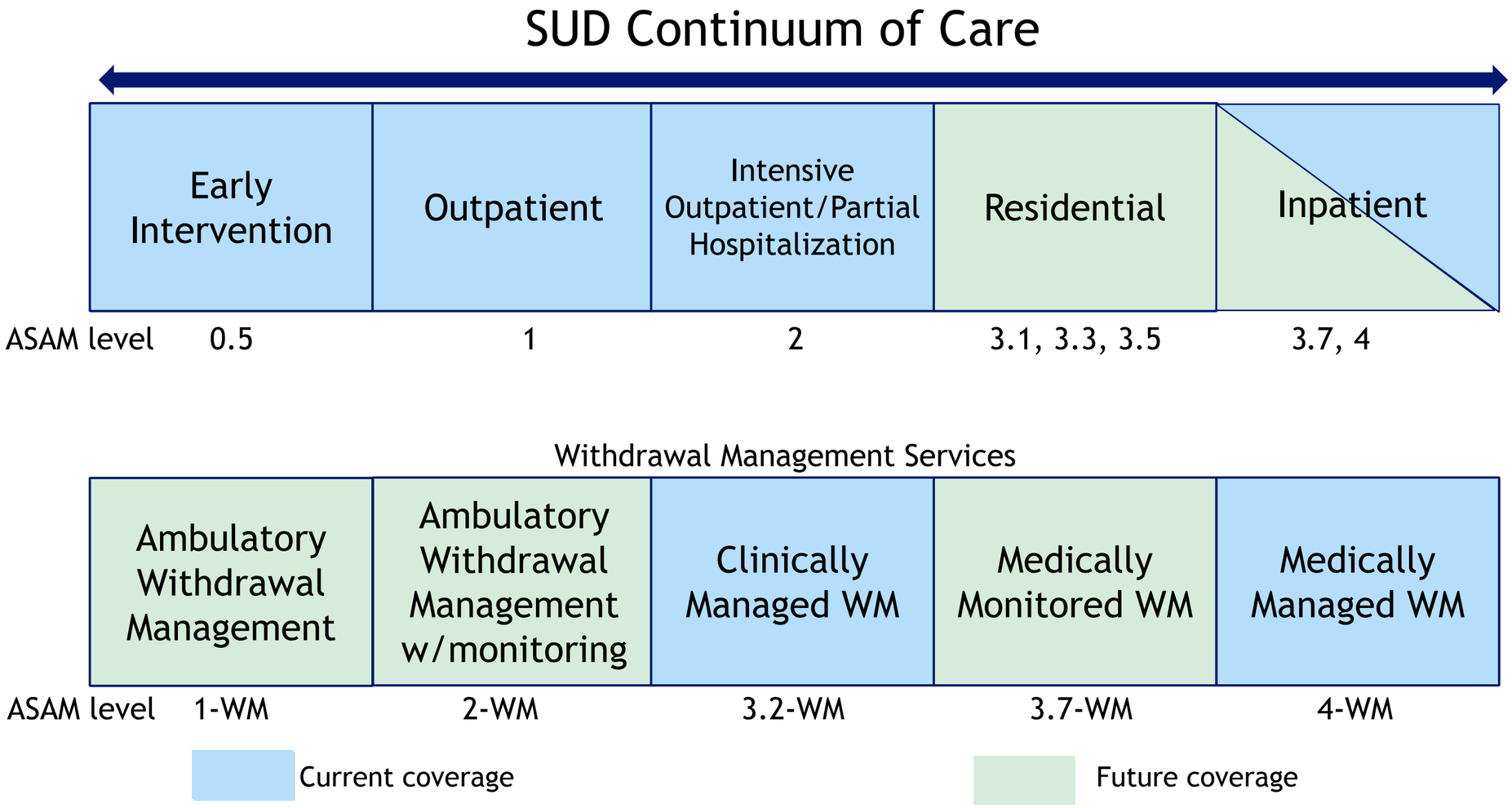
Care Model Changes:
Percentage of Capitated BH Visits Conducted Via Telemedicine
January through June 2020



SUD – What Changes

- Regional Accountable Entities will administer
- Services must be medically necessary
- Placements determined by American Society of Addiction Medicine (ASAM) criteria
- Prior authorizations/continued stay reviews for residential and inpatient
- Medicaid financing for treatment, OBH for room & board

Coverage of SUD Services



SUD Financing Changes

	Prior to 1/1/2021	Beginning 1/1/2021
Inpatient SUD Treatment		
Treatment Expenses	OBH	HCPF
Room and Board[1]	OBH	HCPF
Residential SUD Treatment		
Treatment Expenses	OBH	HCPF
Room and Board[2]	OBH	OBH

Room & Board Cost Estimates

368 beds can be covered with proposed CDHS Budget using current $67 rate

Differences in Methodologies

CDHS Estimate

- 210 Residential Beds
- Based on:
  - Current OBH funded beds
  - Historical utilization
- Considering increasing rate to $100 (up from $67)

HCPF Estimate

- 374 Residential Beds
- Based on:
  - All CO beds
  - Projected utilization

Health Care Policy & Financing JBC Hearing

Office of Community Living

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

January 7, 2021

Long-Term Services and Supports System

Direct Services

- At home
- In community
- In facilities

Case Management

- Community Centered Boards (CCBs)
- Single Entry Points (SEPs)
- Private Agencies
  (Children's Home and Community-Based Services Waiver (CHCBS) Only)

NOTE: CCBs also provide direct services.

Who Receives Long-Term Services and Supports?

13%

Children & Adolescents

ages 21 & younger
& qualifying former
foster care youth

45%

Adults

ages 22-64

42%

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 41% of the rest of the Medicaid); 31% have 5 or more of them

SOURCE: FY19-20 data; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Long-Term Services and Supports Programs

Home and Community-Based Services (HCBS) Waivers

- Children with Life Limiting Illness Waiver — **182**
- Children's Habilitation Residential Program Waiver — **129**
- Children's Extensive Support Waiver — **2,288**
- Children's Home and Community-Based Services Waiver — **1,853**
- Brain Injury Waiver — **566**
- Community Mental Health Support Waiver — **3,758**
- Elderly, Blind, and Disabled Waiver — **27,237**
- Persons with Developmental Disabilities Waiver* — **6,903**
- Spinal Cord Injury Waiver — **189**
- Supported Living Services Waiver — **5,026**

State-Funded Only Programs

- Supported Living Services (SLS) — **822**
- Family Support Services Program (FSSP) — **5,001**

- Home and Community-Based Services (HCBS) Waivers — **48,131**
- State-Funded Only Programs — **5,823**
- Program of All-Inclusive Care for the Elderly (PACE) — **5,593**
- Nursing Facilities — **14,092**
- Intermediate Care Facilities — **166**

SOURCE: FY 2019-20; based on claims in MMIS. * There is a waiting list for the HCBS-DD waiver. As of June 30, 2020, there were 2,959 people waiting for enrollment into the HCBS-DD waiver "As Soon As Available."

Recognition

Alliance
Colorado Communities United for People with Developmental Disabilities

Alliance Honors Colorado's Office of Community Living Directors with Special Recognition Awards

September 17, 2020

"Because of OCLs work, Colorado has consistently been held out as a national leader during the pandemic," said Josh Rael, Alliance Executive Director. "Our members are truly grateful to have such an impressive team at the helm, and these awards extend to the many OCL staff working tirelessly to answer questions and adapt to the new world we find ourselves in."

AARP®

"I commend Gov. Jared Polis and CDPHE, and specifically the Residential Care Strike Team, for their *leadership as national models for proactively addressing a difficult situation,*" said Bob Murphy, the State Director of AARP Colorado. In its initial assessment, analyzing data through Sept. 20, Colorado fared significantly better than the U.S. national average in three critical categories.

Colorado ranked 8th overall on 2020 LTSS Scorecard in state-level performance of LTSS systems that assist older adults, people with physical disabilities, and family caregivers.

CCCDC

Joelle Morrison received the Colorado Cross-Disability Coalition (CCDC) "David and Goliath" award this year for her work to make the eligibility system better for clients and her continued willingness to help individuals and advocates with challenging situations.

COVID-19 Response

Questions 46 & 47

Office of Community Living Strategic Direction

- **Direct Care Workforce:** Stabilize and expand long-term care workforce

- **Modernized and Sustainable Long Term Care System:** 1) Refine programs and benefits that meet the needs of members in the location that they want with the services that they need, 2) Redesign case management system, ensuring federal compliance, quality, simplicity, stability, and accountability

- **Communication & Engagement** Continue focus on stakeholder engagement with expanded opportunity for feedback from all stakeholders

Regulatory Flexibilities

11 Federal Amendments- 6 Appendix K Amendments to HCBS Waivers and **5 State Plan Amendments** (2 additional pending) allowed flexibilities to:

- **Provider qualifications** (ex. Personal care provided by a Member's spouse; Host homes provided Supported Community Connections)
- **Type of service** (ex. Adult day services provided one-on-one)
- **Location & manner of service delivery** (ex. Behavioral therapies delivered in the Member's home via phone or video)
- **Administrative flexibility** (ex. Digital signatures allowed)

Stakeholder Communication

- 129 Operational Memos Issued
- 63 webinars tailored to unique stakeholder group
- 11,110 total attendees
- A new standard for engagement

Residential Care Strike Team

- Completed **1,478 infection control surveys across all 1,052 residential facilities** in order to assess compliance and provide technical assistance and training.
- Reviewed **isolation and prevention plans for all 1,000+ residential care settings.**
- Implemented **system-wide surveillance and outbreak testing**, completing approximately **90,000 tests per week across all settings**.
- Added all residential care settings to the **EMResource platform** for insight into critical PPE, staffing, and bed shortages.
- Launched the **ConnectToCareJobs website** to connect residential care settings seeking to fill open positions with available job seekers.
- Collaborated with the Staff Shortage Fusion Center to distribute **$1.3 million to support residential care settings experiencing critical staffing shortages**; deployed teams of Colorado National Guard to provide hands-on support to those facilities in crisis.

State & Federal Financial Support

Federal Provider Relief Fund for Skilled Nursing Facilities (SNFs)

At least $106 million

Supplemental Payments for SNFs

$14,672,248

Civil Monetary Penalty Funds to SNFs

$287,394

TOTAL FOR SNFs

At least $120 million

Retainer Payments

$47,624,609

Residential Settings 8% Rate Increase

$6,663,900

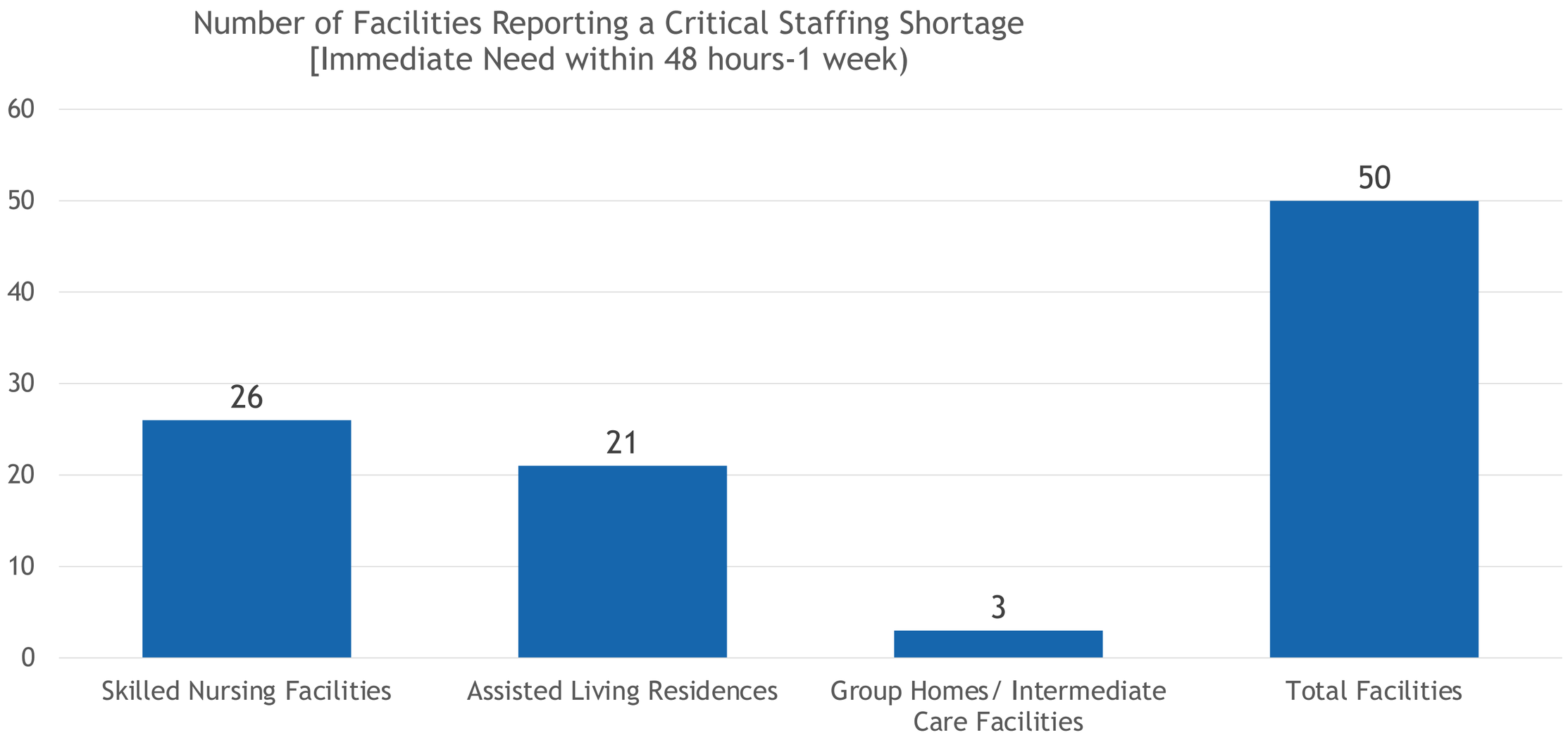
Personal Care & Homemaking 4% Rate Increase

$8,086,054

TOTAL FOR HCBS PROVIDERS

$62,375,364

Critical Staffing Shortages



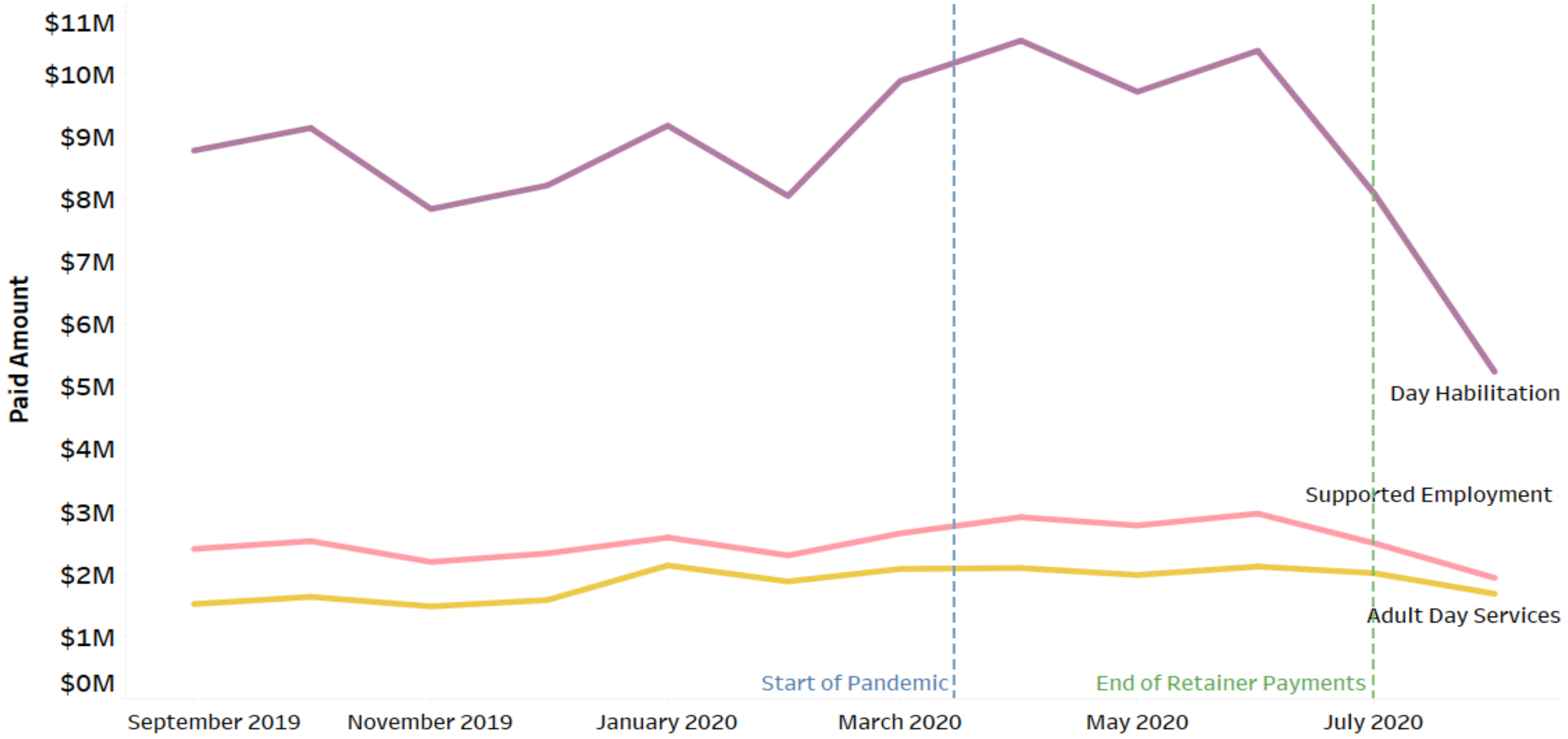
Source: EM Resource as of 12/29/2020

Addressing the Staffing Crisis

- Since 11/23 when the request form went live, 51 facilities have received state supported staff assistants
- Across these facilities, ***852 shifts have been fulfilled*** to address their staffing needs
- These shifts were fulfilled through a number of resources, including:
  - The Colorado National Guard, Medical Staffing Solutions, Volunteers, and the Colorado Staffing Collaborative

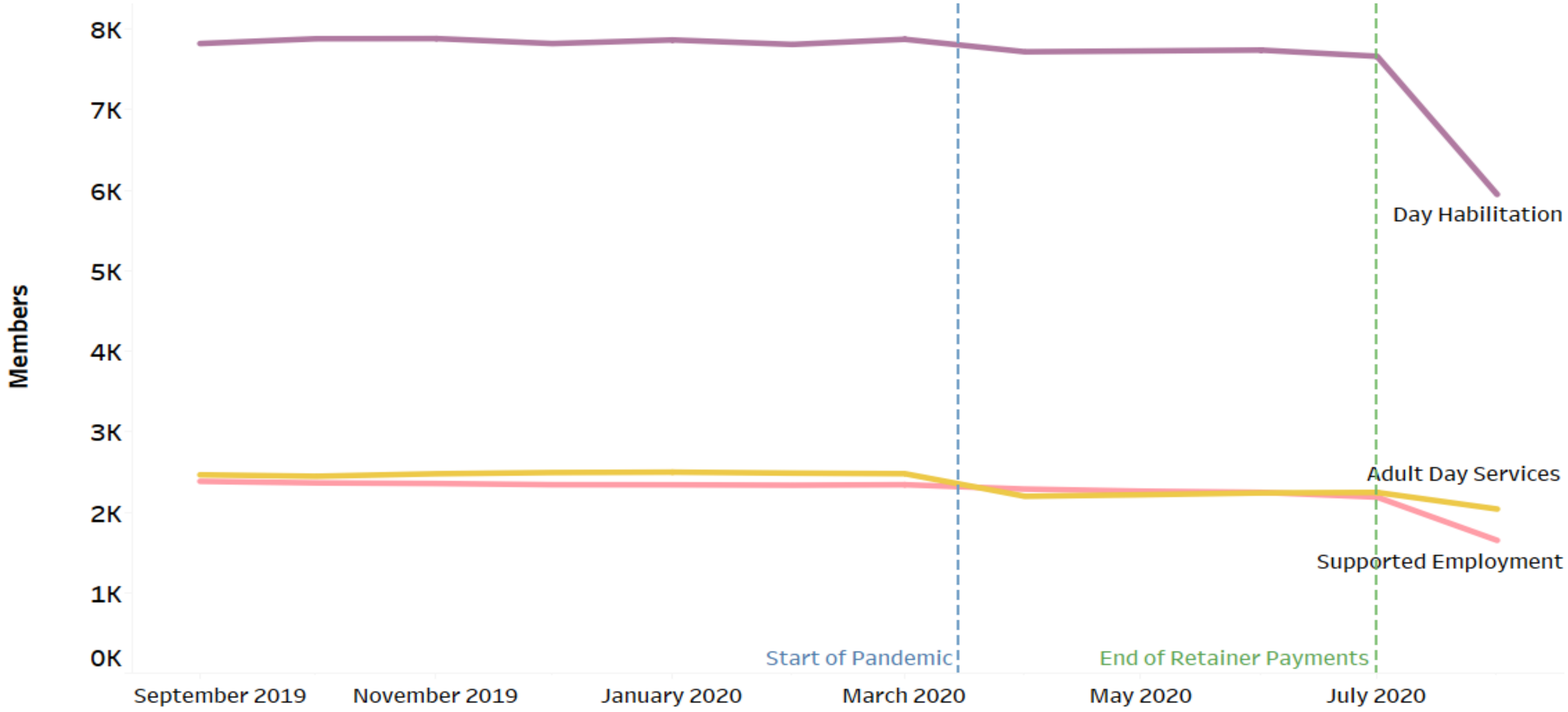
COVID-19 Impacts

Day Habilitation, Supported Employment, Adult Day Services



COVID-19 Impacts

Day Habilitation, Supported Employment, Adult Day Services



Day Program Policy Changes

- Through the end of the **Department's Appendix K approval**, members can receive Day Habilitation Services, Specialized Habilitation or Supported Community Connections, **virtually or in-person**, utilizing the existing rate structure, based on the members' current Support Level. The Appendix K authority is approved through March 9, 2021.

- After listening to significant stakeholder feedback, members enrolled in either the HCBS-DD or the HCBS-SLS waivers will have the **option to add the individualized service, offered one-on-one (1:1)**, to their service plan. This change is scheduled for implementation on January 15, 2021.

Nursing Home Funding

Question 48

Removal of Automatic Growth in Nursing Facility Rates

- HCPF has proposed removing the ***statutory automatic annual growth*** in nursing facility rates (currently 2%)
- Future increases would be ***subject to appropriatio***n, like other provider types
- Would go into effect July 1, 2021, after vaccinations in nursing facilities
- The proposal would impact ***future rates*** as part of a long-term change to nursing facility reimbursement
- It ***does not impact COVID-19 related assistance*** in the short term (PPE, staffing, testing, cash)
- In 2020, Colorado and the Federal Government provided at least $120 million in COVID-19 related assistance payments

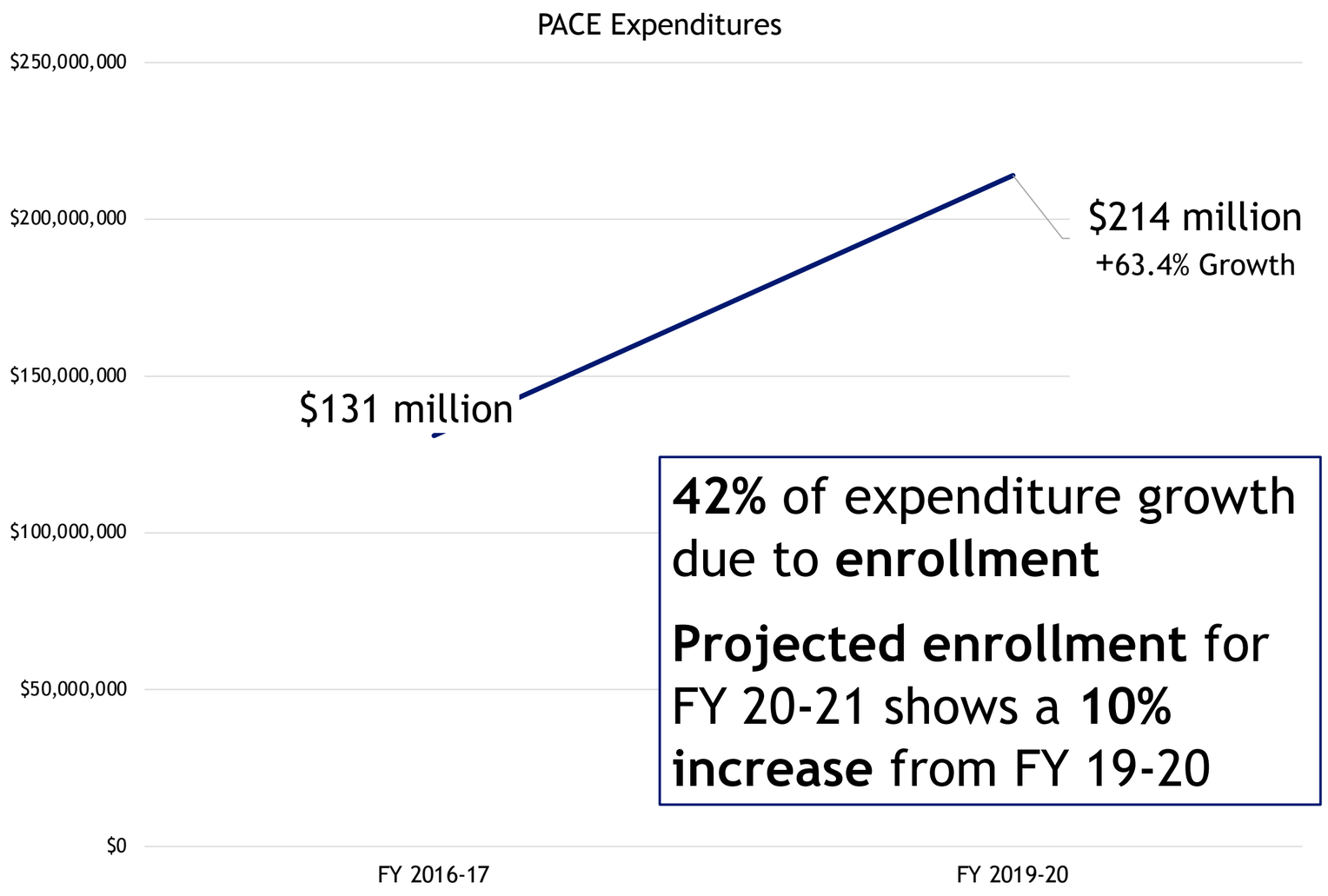
Support for Nursing Facilities

- **Financial Supports**
  - Over $14 million in State relief payments, and
  - Over $106 million in Federal payments
- **Staffing Support**
  - Development of ConnectforCareJobs.com
  - $1.3 million emergency staffing support & Colorado National Guard Teams
- **Testing Support**
  - Contract with Curative and CSU, free of cost testing for staff and residents
  - State Lab support
- **Personal Protective Equipment (PPE)**
  - State Emergency Operations Center coordinating PPE delivery since March 2020
  - Federal support since June
- **Other**
  - $300,000+ in Civil Monetary Penalty funds for visitation and electronic communication supports

Program of All-Inclusive Care for the Elderly (PACE)

Questions 49-52

PACE Growth & Cost Savings



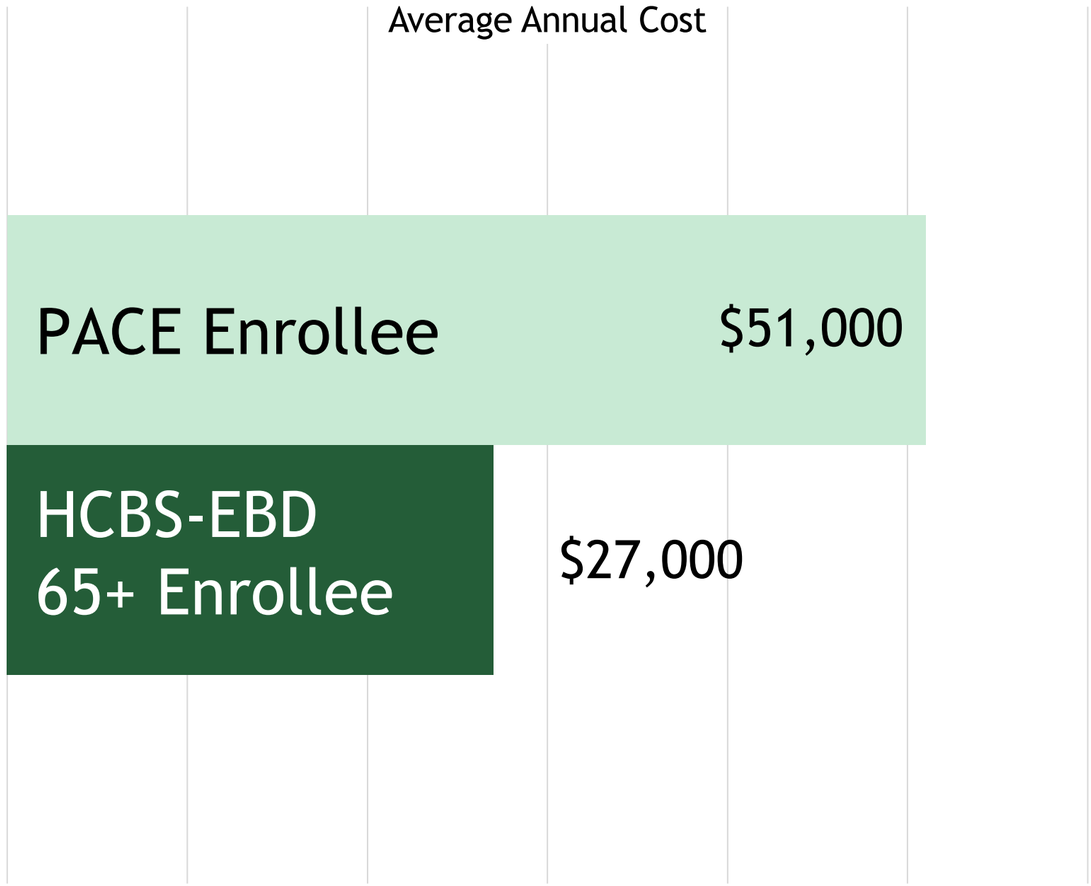
42% of expenditure growth due to **enrollment**

Projected enrollment for FY 20-21 shows a **10% increase** from FY 19-20

Based on currently available data, it is **not clear** whether PACE provides cost savings.

Disenrollment data shows that almost **half of PACE members who do so disenroll into higher-cost settings** (like nursing homes) and the **other half into HCBS** (typically lower costs compared to PACE, resulting in overspending for the time these members were enrolled with a PACE organization).

PACE Enrollment Cap



- The Department is proposing a **limit on PACE enrollments** to ensure reasonable growth
- Individuals enrolling in PACE often **only require Home- and Community-Based Services** (HCBS)
- Individuals seeking PACE enrollment will be **placed on a PACE waiting list and may access both State Plan and HCBS waiver services**

PACE Client Satisfaction & Outcomes

- Because of PACE's unique capitated all-inclusive model, the Department **cannot directly compare PACE to alternative services**
- However, the Department has **several strategies to track and ensure PACE client satisfaction and provider quality**:
  - Collect data on an annual basis and require providers to develop and submit quality improvement initiatives for identified client issues
  - Ensure health, safety, and welfare by conducting compliance investigations, technical advisory visits, involuntary disenrollment reviews, and restructuring quality data submission to include best practices
  - Capture encounter data to understand the unique experience of each member to better identify outcomes and quality of the program

Remote Supports & Electronic Visit Verification Update

Questions 53-58

Remote Supports

- Adding remote supports gives the Department an opportunity to **modernize** electronic monitoring for members, increase **efficiencies**, and improve **quality** of care and **independence** for members while achieving **cost savings** during a budget shortfall
- Remote supports will be implemented by expanding the existing electronic monitoring benefit found in five adult HCBS waivers (EBD, SLS, SCI, CMHS, and BI)
- **When hands-on care is not required**, remote supports make it possible for direct care staff to provide supervision, prompting, or instruction from a remote location

Remote Supports

Choice

- Choice and preference of the member
- Technology that will best meet their needs based on their comfort level

Individualized

- Careful assessment of the member's individual needs and preferences
- Ongoing assessment of mental health and behavioral support needs

Provider Capacity

- Rural communities with long travel times
- Frees up direct support providers to care for those members that do require hands-on assistance for homemaker and personal care services

Electronic Visit Verification

- State Medicaid Agencies must implement Electronic Visit Verification (EVV) for select services as required by the 21st Century Cures Act
- ***EVV has been implemented and was mandated by 10 CCR 2505-10 8.001 on August 3, 2020***

- EVV must collect 6 points of data:
  - Type of Service
  - Individual Receiving the Service
  - Individual Providing the Service
  - Date of Service
  - Time the Service Begins and Ends
  - Location of Service

Electronic Visit Verification

- ***The purpose of EVV is to ensure that services are delivered and that providers only bill for services rendered***
- *EVV data will be required prior to claims adjudication beginning* January 15, 2021
- Services offered through both Home and Community-Based (HCBS) waivers and the State Plan require EVV
- Telehealth services that are required in other delivery methods require the use of EVV
- The proposed Remote Supports benefit will require EVV

Local Minimum Wage Increase Reporting

Question 59

Local Minimum Wage Increase

- HB 19-1210 effective on January 1, 2021
- Rate increases require General Assembly allocation of funds and CMS approval
- Process for nursing facility supplemental funding in progress
- Systems changes required to allow for variable billing
- SB 19-238 reporting underway and compliance reviews to follow

Buy-In Program

Questions 60 & 61

Buy-in Premiums and Lessons Learned

- **Buy-In programs are special targeted programs for individuals with disabilities. Members pay monthly premiums to access Medicaid coverage.**
  - Premiums are based on a sliding scale based on income and are a maximum of 7.5% of the individual or family's income
  - Monthly premiums range from $0 to $200 per month for Working Adults with Disabilities and from $0 to $120 per month for Children with Disabilities

- **Lessons learned from the programs that could inform a broader program include:**
  - Provide members sufficient time to pay premiums and a robust tracking mechanism for partial payments, overpayments, schedule payments, and manage various forms of payments (such as credit/debit cards, checks, and in-person cash payments)
  - Establish a consolidated group to provide support and answer questions as well as managing the premiums
  - Provide training and program awareness to ensure individuals understand the program and nuances for accessing affordable health care.

Waiver Consolidation & New Assessment Tool

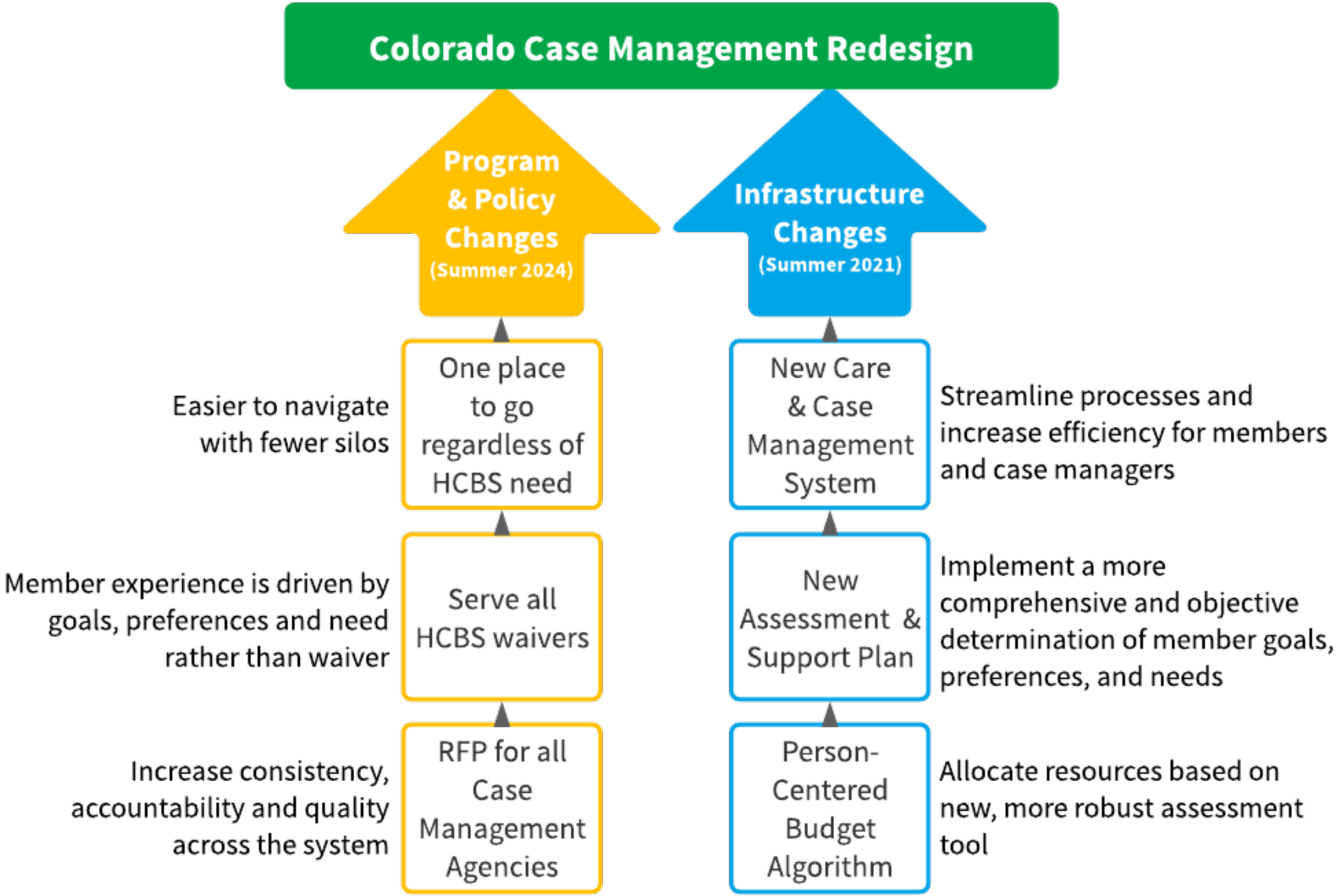
Question 62

Adult I/DD Waiver Consolidation

- The Department is taking steps to move consolidation forward with incremental changes to provide a better experience for members
- Next step: Build upon significant stakeholder work and align services across waivers

- Key progress to redesign services over the past year includes:
  - Launching a supportive employment pilot aimed at incentivizing providers to increase member quality outcomes at a cost savings for the state
  - Creating a new telehealth (virtual) service delivery option
  - Expanding and making improvements to day services leading to a more customizable and streamlined approach benefiting both members and providers

Colorado Case Management Redesign



NEW Assessment and Support Planning Process

Member participates in Assessment Process with Case Manager in new Care & Case Management System

Assessment Output produced automatically by Care & Case Management System

Person-Centered Budget Algorithm (PCBA) Output produced automatically based on Assessment Output and provides a range of resources

Support Planning conducted by Case Manager with Member using Assessment and Person-Centered Budget Algorithm Outputs as guides, including all goals, natural supports, personal story elements, desire to self-direct, etc.

Person-Centered Support Plan produced by the Care & Case Management System as a printout for Member, Case Manager, and Providers

Member, Case Manager, and Providers sign off on Person-Centered Support Plan

Foundation

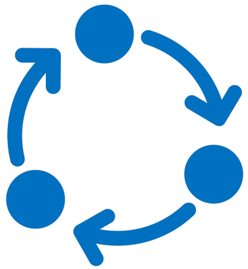
- More comprehensive assessment and support planning process
- Whole process conducted at least annually
- New Case Manager training
- More objective, fair and equitable allocation of resources
- New exceptions process

Supported Living Services (SLS) and Developmental Disability (DD) Waiver

Questions 63 & 64

Waiting List Management

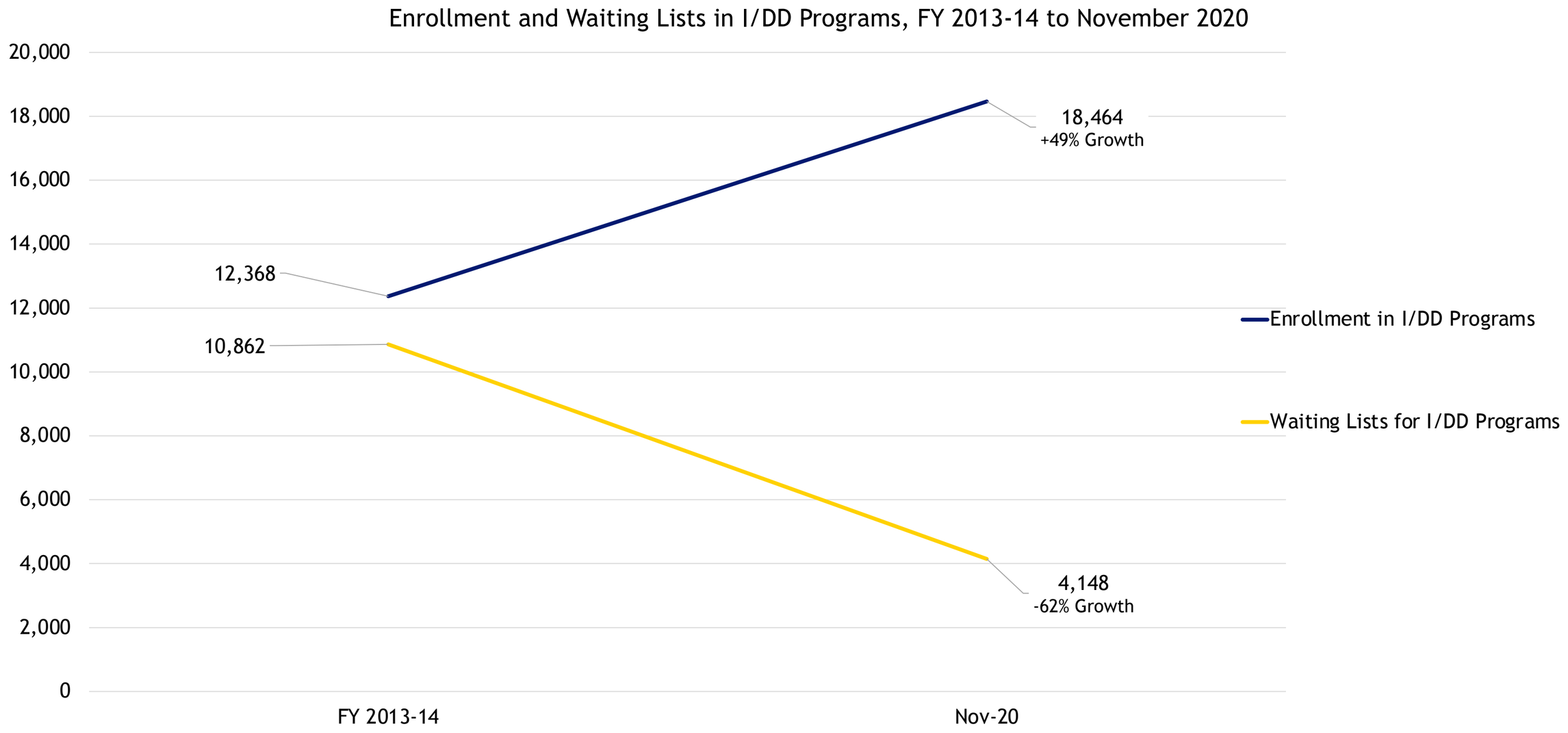
Elimination of HCBS-CES, HCBS-SLS, and State SLS Waiting Lists



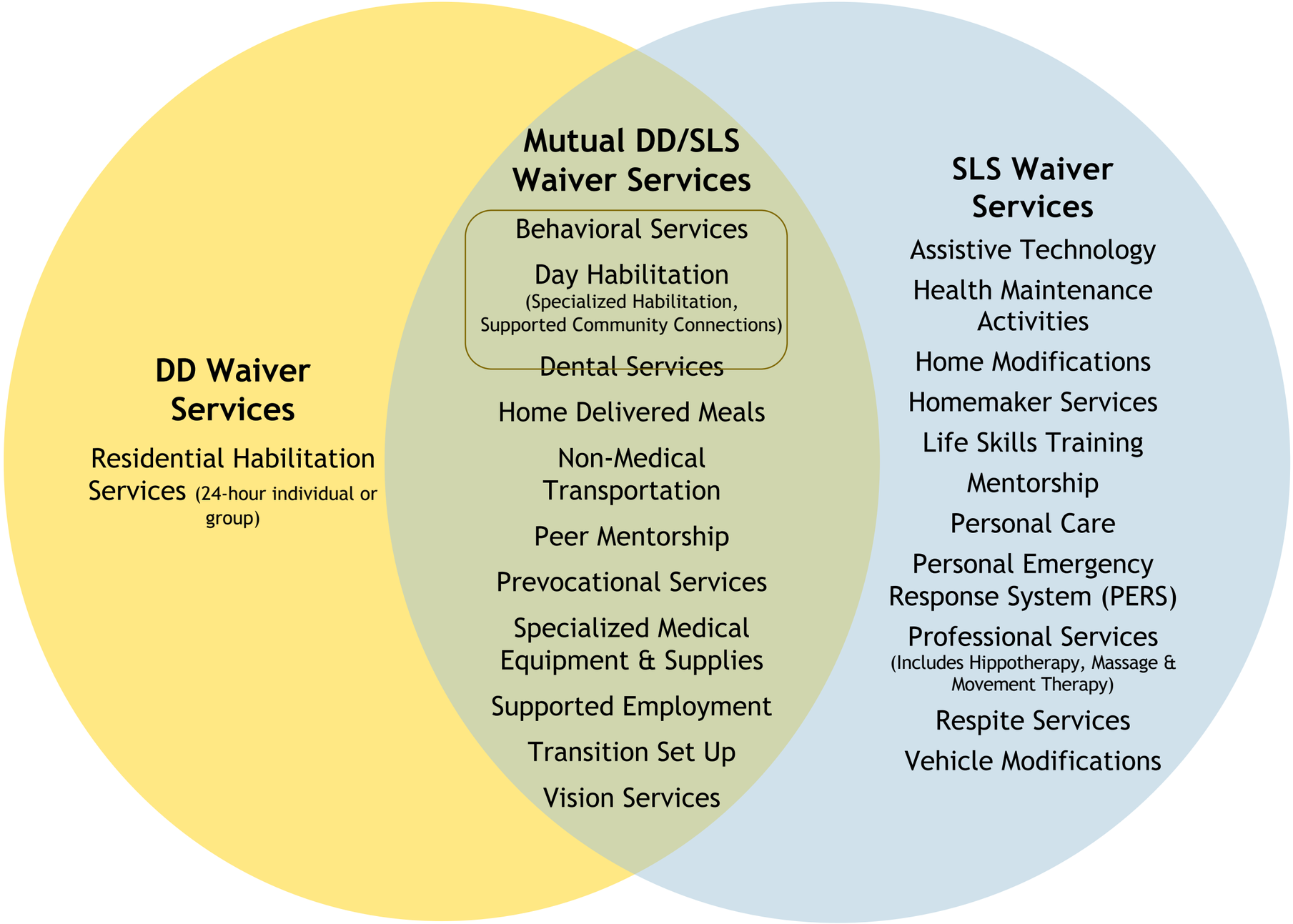
Authorization of Churn Enrollments from the Waiting List

New One-Time Legislative Appropriation Policy

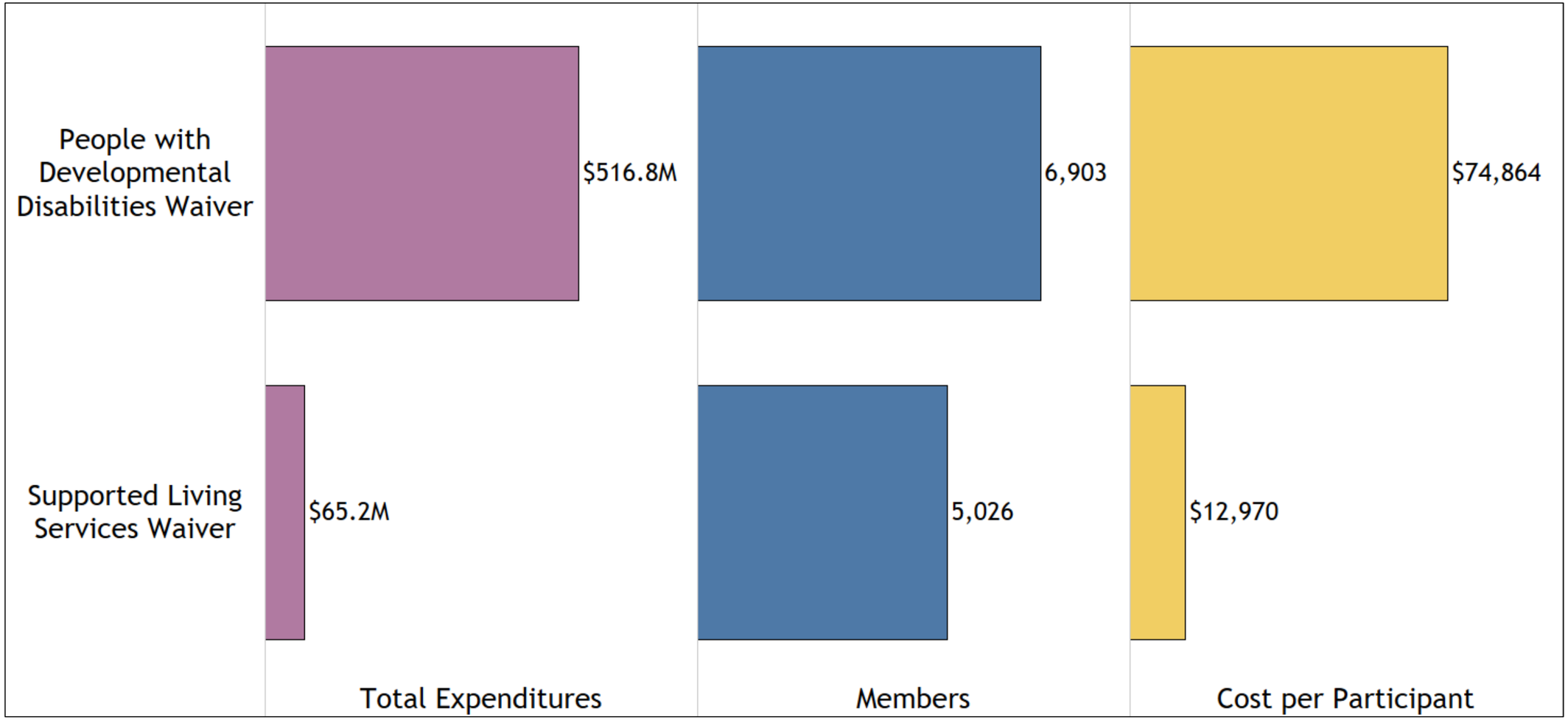
Enrollment and Waiting Lists



Waiver Services



Adult IDD Waiver Comparison



Explanation of R8

- The Department is requesting additional funds to provide additional services and supports to members on HCBS-SLS who demonstrate need.
- The requested funding would be used to offer exceptions to unit limits and Service Plan Authorization Limits (SPAL) to members on HCBS-SLS on a member-by-member basis.
- Members on HCBS-SLS who have met the total allowable units for a service or have filled their SPAL could request access to additional services and supports.

Consolidation of Appropriations for Case Management Agencies

Question 65

Consolidation of Appropriations

- Reduce administrative burden
- More effectively manage and track funding
- Increase transparency
- No impact to funding allocations or payment methodology

THANK YOU