DEPARTMENT OF HEALTH CARE POLICY & FINANCING
FY 2020-21 JOINT BUDGET COMMITTEE HEARING AGENDA
Wednesday, December 18, 2019
1:30-5:00 p.m.

1:30-1:50 INTRODUCTION & DEPARTMENT OVERVIEW

Main Presenters:

- Kim Bimestefer, Executive Director

1:50-2:50 RESPONSES TO COMMITTEE QUESTIONS

Main Presenters:

- Kim Bimestefer, Executive Director
- Tom Leahey, Interim Pharmacy Director
- Craig Domeracki, Chief Operating Officer

Topics:

- Questions 1-27, Pages 3-23, Slides 25-34
- Pharmacy
- Eligibility & Enrollment
- Customer Service

2:50- 3:00 BREAK

3:00-4:00 RESPONSES TO COMMITTEE QUESTIONS

Main Presenters:

- Bonnie Silva, Office of Community Living Director
- Tracy Johnson, Medicaid Director
- John Bartholomew, Chief Financial Officer/Finance Office Director

Topics:

- Questions 28-72, Pages 23-71, Slides 35-43
- Long-Term Services and Supports
- Rates
- General Financing & Miscellaneous

4:00-4:10 BREAK

4:10-4:40 BEHAVIORAL HEALTH

Main Presenters:

- Tracy Johnson, Medicaid Director
- Laurel Karabatsos, Deputy Medicaid Director

Topics:

- Questions 73-86, Pages 71-85, Slides 44-48

4:40-4:50 CLOSING REMARKS & ADDITIONAL QUESTIONS

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PHARMACY

1. **How will the legislation proposed in *R7 Pharmacy pricing and technology* to allow the Department access to the Prescription Drug Monitoring Program (PDMP) benefit Medicaid clients? Is the Department requesting that the Joint Budget Committee sponsor this legislation?**

RESPONSE

Prescription Drug Monitoring Programs (PDMPs) collect, monitor, and analyze electronically transmitted dispensing data submitted by pharmacies and dispensing practitioners. The PDMP would provide the Department with utilization data for controlled substance medications (e.g., opioids) that the Department cannot currently access, such as when a member chooses to pay cash for prescriptions. With access, the Department would be able to more effectively monitor drug utilization for Medicaid members, contributing to more enhanced medication utilization management including identification of members at high risk for overdose, and allowing for better care coordination and health outcomes. With a more complete picture of members' utilization, the Department would also be better able to understand how Medicaid pharmacy benefit policies impact drug utilization and member health.

Access to the PDMP would also allow the Department to align with initiatives set forth by federal law in the SUPPORT Act, which aims to prevent opioid abuse and opioid use disorder. The SUPPORT Act added requirements that providers must check PDMPs for a member's prescription drug history before prescribing a controlled substance, as of October 1, 2021. The Centers for Medicare and Medicaid Services have encouraged states to link PDMP data to the state Medicaid program and to use this data in conjunction with pharmacy benefits management in order to maximize utility and improve interoperability of the PDMP.

The Interim Opioid Committee is sponsoring a bill that includes granting the Department PDMP access.

2. **How would the Department preserve patient privacy and rights under HIPAA with access to the PDMP?**

RESPONSE

Appriss Health is responsible for administering the PDMP program in most other states and has full custody of the data. All HIPAA regulations apply to Covered Entities, which are health plans, health care clearinghouses, and health care providers conducting billing transactions electronically. As a Covered Entity, the Department takes member privacy very seriously. The Department provides new hire training and annual training thereafter with regard to safeguarding individually identifiable health information and personally identifiable information. If granted access to the PDMP, the Department will continue to comply with HIPAA and preserve patient privacy.

3. **Compare the development and ongoing maintenance costs for the prescriber tool requested in *R7 Pharmacy pricing and technology* with the assumptions about costs when the tool was first authorized in S.B. 18-266. Why are the costs so much higher now?**

RESPONSE

The funding request in SB 18-266 for the prescriber tool was made based on the best information that was available to the Department at the time. This type of tool is relatively new in health care, and only limited information was available at the time to provide a cost estimate. Since then, the Department has gathered significantly more information through multiple stakeholder meetings, a Request for Information and an Invitation to Negotiate (a competitive solicitation). The Department has been developing a tentative system design based on the submitted bids and it is now apparent that at least three vendor solutions will need to be integrated into the prescriber tool to achieve the desired functionalities. The Department anticipates that one vendor will provide the real-time patient-specific benefit information to the Electronic Medical Record and a second vendor will provide opioid risk metrics. Further, a third vendor, which manages the current pharmacy benefit management system, will require system changes for a new rules engine for processing benefit check requests. The Department also expects to leverage the efforts of the Joint Agency Interoperability project to secure needed data regarding other health-related state services which will require additional interfaces. To the Department's knowledge, no current tools provide this last functionality. The Department is currently in contract negotiations with vendors but anticipates that the original funding will be insufficient and that a phased implementation will be required.

In phase I, the Department will implement the core prescriber tool functionality, which is the ability to provide prescribers with a real-time, patient-specific Medicaid pharmacy benefit check. The information that would be returned to a prescriber will include member eligibility and co-pays, more cost-effective therapeutic alternatives (if available) and utilization management policies like when a prior authorization is required. The Department also expects that the tool will provide opioid risk metrics to guide the prescribing of opioids thereby reducing the risk of patient

addiction and its consequences. The Department anticipates that this core functionality will produce measurable cost savings (as discussed in the Department's response to question 4).

In phase II, added functionality will allow the prescriber tool to return information on health improvement programs so that a provider can prescribe or recommend a health improvement program to a patient, not just a pill. These programs might include tobacco cessation, diabetes management, maternity support, or social determinant of health supports and more.

4. What are the projected savings when the prescriber tool is implemented and how will we know if the savings materialize?

RESPONSE

The Department is projecting savings of $5,336,522 total funds, including $1,408,842 General Fund, for FY 2020-21 and ongoing due to the implementation of the prescriber tool. The savings assumptions have not changed from SB 18-266, "Controlling Medicaid Costs," but the Department is estimating that there will be a one-year delay in achieving the savings due to a delay in implementation of the prescriber tool.

The prescriber tool is intended to track, measure and report on end-user prescribing patterns at the drug detail level and by therapeutic category. The cost savings would be calculated as the difference in the estimated Medicaid payment amount of the original medication for which the prescriber requested coverage information and the alternative therapy as returned by the prescriber tool, when the medication prescribed is for a lower cost therapeutic alternative.

5. Why does the Department need 5.0 additional FTE for the pharmacy program as requested in *R7 Pharmacy pricing and technology*?

RESPONSE

The Department needs two FTE to research, implement and manage cost containment initiatives primarily to address the looming fiscal impact of specialty drugs. Over six calendar years (2012-2018), gross expenditures for specialty drugs increased by 171 percent, or an average of 8.5 percent per year. Since specialty drugs are dominating the pipeline of drugs in development (75 percent of drugs launched in 2017), the Department must pursue innovative strategies for containing specialty drug costs. Examples of projects include value-based contracts with drug manufacturers (which is a very labor-intensive process), implementing and managing an alternate payment methodology for specialty drugs administered in a hospital setting, and incorporating patient lab value data into pharmacy claims processing to ensure proper utilization of high-cost drugs.

One FTE is needed to develop, implement and manage a Maximum Allowable Cost program. This is a new program that would create a payment methodology to address gaps in the current rate

setting, especially for specialty drug rates. Maximum Allowable Cost programs are considered a best practice for the Medicaid pharmacy benefit. This new reimbursement methodology more closely aligns rates with acquisition costs, in contrast to the current Wholesale Acquisition Cost rates which do not represent actual transaction prices. This is a critical change needed to better manage reimbursement on the emerging high cost specialty drugs.

One FTE is needed to manage member pharmacy appeals. The volume of appeals has grown from 84 in CY 2016 to about 239 in CY 2019 to date. The pharmacy claims system implemented in 2017 is better enforcing prior authorization requirements than the legacy system, which has led to more prior authorization appeals. In addition, new utilization management and cost containment policies are contributing to the growth of appeals as well. Appeals were managed part-time by an existing FTE, but the volume of cases has grown to such an extent that a dedicated FTE is required.

Finally, one pharmacist manager FTE is needed to provide clinical expertise, supervision and strategic guidance to the FTEs requested above.

6. **Describe the Department's use of Appendix P in the preferred drug process. Why are drugs added to Appendix P and what purpose does it serve? What process does the Department use to review the utilization management criteria for products on Appendix P and how does it compare to the process for products listed on the preferred drug list? Does the utilization management criteria for products on Appendix P make it more difficult for Medicaid members to access than in private insurance?**

RESPONSE

"Appendix P" is the Department's guidance to providers for "Prior Authorization Procedures and Criteria and Quantity Limits for Physicians and Pharmacists" and is available on the Department's website.[1] The goal of the Appendix P and the preferred drug list (PDL) is to provide a comprehensive view of coverage and prior authorization policies for select medications covered under the Medicaid pharmacy benefit. These documents serve as a tool for providers to reference and provide medication coverage details. Appendix P also outlines coverage and prior authorization criteria for specific medications that are not included on the PDL.

The Department determines which medications will be added to Appendix P with consideration for many different factors. Some examples of these include safety, efficacy, cost, access, concerns for misuse, and ensuring appropriate use. The purpose of the Appendix P is to work in conjunction with the PDL to provide a more comprehensive view of medication utilization management and prior authorization policies for the pharmacy benefit. Review of any newly proposed changes to

[1] https://www.colorado.gov/pacific/hcpf/pharmacy-resources

prior authorization and utilization criteria for products included on the Appendix P is conducted by the Department's Drug Utilization Review (DUR) Board. The DUR Board conducts quarterly reviews of proposed utilization management criteria and makes recommendations to the Department. DUR Board meetings are open to the public and testimony may also be provided by members of the public and stakeholders during the meeting.

Similarly, for medications included on the PDL, an initial review of safety and efficacy for preferred and non-preferred products in selected PDL drug classes is conducted by the Department's Pharmacy and Therapeutics (P&T) Committee at quarterly meetings. PDL drug products then undergo a subsequent review by the DUR Board for any proposed changes to coverage and prior authorization criteria for medications in PDL drug classes.

The Department has not compared the utilization criteria on Appendix P with those from commercial plans and is unable to comment on any differences between them.

7. **Has the Department evaluated the use of biosimilars to reduce costs to the Medicaid program? How much savings can be achieved by prioritizing biosimilars?**

RESPONSE

The Department evaluates the use of biosimilars for cost savings and has been including them into the normal pharmacy benefit drug review process (evaluation of clinical evidence, financial consideration, and stakeholder input). Biosimilar savings are evaluated on an individual drug level as well as impact to overall drug spend and savings. Two biosimilar drugs are currently preferred products. As more biosimilars become available in the US market, the Department anticipates there will be opportunities for additional cost savings though there is not sufficient data to provide an estimate of savings at this time.

8. **Has the Department considered value-based contracting with pharmaceutical manufacturers to reduce pharmacy spend? Has the Department been approached by pharmaceutical manufacturers interested in entering into a value-based contract, and if so, what was the result?**

RESPONSE

The Department received authorization from the Centers for Medicare and Medicaid Services (CMS) in February 2019 to pursue value-based contracting with pharmaceutical manufacturers. Since then, the Department has had preliminary discussions with approximately 10 manufacturers and is currently evaluating two proposals in more detail for potential contract negotiations. The Department has not executed any value-based contracts at this time. The evaluation process requires a significant amount of clinical research and analysis in addition to a fiscal impact analysis. Since the clinical evaluation is resource intensive, the Department has enlisted assistance

from the University of Colorado School of Pharmacy, within the scope of its Drug Utilization Review Contract, to assist pro bono for these two evaluations only. In the long-term, the Department is requesting additional cost containment staff in its November 1, 2019 budget request R-7, "Pharmacy Pricing and Technology" who would evaluate proposals, negotiate the value-based contracts and analyze post-contracting patient health outcomes as part of their job duties.

ELIGIBILITY & ENROLLMENT

9. **Given what we know about the state's demographics, is there a peak year for the elderly population after which Medicaid enrollment of the elderly is expected to decline or return to the trend?**

RESPONSE

No, the Department does not expect enrollment of older adults to decline.

Medicaid enrollment of older adults has been growing steadily, with an increase of 51 percent, or 27,967 members, between FY 2009-10 and FY 2018-19. This increase closely tracks the statewide growth of the older adult population during the same time period (increase of 52 percent or 286,999 people between CY 2010 and CY 2019), indicating that with the continued expansion of this population generally, the Department is likely to see a similar, consistent trend in enrollment.

The aging of Colorado's residents is only just beginning, with the 65-and-older population expected to increase by 37 percent between 2020 and 2030. Currently, the proportion of the total Colorado population that falls into this age category is approximately 15 percent, but this will continue to grow, reaching 20 percent in 2050.

Table 1.1: Forecasted Population of Colorado by Age Group

Year	Age 0-64 Population	% Age 0-64	Age 65+ Population	% Age 65+	Total Population
2020	4,965,763	85.00%	876,340	15.00%	5,842,103
2025	5,201,546	83.19%	1,051,343	16.81%	6,252,889
2030	5,485,345	82.04%	1,201,174	17.96%	6,686,519
2035	5,780,892	81.51%	1,311,743	18.49%	7,092,635
2040	6,050,117	81.09%	1,410,499	18.91%	7,460,616
2045	6,271,292	80.66%	1,503,423	19.34%	7,774,715
2050	6,433,404	79.93%	1,615,844	20.07%	8,049,248

Source: Colorado State Demography Office
https://demography.dola.colorado.gov/population/data/sya-county/

Trends in Colorado also mirror the national growth of the 65-and-older population. The current proportion of the total U.S. population that falls into this age category is approximately 19 percent and will increase to 26 percent of the population in 2050.

Table 1.2: Forecasted Population of United States by Age Group (in thousands)					
Year	**Age 0-64 Population**	**% Age 0-64**	**Age 65+ Population**	**% Age 65+**	**Total Population**
2020	276,588	81.49%	62,845	18.51%	339,433
2025	279,008	79.31%	72,796	20.69%	351,804
2030	281,963	77.40%	82,352	22.60%	364,315
2035	286,865	76.13%	89,946	23.87%	376,811
2040	292,702	75.41%	95,453	24.59%	388,155
2045	298,556	74.90%	100,058	25.10%	398,614
2050	303,248	74.35%	104,622	25.65%	407,870
Source: Projected Age Groups and Sex Composition of the Population: Main Projections Series for the United States, 2017-2060. U.S. Census Bureau, Population Division: Washington, DC. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html					

The largest growth in the coming years will be in the older categories, those 75-84 and 85+. Between 2020 and 2030, the number of older Coloradans age 65-74 will increase by 20 percent; during that timeframe, the number of people age 75-84 will grow by 70 percent, and the 85-and-older population will grow by 50 percent. And among those 85 and older, the population will expand by 244 percent between 2020 and 2050. Hence, looking into the future, the largest growth will be in Colorado's oldest old, or those with more significant long-term care needs.

Table 1.3: Forecasted Older Adults Population of Colorado							
Year	**Age 65-74 Population**	**% Age 65-74**	**Age 75-84 Population**	**% Age 75-84**	**Age 85+ Population**	**% Age 85+**	**Total 65+ Population**
2020	535,168	61.07%	246,275	28.10%	94,897	10.83%	876,340
2025	605,664	57.61%	334,956	31.86%	110,723	10.53%	1,051,343
2030	641,546	53.41%	417,526	34.76%	142,102	11.83%	1,201,174
2035	638,813	48.70%	477,102	36.37%	195,828	14.93%	1,311,743
2040	653,629	46.34%	509,085	36.09%	247,785	17.57%	1,410,499
2045	695,089	46.23%	512,269	34.07%	296,065	19.69%	1,503,423
2050	758,641	46.95%	530,371	32.82%	326,832	20.23%	1,615,844
Source: Colorado State Demography Office https://demography.dola.colorado.gov/population/data/sya-county/							

In addition to the demographic changes anticipated in Colorado over the next 30 years, it is also important to consider other outside factors that could contribute to Medicaid enrollment among the older adult population. Though trends for this population's enrollment are often not as susceptible to economic factors, given that demand is primarily based on disability status and care

needs, there are considerations that may contribute to increased demand beyond those projected using only demographics. For instance, the National Institute on Retirement Security found that in 2018, 62 percent of working households age 55-64 had retirement savings less than their annual income[1] and 79 percent had no money set aside specifically for their long-term care needs.[2] Low savings rates among older adults mean that less money is available for basic living expenses in retirement, in addition to required health care costs as people live longer with more complex chronic conditions.[3] These factors have strong implications for Colorado's Medicaid system, as not only the number of older Coloradans grows but the proportion who are likely to fall into the low-income category also rises, requiring increased reliance on Medicaid services.

10. What is causing the recent steep declines in enrollment?

RESPONSE

Colorado continues to boast the strongest economy in the nation, with an historically low unemployment rate of 2.6 percent in October 2019. The Colorado unemployment rate is a full percentage point below the national average of 3.6 percent and has been significantly below the national average since June. As provided in the September 2019 Economic and Revenue Forecast by the Colorado Legislative Council Staff, the unemployment rate in Colorado remains at historic lows as job creation continues. The report states that "[Colorado] continues to be among the top states for economic activity. After growing by a solid 3.5 percent in 2018, the state's economy continued to pick up pace through the first quarter of 2019, increasing by a robust 4.4 percent over the same quarter last year. The year-over-year improvement tied the state for the fifth fastest growth in the nation."[2]

Based on this extraordinary economic growth, many Coloradans have experienced a positive impact through increased wages and increased working hours. The Department celebrates the fact that Coloradans are rising out of poverty, which is a major contributor to a reduction in Medicaid enrollment of 2 percent in FY 2017-18 and 4 percent in FY 2018-19. These reductions are in line with the reductions in overall enrollment during the economic recovery in FY 2005-06 to FY 2007-08. It should be noted that not all Medicaid populations are directly impacted by low unemployment rates and wage growth, such as older adults and non-working individuals with a disability, and those populations' enrollment continue to increase as expected.

It is also important to acknowledge the federal context for changes to eligibility policy and operations. In recent years the Department has been subject to numerous audits by the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG) and the Office of the State Auditor (OSA) which have noted issues in the Department's eligibility processes that allowed individuals to enroll or remain on Medicaid without the proper paperwork or verifications

[2] https://leg.colorado.gov/sites/default/files/images/septforecast.pdf

being on file. The Department has actively increased its controls over the eligibility process – not to restrict enrollment, but to ensure that individuals are correctly and accurately enrolled according to evolving federal policy and state rules. Without these additional controls, the Department is subject to significant sanctions and recoupment of federal funds by the federal government.

As an example, the automatic Income and Eligibility Verification (IEVS) interface for income verification was implemented in August 2011. This was in coordination with the rule updates that eliminated documentation for income verification and instead accepted self-attestation of income verified by a credible data source for all categories of Medical Assistance. Since the implementation of this federal policy and system change, CMS and OSA audits found that the verification was not applied appropriately through the system and the Department was placed on a corrective action plan. In March 2017 there was a system change to remedy the corrective action and comply with federal policy[3]. This change was communicated widely through all communication channels and a Frequently Asked Questions (FAQ) document[4] was posted. The change identified enrolled individuals that had self-attested their income but had not been verified through the IEVS nor had they provided income documentation to verify their eligibility. The change triggered a verification request letter to members to collect the documentation and terminate coverage if there was no response. An additional IEVS system change was made in June 2018 to comply with an audit finding and further align with the policy. The Department provided guidance regarding the reason for this system change and the impact on the caseload through electronic Departmental communications.

Out of the decline in Medicaid enrollment, the Department estimates that 34 percent of those individuals were disenrolled due to the IEVS project in March 2017 and 24 percent were disenrolled due to the IEVS project in June 2018. The Department will continue to make system adjustments to come into full compliance with CMS, OIG, and OSA audit recommendations, which may impact caseload. As these occur, the Department will provide proper noticing to members and guidance regarding the reason for this system change.

In addition, the Department recognizes the need to strengthen its ability to hold eligibility sites (counties and medical assistance sites) accountable for exceptional eligibility performance that includes timely processing along with high-quality eligibility results. Based on an OSA audit and hearing before the Legislative Audit Committee in 2018, the Department is undertaking several initiatives to strengthen internal controls over eligibility processing. These include:

- System changes to improve eligibility accuracy and create efficiencies in processing;

[3] 10 CCR 2505-10 8.100.4.B.1.c. and 8.100.5.B.1.c.
[4] Pending verifications at redetermination (RRR) for medical assistance
https://www.colorado.gov/pacific/sites/default/files/Pending%20Verifications%20at%20RRR%20FAQs.pdf

- Implementing a mail center initiative to maximize the turnaround time and application of eligibility rules;
- Improving training of the of the 4,500+ eligibility site workers;
- Further leveraging the county incentive program to address audit findings; and
- Implementation of county performance scorecards, including partnering with the Department of Human Services to leverage its processes for monitoring and addressing performance trends with counties

These initiatives to strengthen internal controls over eligibility processing are necessary, as the Department will continue to face increased scrutiny and audits related to eligibility processing, which may require the repayment of federal funds if audits find that people were inappropriately determined eligible. The Department believes in having accurate eligibility processes so that people are determined eligible appropriately and efficiently.

Additionally, the Department is concerned about federal policies, such as public charge, that it believes are causing Coloradans in some communities to drop out of or not apply for Medicaid out of fear it will impact their or their family's immigration status. The Department does not have data to determine whether Coloradoans are being negatively impacted by this federal policy; however, the Department has received anecdotal information from its provider community that the federal public charge policy is a contributing factor in the increase in uninsured Coloradans and deterring potential eligible families from applying for public assistance.

11. What is the Department doing to better understand changes in enrollment and churn, including gathering more information on:

a. Non-citizens that are eligible but not enrolled,
b. Eligibility denials by reason code
c. Why is the length of enrollment for some children is less than a year?

RESPONSE

The Department is analyzing internal data along with external data sources to continuously evaluate enrollment and churn. The Department contracted with an Associate Professor of Medicine from the University of Colorado Anschutz Medical Campus to provide a study on Medicaid churn. At the same time, the Department has built its own internal system to enable the Department to continuously monitor Medicaid churn. The Department is targeting the first quarter of 2020 to compare the two methodologies and to produce churn findings.

Following is additional detail on what the Department is doing regarding the specific topics requested:

a. Non-citizens who are eligible but not enrolled – The Department does not have data to identify non-citizens who are eligible but not enrolled. However, the Department reviews the Colorado Health Access Survey (CHAS) and the American Community Survey (ACS) to gain insights on non-citizens who are eligible but not enrolled.
b. Eligibility denials by reason code – The Department actively reviews eligibility denials by reason code and pursues any anomalies that are identified.
c. Why the length of enrollment for some children is less than a year – The Department is not actively gathering information regarding enrollment of less than a year for some children due to a nuance to policy that indicates that continuous eligibility does not apply when there is an electronic data source provided that is not compatible with the self-declared information used to make the initial determination. This applies for verifications such as income and health insurance (for CHP+ purposes). In other words, all eligibility criteria must be fully verified before having a full year's coverage; therefore, there are children who will have less than a year if their eligibility information is not verified. This nuance is the primary reason that children may not be enrolled for a full year; however, there are other exceptions that may cause less than a year of enrollment such as no longer being a Colorado resident or becoming an inmate of a public institution.

12. What is the Department's plan to increase enrollment of people who are eligible but not enrolled?

RESPONSE

The Department works with our county partners, providers, and community-based organizations on educating and enrolling individuals and families who are potentially eligible for Medical Assistance programs. For example, Connect for Health Colorado screens all applicants for eligibility in Medicaid and CHP+, prior to enrolling individuals in a subsidized health plan. In addition, Federally Qualified Health Centers perform outreach efforts to get uninsured individuals and families enrolled in Medicaid, CHP+, and the Colorado Indigent Care Program. Further, Denver Health Medical Center and other hospitals serve as enrollment sites.

The Department does not have funding or FTE for outreach efforts (such as advertising) for individuals who are eligible but not enrolled. In the past, the Department used grant funding to perform outreach, such as a grant from Health Resources and Services Administration (HRSA) which ended approximately in 2012.

As another effort to increase education and enrollment, the Colorado Department of Human Services (CDHS) has received funding for the Joint Agency Interoperability (JAI) project to provide information on the state's programs that help provide financial and social support to members and their families. The Office of Information Technology (OIT), CDHS and the

Department have implemented the initial phase of the project which connected four primary systems: Colorado Benefits Management System (CBMS), Trails, Childcare Automated Tracking System (CHATS), and Automated Child Support Enforcement Services (ACSES). The JAI project will be in the next stage of development in FY 2019-20 and FY 2020-21, when the agencies will use the JAI program infrastructure to provide interfaces to additional systems. Eligibility determinations for Medical Assistance happen through CBMS. Other programs such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Colorado Low-Income Energy Assistance Program (LEAP) are administered outside of CBMS. Through JAI, the Department envisions the ability to connect this information with county caseworkers, case managers (e.g., RAEs), and medical providers so they have information when a member is potentially eligible for these programs. The Department has requested funding through the November 1, 2019 R-7 budget request "Pharmacy Pricing and Technology" to help fund these system integrations into the Department's Prescriber Tool. The JAI project and future integrations with the Prescriber Tool provide an opportunity for the Department to increase outreach, education, and enrollment.

13. How much of the decline is attributable to the "chilling" effect of federal immigration regulations that could deny a green card to applicants determined likely to use Medicaid or other public benefits and become a public charge? Is the Department seeing disproportionate declines in enrollment by family members of immigrants?

RESPONSE

The Department does not have specific data showing how the "chilling effect" is impacting enrollment. There are limitations in the way the Department collects data on its members that do not allow the Department to gather information to know which applicants would be impacted by a public charge determination. For example, eligibility information, including citizenship status, is only gathered for individuals applying; therefore, questions are not asked regarding citizenship status of applicants not requesting assistance which may include immigrant parents applying for their children. Given the provisions of the public charge rule, very few non-citizen Medicaid members would be subject to a public charge determination. For many non-citizens the only Medicaid benefits for which they are eligible are Emergency Services, which is granted when a person is experiencing a life or limb threatening emergency. Use of Emergency Services is an exempted category in public charge determinations; therefore, use of this Medicaid service would not be used against a non-citizen in immigration proceedings. Likewise, the Department cannot evaluate whether enrollment is declining for family members of immigrants.

However, the Department is hearing anecdotally from advisory councils, provider partners and Medicaid members who serve on the Member Experience Advisory Council (MEAC) that there is fear in the community. Members said specifically that there is a lack of trust that there will not someday be future changes to regulation that would allow the past use of public assistance to be

used in immigration determinations (the current rule does not look at use before the enforcement date of the regulation).

14. **Has the Department done any outreach to clarify the impact of the federal immigration regulations for existing Medicaid clients and new applicants? Would the Department be willing to perform outreach going forward? What concerns or resource limitations does the Department have about performing outreach?**

RESPONSE

The Department has not conducted outreach to communicate the impact of new federal immigration regulations for existing Medicaid members and new applicants. The Department is constrained in its outreach and other efforts because Medicaid is a federal-state partnership, with broad oversight from the federal Centers for Medicare and Medicaid Services. The Department is bound by all federal statutes and regulations applicable to the program and the Department is concerned that the outreach described here could jeopardize federal funding of Colorado's Medicaid program, which serves approximately 1.2 million Coloradans. Furthermore, there are multiple lawsuits in federal court challenging the new federal immigration regulations and, therefore, the potential impact of these regulations is unknown until the litigation is resolved. Finally, the Department cannot provide legal advice or direction to existing Medicaid members and new applicants related to federal immigration law; rather, this is a responsibility most appropriately fulfilled by immigration advocates, experts, and attorneys.

15. **Why did the Department change from beginning the process to terminate eligibility after three pieces of returned mail to beginning the process after one piece of returned mail?**

RESPONSE

The Department changed the policy and process for acting on three pieces of returned mail to one piece of returned mail in order to streamline the process, decrease the quantity of returned mail, decrease workload for county and medical assistance site workers, and create immediacy in processing the case. This policy change was thoroughly vetted with the Centers for Medicare and Medicaid Services (CMS) as well as the Attorney General's Office to ensure compliance with federal and state regulations. The policy regarding returned mail is intended to provide guidance necessary to comply with federal regulations and ensure accuracy of eligibility. The policy also provides guidance on populations with extenuating circumstances such as homeless or former foster care populations.

The policy is meant to trigger action to occur on a case immediately versus waiting several months for three pieces of mail. This does not mean that individual's eligibility changes immediately; instead, taking action means that workers must do research and attempt to contact a member to

verify the address prior to any eligibility changes. The changes due to returned mail may only be an address change or may lead to disenrollment due to no longer being eligible based on moving out of state or whereabouts unknown. In a recent informal survey of the counties regarding returned mail, counties indicated that on average they are contacting the member two times before taking action. However, the change in policy has not drastically changed the county's workload priorities. Many counties continue to indicate that there is a backlog of returned mail due to them prioritizing new applications, renewals, verifications, and change requests prior to working the returned mail.

16. **What impact is the returned mail policy having on enrollment? Can the Department track this impact? Is there information from other states that implemented a similar policy that could be used to project the impact on enrollment?**

RESPONSE

The impact of the returned mail policy on enrollment is unknown. There is not a centralized, state-wide database nor tracking within CBMS to identify returned mail and the result of processing that returned mail. The Department plans to implement data metrics to begin tracking the quantity and impact of returned mail statewide (based on correspondence sent from CBMS) with the implementation of the centralized returned mail vendor scheduled for July 2020.

The Department does not have information from other states that may have implemented a similar policy that could be used to project the impact on enrollment.

17. **Is the returned mail policy causing people who are legitimately eligible for Medicaid or CHP+ to lose coverage?**

RESPONSE

No, the returned mail policy is not causing people who are legitimately eligible for Medicaid or CHP+ to lose coverage. Federal regulations at 42 CFR 431.231(d) permit discontinuance of Medicaid benefits when the member's "whereabouts are unknown and the post office returns agency mail indicating no forwarding address." However, services may be reinstated if whereabouts become known through member contact or other information that may become available as long as the member meets all other eligibility criteria. Not all returned mail is based on whereabouts unknown; some provide new addresses which does not lead to a loss of Medicaid or CHP+ eligibility.

18. **What is the status of the new process for centralizing returned mail? How is it working?**

RESPONSE

The new process for centralizing returned mail is currently within the planning stage. A workgroup was formed in July 2019 including HCPF as well as partners from the Colorado Department of Human Services (CDHS), Governor's Office of Information Technology (OIT), Connect for Health Colorado (C4HCO), counties, and advocates to strategize and make decisions on policy, systems, and operations for implementing the new center. The approved contract manager was hired in August 2019 to support this effort. Recently the workgroup solicited county interest in taking on the centralized return mail center as a separate line of business to their current eligibility functions. Depending on the number of counties interested, the target date for deciding on the county is no later than the end of January 2020. In the case that a county is not selected or does not accept the offer, the Department will proceed with a Request for Proposal (RFP) for a private entity. The project is scheduled for a July 2020 implementation date as outlined within the Department's FY 2019-20 R-6 budget request "Local Administration Transformation."

19. How long are counties taking to process enrollments, redeterminations, and income resource verifications? How does this compare to historic performance? What is causing the recent increase in the backlog? What impact is it having on enrollment and the administrative burden on clients and applicants who may need to resubmit or appeal?

RESPONSE

The majority of counties are processing enrollments and redeterminations within the required 45 calendar days. However, counties are taking longer to process applications now than they were prior to system changes that were made. For example, counties were able to process applications within 7 to 10 days and currently they may be taking between 30 to 40 days. The Department tracks data based on the 45-day requirements and historic performance shows a slow decline in performance. The decline is primarily due to approximately 7 out of the 64 counties that are at 92 percent or lower in timely processing. However, all counties are working significant overtime and using additional resources where available to attempt to decrease the backlog and process timely. Additional detailed data is provided to break down the performance by month and county.

	Goal	Jul	Aug	Sept	Oct	Nov
New Applications	95%	97.7%	97.5%	94.8%	92.9%	92.5%
Redeterminations	95%	98.3%	98.3%	96.7%	95.8%	95.2%

The cause of the recent increase in backlog is due to multiple factors such as:

- Implementation of CBMS Transformation August 26, 2019
    - The Colorado Benefits Management System (CBMS) Transformation project involved the migration of the Java-based application to a cloud-based application using Salesforce and Amazon Web Services (AWS) to improve efficiency, user

experience, and ongoing system maintenance challenges. The CBMS Transformation project went live in three distinct phases:

- Phase 0 (Sep 2018): This phase included the migration of CBMS from an on-premise environment into a cloud-based environment in Amazon Web Services (AWS)
- Phase 1 (Sep 2018): This phase included the migration of a few CBMS application modules (10 screens) from Java to Salesforce
- Phase 2 (Aug 2019): This phase included the migration of the remaining CBMS application modules (450+ application screens) from Java to Salesforce

  - The implementation has had intermittent hours and a few full days of downtime, decreasing time availability to process applications. There have been numerous fixes (over 400) to stabilize the system.
  - There is also a learning curve for eligibility workers to learn the new changes.

- Some counties experiencing backlogs prior to CBMS Transformation.
- Staffing problems such as vacancies at some counties.
- Normal increase in applications driven by:
  - September – Back to school
  - October – ACA renewals (Medicaid only)
  - November – Connect for Health Colorado Open Enrollment and Low-income Energy Assistance Program (LEAP)

The backlog is impactful to both new individuals applying as well as members going through their redetermination (renewal) application. For new individuals, there are delays in getting their benefits if they are determined eligible. Once processed and approved however, their enrollment begins as of the 1st of the month of the application date. For renewing members, it is possible that there may be a lapse in coverage; however, if they are approved, their eligibility will begin retroactively to their renewal date.

The Department has partnered with Colorado Department of Human Services (CDHS) and the Governor's Office of Information Technology (OIT) in engaging and supporting the counties with the backlog. This has included the following:

- Eligibility site visits as a group effort from OIT, Deloitte, CDHS, and HCPF to conduct on-site, over the shoulder observations to identify potential issues (system, policy, operational, training) and provide solutions.
- Continuous exploration regarding the cause of system slowness and inefficiencies. Classifying and categorizing projects according to system and user efficiencies and prioritizing for expeditious resolution.

- Regular leadership (CDHS, HCPF, OIT) touchpoints with counties to hear their concerns, frustrations, and ideas and identify opportunities for addressing them.
    - This includes creating a plan for enhancements to provide a stable system environment for counties to process eligibility work.
- The Department allocated $390,000 in funding through the County Grant Program[1] to support county backlog efforts resulting from CBMS Transformation. This funding supports two goals:
    - Utilizing eligibility supervisors as an untapped workforce to help process backlogged Medical Assistance applications, redeterminations and case changes. Each county participating (25 counties, 125 supervisors) received an allocation effective December 1, 2019 to pay supervisors to reduce backlog. Based on the initial allocation, the Department believes that up to 5,000 unprocessed tasks (either application, redetermination, or case change) can be processed utilizing the funding allocated. This work is granted $270,000.
    - A data resolution team stationed in Pueblo County to help resolve data inconsistencies, exception reports and ad hoc data entry issue reports on behalf of all counties. This helps counties by reducing secondary workload to allow them to focus on processing benefits for eligible individuals. In addition, this team will help assist with redetermination exceptions for certain counties, reducing the amount of backlog rolling over from month to month. This work is granted $120,000.

20. How is the Department responding to the concern raised by advocates that when Medicaid clients and applicants submit documentation to gain or retain eligibility, such as for income or resource verifications, the documentation is, "chronically lost or misplaced." In particular, advocates identified issues with the electronic portal for uploading information not registering timely submittals.

RESPONSE

The Department, alongside the Governor's Office of Information Technology (OIT), has not received a significant amount of complaints or system issue tickets (less than five received) that would indicate that documentation is "chronically lost or misplaced." The few issues that were received have promptly been addressed. The Department collaborated with OIT to see if there were significant issues and did not find anything to indicate a systemic problem that needs to be addressed. It was identified that there are opportunities for additional enhancements for uploading documents through the electronic portal (PEAK); these enhancements will be reviewed and prioritized within the upcoming year. This work will be supported by the recently approved PEAK Product Leader chosen by senior leadership from HCPF, CDHS, OIT, C4, and counties. The Department will work with the Staff Development Center to ensure there is proper training provided to all sites on retrieving documentation submitted electronically.

21. **What impact is the "chronically lost or misplaced" documentation having on enrollment? What impact is it having on the administrative burden for clients and applicants who may need to resubmit or appeal?**

RESPONSE

The Department is not aware of a systemic problem with "chronically lost or misplaced" documentation; as such, there is no reason to believe that there is an impact on enrollment. If there is an instance of documents being lost, eligibility workers attempt to find the documentation through the electronic portal prior to requesting the documentation from the member or applicant again.

22. **Is the smoothing of income to make it easier for people with seasonal or fluctuating income to retain eligibility working as intended? How does fluctuating income interact with income verification procedures? Is the administrative burden on clients and applicants higher to verify income when the client or applicant has fluctuating income?**

RESPONSE

Yes, the policy of annualized income (smoothing of income) for Medicaid is working as intended. This policy is intended to support applicants and members whose income fluctuates due to seasonal employment, commission-based pay, and self-employment. The policy annualizes the applicant's income and applies the monthly average income for the eligibility determination. This supports applicants that may be applying in a month where there is significant income, but that income is only received a few months out of the year. The Department has not heard of any functionality issues nor received any case examples regarding annualized income and there have not been any audit findings regarding the application of the policy. A random sample of cases are being identified to be reviewed from a policy and systems perspective to ensure accuracy and appropriate eligibility determinations based on the annualized income policy.

The annualized income policy (fluctuating income) follows the same income verification procedures as other cases. This means that the income is either verified with an electronic income data source or documentation is requested (such as for self-employment). In the instance that the self-attested fluctuating income is not reasonably compatible with the electronic income data source, members are given the opportunity to provide a reasonable explanation for the discrepancy (such as "hours changed due to fluctuating income") or provide income documentation.

The administrative burden on members and applicants is not higher to verify income when they have fluctuating income. Currently they can self-attest their current month's income and indicate if they are seasonal, commission-based, or self-employed. This provides them the opportunity to

provide their yearly income which is used to determine their eligibility. As discussed above, their application will then follow the same income verification procedures as other cases.

23. How will the automated income checks proposed in R12 Work number verification impact enrollment? How will the automated checks impact the administrative burden on clients and applicants to document and verify their income?

RESPONSE

The Department estimates that the automated income checks proposed in FY 2020-21 budget request R-12, "Work Number Verification" would decrease enrollment by approximately 0.5 percent of total caseload in FY 2020-21 and 1 percent of total caseload in FY 2021-22, which corresponds to a decrease of approximately of 6,855 members in FY 2020-21 and 14,198 members in FY 2021-22. The Department arrived at these estimates by identifying 74,157 members who received a notice of a discrepancy in their self-attested income compared to the income reported by the Income Eligibility Verification System (IEVS) in FY 2017-18 and no longer had an active Medicaid span after their reasonable opportunity period of 90 days. The Department estimates that these members would have had four months less eligibility through the work number verification process compared to the current process, which verifies income on a lagged basis. The Department estimated that 55 percent of these members would have employers that provide data to the work number verification database, based on the experience of matching records within the Supplemental Nutrition Assistance Program (SNAP). Finally, the Department expects the implementation date of the automated income checks to be January 1, 2021, so there is only a half-year impact in FY 2020-21.

The automated checks will not have a different administrative burden on members and applicants to document and verify their income than what is experienced currently with the IEVS verification process. Federal regulations require states to accept self-attestation of income as long as it can be verified through a credible electronic data source and a reasonable compatibility test is applied.

24. What precautions is the Department taking to ensure that people who are eligible for Medicaid and CHP+ are not denied access as a result of the automated income checks proposed in R12 Work number verification.

RESPONSE

The Department will implement quality control measures (such as automated system monitoring and periodic review of the process) as a precaution to ensure that people who are eligible for Medicaid and CHP+ are not denied access as a result of the automated income checks. This is in addition to the various checks in place based on federal requirements to use the automated income appropriately and provide the member an opportunity to dispute any discrepancies identified through the automated income check. These checks include verifying the self-attestation of income

instantaneously with the payroll data from the Work Number and applying a test of whether the self-attested income is reasonably compatible with the electronic data source. If the individual self-attests income that is under the Medicaid income limit but is not reasonably compatible (contradicts) with the electronic data source, the individual will be requested to provide a reasonable explanation or income documentation to clear the discrepancy.

CUSTOMER SERVICE

25. How does the Department evaluate the performance of the Member Contact Center? What measures does the Department have of customer satisfaction other than time to respond to a call? Are people who are calling and using the chat feature getting their questions answered?

RESPONSE

In addition to the Average Speed of Answer (ASA), Abandonment Rate and Average Handle Times, the Department also evaluates quality and customer satisfaction. The Department measures customer satisfaction through the following metrics:

- First Contact Resolution (FCR) is defined as a single contact in a 30-day period. The Member Contact Center consistently achieves a monthly average of 85 percent across both call and chat service.
- Quality Assurance (QA) is performed for each agent monthly by the supervisor, trainer and quality assurance specialists. The Department reviews every agent by randomly selecting calls and chats to evaluate for accuracy, quality, call/chat processes and customer service which includes tone and courtesy. Each agent must score at least 90 percent to remain in good standing.

The Department currently does not offer a customer satisfaction survey to individuals who call or chat with the Member Contact Center.

26. Why is the Department requesting funding now after the call wait times have declined?

RESPONSE

Over the past year, the Member Contact Center reduced its Average Speed of Answer (ASA) to below 25 minutes. In addition to changing the contact center hours and correcting dental enrollments, the Department attributes its success to hiring temporary staff to augment the permanent staff. Supplementing the permanent staffing with 12 full-time temporaries is a major contributor to the Department's ability to maintain the current ASA.

The Department recognizes that an ASA of 25 minutes also means that many customers can experience hold times as high as an hour. The reduction in wait times is a significant improvement, but still is not acceptable

The Department is requesting funding to continue to improve customer service as expected by Coloradans.

27. Have other states implemented similar technology for their call centers and is there any evidence to show that the technology has been effective in improving customer satisfaction and reducing response wait times?

RESPONSE

The Department is not aware of any State Medicaid Agencies who have implemented technology like that of private industry. Private industry holds the evidence in leveraging artificial intelligence (AI) and chat bots to provide an improved customer experience. IBM's article, "10 reasons why AI-powered, automated customer service is the future," provides supporting industry evidence that Departments efforts to implement AI and a chatbot can free up contact center staff from more routine, tier-1 requests so they can focus on more complex tasks. This technology has the capability to reduce wait times and abandonment rates as it offers issue resolution without using staff resources. The Department's budget requests both last year and this year build upon this evidence of leveraging technology to both better equip staff to provide better customer experience and to enable customers to effortlessly find answers to their questions.

LONG-TERM SERVICES AND SUPPORTS

28. Having a vendor review authorizations for in-home skilled care within the participant directed programs, as proposed in *R13 Long-term care utilization management,* adds another layer of bureaucracy involving people who are farther away from the client. Why is this request necessary? How would it improve services?

RESPONSE

Utilization management by a Quality Improvement Organization (QIO) is considered best practice by the Centers for Medicare & Medicaid Services (CMS) and is thereby funded at a higher match rate. The Department's request will bring alignment to how skilled care is authorized across long-term care delivery models. Consumer Directed Attendant Services and Supports (CDASS) and In-Home Support Services (IHSS) Health Maintenance Activities (HMA) are the only skilled services in Medicaid not ordered, reviewed, or approved by a clinician. Case managers are not clinicians, nor are they required to be. This change will align the process for all skilled services across the spectrum of delivery models. The case manager acts as the intermediary between the member and the reviewer, providing supporting documentation for the skilled care request. Only IHSS and

CDASS Prior Authorization Requests (PARs) that include HMA will be reviewed; PARs that do not have HMA will continue to follow the current process.

29. If the problem that *R13 Long-term care utilization management* is trying to address is primarily with increasing utilization of health maintenance activities in In-Home Support Services (IHSS), then why is Consumer Directed Attendant Support Services (CDASS) being included?

RESPONSE

While a primary purpose of this request is to better understand the increasing utilization of health maintenance activities in In-Home Support Services (IHSS), the Department is also seeking to bring alignment to how skilled services are authorized across all service delivery models, which is why Consumer Directed Attendant Support Services (CDASS) is also included. The current review process for skilled services is bifurcated and varies by service and program. In both CDASS and IHSS, skilled service authorization is currently completed by a case manager who is not a clinician (and is not required to be a clinician). By contrast, all other skilled services receive clinical review. To ensure members have access to skilled services that meet their unique care needs, the Department intends to utilize a vendor that specializes in utilization reviews of skilled services and understands participant direction. Another consideration is that in CDASS, participants cannot access traditional agency-based Long-Term Home Health (LTHH) services. The clinical review of skilled services will benefit members requiring higher-acuity care by ensuring that all skilled services are captured appropriately to allow the member to receive all necessary skilled services while preserving the case manager's connection to the member and promoting continued independence in the home and community.

30. What measures will the Department take to ensure that utilization management reviews are completed in a timely manner to ensure continuity of services?

RESPONSE

The Department will ensure that the vendor's contract integrates specific turn-around requirements, including that emergency reviews be completed within a 48-hour period. The contract will also include data collection as a reporting deliverable to ensure that the vendor is meeting requirements as well as tracking trends within the reviews. If any troublesome trends appear, the Department will take action to further hold the vendor accountable. Additionally, case managers conduct Continued Stay Reviews (CSRs), renewing authorization of services, up to 60 days prior to the end of the certification period. It is the Department's intent to ensure that case managers are trained in the submission process and held accountable for timely and accurate submissions. This would include training on concurrent CSR and Utilization Reviews periods for all members receiving community-based care.

31. What has the Department done to consult with stakeholders on *R13 Long-term care utilization management*? What outreach efforts to solicit stakeholder feedback does the Department plan before implementing the proposed utilization management?

RESPONSE

Stakeholders share concerns about the continued growth trends of In-Home Support Services (IHSS) and have supported Department efforts to implement training requirements and rule amendments. Whenever a budget or legislative request is ultimately approved, the Department engages with stakeholders on the implementation of the policy. Upon approval of the budget request, the Department will work closely with community partners on the development and implementation of a utilization management and review process. Importantly, the Department will collaborate to ensure that the vendor selected for utilization review will have experience with the practice and philosophy of participant-directed programs, including a core understanding of person-centered processes. The Department looks forward to an ongoing collaboration to ensure a fair and transparent transition to this new process.

32. Has the Department identified performance issues with the current utilization management contracts for long-term home health and private duty nursing, such as inappropriate denials or inadequate notice of changes in authorizations? If so, what are the performance issues and what is the Department doing to address them?

RESPONSE

The Department conducted a targeted review of the Long-Term Home Health (LTHH) and Private Duty Nursing (PDN) denials and found the determinations to be supported by the policy and the clinical documentation submitted with the PAR. The Department is monitoring determinations closely to ensure the utilization management vendor is adhering to Department policy. The Department has also added to the External Quality Review Organization's scope of work a quarterly audit of the utilization management vendor.

LTHH services require a Prior Authorization Review (PAR) for pediatric and adult members. LTHH services for pediatric members, ages 20 and under, are reviewed by the Department's third-party utilization management vendor. LTHH services for adult members, ages 21 and older, are currently reviewed by the member's Single Entry Point or Community-Centered Board. There has been an almost 37 percent increase in pediatric LTHH requests from January to October this year. The percentage of denials has increased 2 percentage points from 5.8 percent to 7.8 percent.

PDN services for pediatric and adult members are prior authorized by the Department's third-party utilization management vendor. PDN PARs have a low monthly volume of approximately 100 per month, which has remained constant from January to October this year. The number of denials per

month has increased from approximately 5 to 20 from January to October this year. The denials include cases where only a portion of the requested hours were denied. Additionally, the denials are concentrated among a few providers.

There have been no changes to the LTHH or PDN benefit policies in over five years. If policy changes were to be proposed, the Department would engage in a formal stakeholder engagement process and adhere to all public noticing requirements before bringing proposed regulatory changes to the Medical Services Board.

33. Is the Program of All-Inclusive Care for the Elderly (PACE) cost effective in reducing expenditures below what would occur absent the PACE program?

RESPONSE

The Department is undertaking efforts to collect data that will fully determine whether there are cost savings.

The Program of All-Inclusive Care for the Elderly (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 care of these members with multiple conditions by a single organization.

Historically, the Department was unable to identify the true cost of an individual on the PACE program because of the lack of service data. As of July 2019, PACE providers now submit service data. This information will allow the Department to identify cost trends and service utilization of PACE participants to better understand the program's cost effectiveness. To ensure the financial accountability and continued success of the PACE program, the Department is contracting with an actuarial agency to provide additional analysis.

34. How does the quality of care in PACE compare to alternative services? Is there any customer satisfaction data for people participating in the PACE program?

RESPONSE

Currently, the Department does not have a mechanism to effectively compare PACE to alternative services. PACE is a fully capitated program, whereas other long-term care programs are fee-for-service. As part of PACE oversight, the Department captures member health metrics such as hospitalizations, home care visits, falls, injuries, emergency room visits, and behavioral health screenings. This allows the Department to compare quality of care between each provider during

Department-led quarterly quality meetings and to establish best practices. With PACE service level data, the Department can compare utilization trends with performance metrics to develop better practices for incorporation into the PACE program.

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 measure satisfaction between each provider. Additionally, within the Department's November 1, 2019 budget request R-17, "Program Capacity for Older Adults," the Department has requested one-time contractor funding to perform a satisfaction survey to set a benchmark.

35. **Please provide an update on meetings with the PACE providers regarding the appropriate rate setting methodology pursuant to S.B. 19-209. Will there be recommendations for changes that would require approval by the Joint Budget Committee?**

RESPONSE

In 2017, the General Assembly passed a bill to change the PACE rate methodology to incorporate a Grade of Membership (GOM) model. The Department opposed the use of the GOM model because it was untested. There was only one study on the GOM model, conducted by Duke University on PACE clients within a limited provider area in South Carolina. The bill ultimately passed, requiring the Department to develop an Upper Payment Limit (UPL) using the GOM model. The use of this methodology resulted in lower rates for Colorado PACE programs. In particular, this decrease was substantial for smaller and newer providers.

In 2019, SB 19-209 removed language that required the Department to develop PACE rates using a GOM model. Currently, the Department sets rates by developing a UPL through an actuarial contract. This requires identifying a PACE comparable population using existing fee-for-service claims that include both home and community-based and nursing facility services. The Department then negotiates a capitation rate to yield PACE program expenditures below the UPL, and the rate is reviewed and certified by the Centers for Medicare & Medicaid Services (CMS) for compliance with the requirement of being cost effective.

The Department has been holding ongoing meetings with PACE providers as required by SB 19-209 to discuss the data that was used or any other rate impact issues or findings that would affect

the final outcome of the UPL. The Department offers the opportunity for PACE providers to present their business proposal and negotiate for a rate that addresses their business needs.

Department staff also meets with PACE providers on a regular basis through the PACE Advisory Committee and meets monthly with individual providers. The Advisory Committee meetings provide opportunities for the PACE program to provide the Department with recommendations regarding oversight, payment, processes, and funding. Any recommendations will be reviewed for a fiscal impact that may require legislative approval.

Regarding alternative rate models, the Department is executing an actuarial contract to conduct an analysis of various states rate-setting methodologies. This will provide insight into benefits and disadvantages of alternative methodologies that have been certified by CMS. Any recommendations that require additional funding would be submitted through the regular budget process.

36. Are there issues with claims processing for PACE providers? How much does the Department owe the PACE providers and how is the obligation being accounted for in the budget? When does the Department expect reconciliation payments to the providers and when does the Department expect an ongoing resolution of the claims processing issues?

RESPONSE

Unlike other long-term care providers, PACE organizations may choose to enroll individuals and begin providing services before eligibility is established. If the individual is determined not to be eligible, the PACE provider assumes the risk and will not receive payment. If the individual is eligible, the provider is paid for services rendered. However, that determination may take some time, and under federal authorities, the Department cannot pay claims until the member is determined eligible. The practice of enrolling individuals prior to establishing eligibility combined with potential CBMS Transformation delays at the county level with processing eligibility, has likely created delays in payment for some PACE providers.

To mitigate delays the Department manually processes outstanding claims for PACE providers. Currently, the Department estimates approximately $8 million in outstanding claims. Because claims are paid on a weekly basis, the amount that may be owed fluctuates, and it must be offset against what providers owe the Department, which is currently estimated to be $5 million. The delays in claims processing for PACE providers that may be related to CBMS transformation are temporary in nature.

As the Department performs reconciliations, the Department continues to work collaboratively with providers, counties, and the Department's fiscal agent, DXC, to identify issues and implement

systems changes that will improve the provider experience while ensuring claims pay in accordance with Department policies.

The Department has fully budgeted for the expected caseload for PACE, including the reconciliation process. The Department forecasts total PACE enrollment twice per year for the current, next, and out years. The Department projects expenditures based on the total projected number of PACE members and cost per member. In the Department's November 1, 2019 R-1 budget request, the Department included an additional impact of $4.4 million in anticipated costs, which is the estimated amount of retroactive capitations incurred by PACE-enrolled members in FY 2018-19 that were not paid by June 30, 2019 and would therefore be paid in FY 2019-20.

37. Please summarize the available data to support the assumption that home- and community-based services are cost effective in avoiding nursing home care.

RESPONSE

The Department's Home and Community-Based Services waiver agreements with the Centers for Medicare & Medicaid Services (CMS) require yearly demonstrations that on aggregate waiver services are more cost effective than nursing home care. This is referred as demonstration of cost neutrality. The cost neutrality demonstration provides CMS with the assurance that average per capita waiver costs do not exceed the average per capita institutional costs had the waiver not been granted. If cost neutrality is not demonstrated, CMS may terminate the waiver agreement.

The cost neutrality demonstration is presented in CMS-372 reports. The equation used to demonstrate cost neutrality compares home- and community-based waiver and corresponding State Plan Medicaid costs to institutional total costs of care. The table below shows the per capita costs for individuals served on each waiver compared to the equivalent institutional per capita costs (for hospital, intermediate care facility, or nursing facility level of care) that would be incurred if individuals were not on the waiver, as submitted to CMS through the most recent CMS-372 reports. As shown in the table, waiver services are less costly than institutional care.

Waiver	Average Per Capita Total Cost of Care for member receiving Waiver Services	Average Per Capita Total Cost of Care for member receiving Institutional Care
Brain Injury Waiver	$54,055.74	$173,305.00
Children's Extensive Supports Waiver	$78,413.61	$226,531.93
Children's Home and Community-Based Services Waiver	$57,813.63	$95,767.00
Children's Habilitation Residential Program Waiver	$112,289.46	$180,332.00

Children with Life Limited Illness Waiver	$93,314.50	$458,403.36
Community Mental Health Supports Waiver	$22,757.91	$56,786.89
Developmental Disabilities Waiver	$80,409.65	$341,161.00
Elderly, Blind, and Disabled Waiver	$26,426.87	$83,286.00
Spinal Cord Injury Waiver	$62,697.47	$100,853.31
Supported Living Services Waiver	$26,171.92	$275,599.09

38. Please provide an update on the implementation status of the Single Assessment Tool and stakeholder engagement opportunities.

RESPONSE

Implementation of the single assessment tool with the input of stakeholders under SB 16-192 is continuing.

The Department, in collaboration with its systems contractor, has automated the finalized eligibility determination, needs assessment, and support planning documents in the new case management information technology (IT) system, Aerial. The Department completed User Acceptance Testing (UAT) and tested the functionality of the automation with a group of case managers prior to rolling out the automation in the field.

The Department selected a vendor to oversee the pilot of the assessment and support plan process, which began in March 2019 and is scheduled to run until May 2020. Case managers from across the state are testing the content and the automation of the new process in the field with members seeking or receiving long-term services and supports (LTSS). The pilot is occurring in phases in order to make further enhancements to the automation. The first phase of the pilot, which included testing the eligibility determination screen and inter-rater reliability of the new assessment items, is complete. The Department and pilot vendor are facilitating stakeholder meetings to gather feedback on Level of Care eligibility thresholds that use the new assessment items.

The Department is concurrently completing UAT of the enhanced automation in preparation for the next phase of the pilot, which will include testing of the full comprehensive assessment and support plan, in order to gather feedback from case managers and members on which assessment items should be added, altered, or removed. The pilot vendor will make recommendations for a final assessment and support plan, and a time study will be conducted to record the time it will take case managers to complete the process.

Next steps toward implementation of the assessment will be to work with the Resource Allocation (RA) contractor to develop an RA methodology, which will use components of the assessment to inform a person-centered budget for all individuals receiving home and community-based services (HCBS). The remaining phase of the pilot and the development of an RA methodology are dependent on the success of the automation within Aerial, and the implementation of SB 16-192 is dependent on the overall implementation of Aerial.

The Department anticipates initiating statewide implementation of the new assessment tool by June 30, 2021, with all members having their new assessment completed by June 30, 2022. The fiscal note attached to the legislation specified a multi-year approach because of the phases necessary for statewide implementation. This work includes tool development and selection, computer system and procedural modifications, pilot testing of the tool, evaluation of the tool, case manager training, and implementation of the new tool along with reassessment of all current clients. The fiscal note can be found on the General Assembly's website.[1]

The Department currently works with a targeted stakeholder group that will continue to meet for the duration of the pilot. These meetings are open to the public. All information can be found on the Department's website at https://www.colorado.gov/pacific/hcpf/colorados-ltss-assessment-and-support-plan.

In addition, the RA Contractor will facilitate statewide regional stakeholder meetings as well as targeted stakeholder engagement meetings. The Department will also conduct additional statewide and regional stakeholder meetings regarding various aspects of implementation and policy changes.

39. Please compare the quality and client satisfaction with In-Home Support Services (IHSS), Consumer Directed Attendant Support Services (CDASS), and agency-based services.

RESPONSE

The Department worked with a vendor in 2018 to complete member satisfaction surveys to obtain information on the satisfaction of members utilizing IHSS, CDASS, and agency-based services. Overall, those in CDASS and IHSS reported being satisfied with their care plan and attendant quality and reported higher overall satisfaction with services than members utilizing agency-based services.

In addition, Colorado measured the satisfaction of members enrolled in the Elderly, Blind, and Disabled (EBD) and Community Mental Health Supports (CMHS) Waivers through the 2018-2019 National Core Indicator Aging and Disabilities (NCI-AD) Survey. This survey does not differentiate between members receiving agency-based services and those receiving consumer-

directed services. Of those surveyed, the majority (76 percent) of members indicated that paid support staff do things the way they want them done, and most respondents (80 percent) also indicated that they like where they are living.

Colorado measured the satisfaction of families whose child is enrolled in the Children's Extensive Supports (CES) Waiver through the 2018-2019 National Core Indicator Child Family (NCI-CFS) Survey. This survey only measures satisfaction of agency-based care, as consumer direction is not available in this waiver. Of those surveyed, 96 percent of respondents indicated that services and supports helped the child live a good life. The majority of families were satisfied with the services and supports received; 20 percent stated they were always satisfied, and 53 percent stated they were usually satisfied.

40. How many Medicaid children receive certified nursing assistant and private duty nursing benefits?

RESPONSE

Fiscal Year	Pediatric Home Health Members Served by a CNA	Pediatric Members that Received Private Duty Nursing
FY 2017-18	3,492	707
FY 2018-19	3,843	753

41. Please provide a status update on implementation of the new pediatric assessment tool for long-term home health services and private duty nursing (PDN) services. What efforts has the Department made to solicit stakeholder feedback and are there upcoming opportunities for stakeholder engagement?

RESPONSE

The Department released an Invitation to Negotiate (ITN) and corresponding Documented Quote (DQ) on December 11, 2019 in an effort to contract with a vendor responsible for researching and providing existing or developing new acuity tools for adult Long-Term Home Health (LTHH) and adult and pediatric Private Duty Nursing Services. The projected contract start dates are early in 2020, with a PDN tool ready to be piloted and implemented by June 30, 2020 and an LTHH tool piloted and ready by June 30, 2021. The Department is committed to collaborating with the selected vendor(s) to engage stakeholders as the project progresses and provide ample opportunity for input. The scope of work requires the contractor to assist the Department in facilitating stakeholder engagement and a communication plan in developing and implementing the acuity tools. The Department will publicly announce stakeholder feedback opportunities as the project moves forward.

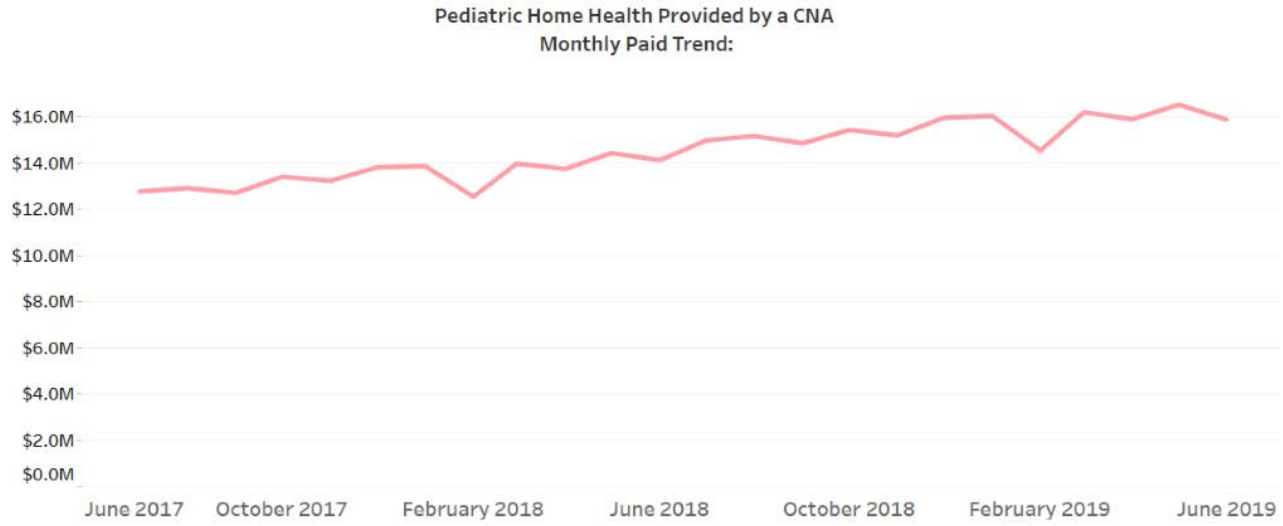
42. Has the Department seen a significant recent change in utilization and expenditures for certified nurse assistant and private duty nursing services specifically for children? If so, what is causing the change?

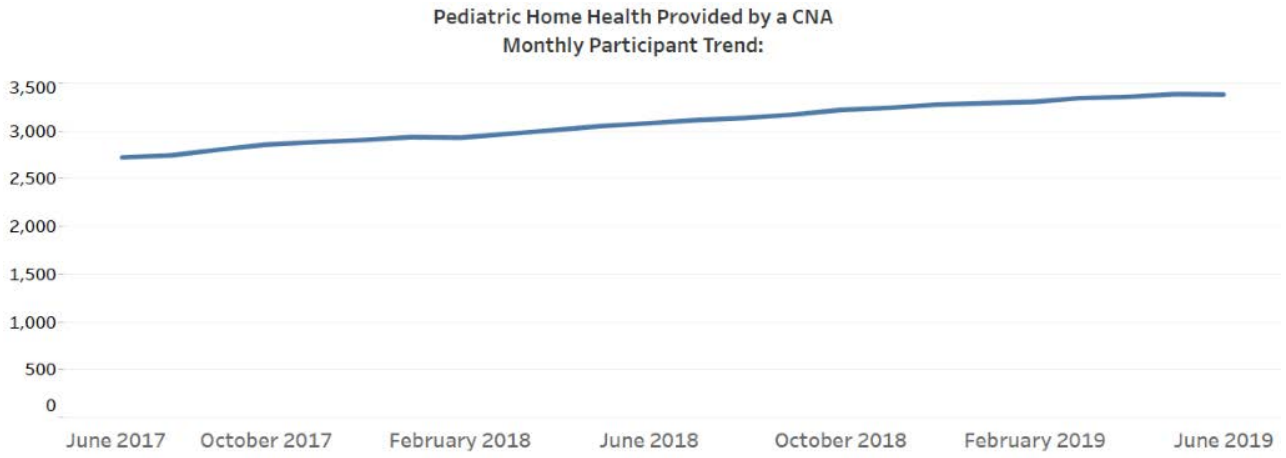
RESPONSE

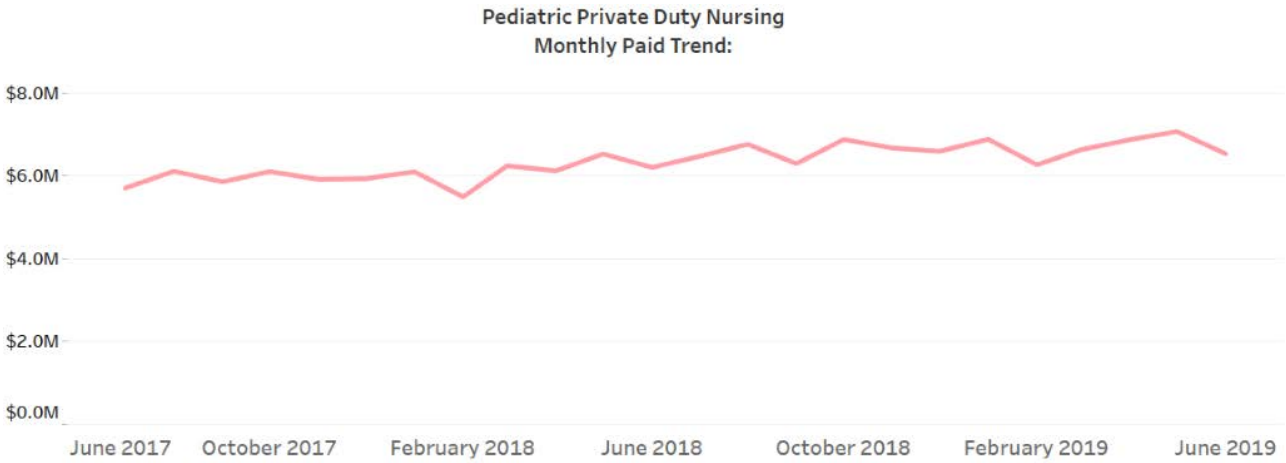
The Department observed an increase in utilization and expenditures for both Certified Nurse Assistant (CNA) and Private Duty Nursing (PDN) services for children when comparing FY 2018-19 to the previous fiscal year. Refer to the graphs below for detailed data. Total expenditures for CNA services increased by 15.6 percent between FY 2017-18 and FY 2018-19. This change is primarily driven by a 10.1 percent increase in the number of children receiving these services.

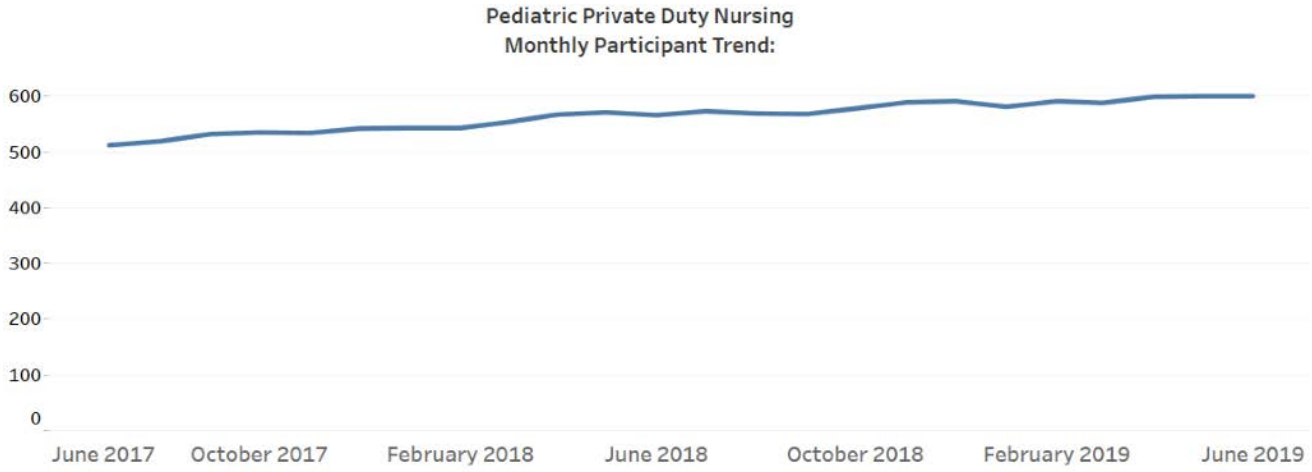
A similar trend is observed for children receiving PDN services. Total expenditures for PDN increased by 10.5 percent when comparing this fiscal year with the last. The number of children receiving PDN services increased by 6.5 percent.

Pediatric long-term home health and PDN services are currently being reviewed by the Department in Year Five of the Rate Review Process this year, which includes evaluation of utilization, expenditures, access, and rates.
The review will result in a Medicaid Provider Rate Review Analysis Report published by the Department on May 1, 2020 and a Medicaid Provider Rate Review Recommendation Report published by the Department on November 1, 2020.









43. The Department brought a proposed rule to the Medical Services Board eliminating the ability for disabled persons over the age of 65 to use pooled trusts and stating that

on death the state would recover 50 percent of the trust. Why was the proposed rule pulled? What legislative changes would be needed to ensure the rule does not come forward again?

RESPONSE

Pooled trusts are trusts established by people with disabilities for the purpose of establishing Medicaid eligibility by allowing the trusts to contain excess resources. Pooled trusts established by individuals 65 years of age and over require the Department to apply the rules addressing transfer of assets to determine whether fair consideration has been received in exchange for the transfer. The Department's rationale for bringing the amendment was to restore compliance with the law and discharge its duty to Colorado taxpayers and the federal government by ensuring pooled trusts are not misused or create an unequal standard for Medicaid enrollees who have the financial wherewithal to shelter substantial assets while these individuals receive Medicaid benefits. The rule provided a fair division of remainder amounts between the pooled trust entities (50 percent) and the Department (50 percent). Of the Department's 50 percent remainder share, half would have been returned to the Centers for Medicare and Medicaid Services, consistent with federal law. The rule was pulled by the Department at the November 2019 Medical Services Board hearing after facing significant opposition from the largest pooled trust organization in Colorado, which currently keeps all of its pooled trust beneficiaries' remainder balances. The organization appeared to persuade Board members that the Department's proposed amendments were contrary to law.

It is the Department's position that the proposed changes to the pooled trust rule were consistent with state and federal law. There is an ambiguity between two provisions in the pooled trust statute, which the Department attempted to clarify via rule regarding the right of the Department to be paid back following termination. See sections 15-14-412.9(2)(c) and (2)(e), C.R.S. The statute is also silent to the use of these trusts by individuals age of 65 and older, which the Department attempted to clarify by rule. In the absence of clarifications in the pooled trust statute, the Department is concerned that these trusts will continue to be a source of litigation for the state.

44. Health maintenance activities, which provide in-home skilled care, continue to be the most common service within In-Home Support Services (IHSS), but the utilization of personal care and a services has increased recently. Why? Is the higher utilization of personal care and homemaker services within IHSS related to recent rate increases for these services?

RESPONSE

HB 14-1357 instituted several changes to IHSS, including expansion of this option to the Spinal Cord Injury (SCI) waiver, allowing spouses to provide attendant services, and permitting services to be provided in the community. In addition, members gained the ability to have personal care

services provided by family members up to 40 hours per week. The previous limitation was 37 hours per month. These changes were approved by the Centers for Medicare & Medicaid Services (CMS) and the Medical Services Board effective in the spring of 2016. In general, increased interest in IHSS—and corresponding utilization of all the services it encompasses—can be attributed to the service limitation changes from HB 14-1357, a higher reimbursement rate for Health Maintenance Activities (HMA), and the inherent programmatic flexibility it offers many members.

Some of the increases in homemaker utilization reflect recategorization of services rather than increases corresponding to rates. Historically, homemaking services were often informally bundled with HMA tasks. Case managers have worked diligently to ensure homemaker units are now authorized appropriately, and separately from HMA. The Department will continue to analyze the enrollment and utilization trends in IHSS.

RATES

45. What are the differences in personal care and homemaker rates across programs? Will the changes in *R10 Provider rates* address these differences? If not, why, and what would it take to address these differences?

RESPONSE

The rates for personal care and homemaker services across the programs are shown in the table below. These rates are effective as of January 1, 2020 and do not include the 2.75 percent increase requested in the Department's R-10 *Provider Rate Adjustment* request. The rates shown are for a unit of 15 minutes.

Row	Service	Programs	Rate
Personal Care			
A	Personal Care	EBD, CMHS, BI, SCI	$4.98
B	IDD Personal Care	SLS, CES	$5.84
C	Pediatric Personal Care	State Plan Only	$4.92
D	CDASS Personal Care	EBD, CMHS, BI, SCI	$4.54
E	CDASS Personal Care	SLS	$5.91
Homemaker			
F	Homemaker	EBD, CMHS, BI, SCI	$4.98
G	Homemaker Basic	SLS, CES	$4.49
H	CDASS Homemaker	EBD, CMHS, BI, SCI	$4.54

I	CDASS Homemaker Basic	SLS	$4.48
Homemaker Enhanced			
J	Homemaker Enhanced	SLS, CES	$7.28

Definitions:
BI: Brain Injury Waiver
CES: Children's Extensive Support Waiver
CDASS: Consumer Directed Attendant Support Services
CMHS: Community Mental Health Supports
EBD: Elderly, Blind, and Disabled Waiver
SCI: Spinal Cord Injury Waiver
SLS: Supported Living Services Waiver

The current rate for personal care within the waivers for people with intellectual and developmental disabilities (IDD) is higher than the rates in programs that are not targeted to people with IDD. IDD waivers have two homemaker services: basic and enhanced. Homemaker basic aligns closely with the homemaker service on non-IDD waivers, but homemaker enhanced includes extra provider requirements, necessitating a higher rate. For the FY 2020-21 budget cycle, however, the Department prioritized increasing the rates for all of these services by 2.75 percent, which is slightly higher than the anticipated increase in the statewide minimum wage, rather than aligning the rates across waivers. In its R-10 request the Department did, however, request funding to align rates for pediatric personal care, a State Plan benefit, with personal care offered on non-IDD waivers.

Aligning rates between the different programs could occur in a number of different ways. For example, the General Assembly could direct the Department to rebalance rates in a manner budget neutral to the Governor's proposed FY 2020-21 budget. Alternatively, if the Department were to raise personal care and homemaker basic rates to the highest current rate, the Department estimates that it would cost $33 million total funds in FY 2020-21 (assuming a January 1, 2020 implementation date) and $65 million total funds in FY 2021-22. Intermediate options, such as a partial rebalancing with targeted budget-positive rate increases, are also possible.

46. **Behavioral health providers report they are losing money on some physician administered drugs for Medicaid clients. How does the Department plan to remedy this situation? The 2016 Medicaid Provider Rate Review Recommendation Report said, "Multiple stakeholders advocated for moving long-acting, anti-psychotic injectables . . . from the physician services benefit to the pharmacy benefit." What is the rationale for not implementing this recommendation?**

RESPONSE

As indicated in the 2016 Medicaid Provider Rate Review Recommendation Report, the Department did not support moving long-acting anti-psychotic injectable drugs from Physician Services to the Pharmacy Benefit. Long-acting injectables must be administered by a health care professional; it is necessary that these drugs remain within Physician Services to ensure a clinically appropriate place of service and clinically appropriate care. Moving long-acting injectables to the Pharmacy Benefit would require Department rule changes and approval of a State Plan Amendment by the Centers for Medicare and Medicaid Services (CMS).

The Department acknowledged in the 2016 report that a new rate methodology was needed for physician-administered drugs (PADs). The Department requested to change the methodology in its FY 2017-18 budget request R-7, "Oversight of State Resources," which was approved in the FY 2017-18 Long Bill (SB 17-254). The new methodology required PAD rates to be set every quarter based on the Average Sales Price (ASP) plus 2.5 percent. This ensured PADs were updated on a periodic basis consistent with pricing reported to CMS by drug manufacturers.

Since the implementation of this new methodology, the Department has learned of situations when the ASP is not representative of the actual price paid by Colorado providers. The Department has proposed to use the Average Acquisition Cost (AAC) methodology for physician administered drugs in its FY 2020-21 budget request R-7, "Pharmacy Pricing and Technology." This new AAC methodology will consist of a periodic survey completed by providers so that rates reflect the amount paid by providers to acquire the drugs. It is also consistent with the current AAC methodology used for the Department's prescription drug benefit.

47. How has the new policy regarding certified public expenditures for emergency transportation providers improved provider rates relative to the benchmark? How will changes in the minimum wage at the local level and statewide impact rates for emergency transportation providers? Does the General Assembly still need to address provider rates for emergency transportation providers? When will rates for emergency transportation providers be reviewed again by the Medicaid Provider Rate Review Committee?

RESPONSE

The first year of the certified public expenditure-funded Public Emergency Medical Services (EMS) Supplemental payment consisted of a six-month time period: January 1 - June 30, 2018. During this period 43 public EMS providers participated. This resulted in $14,451,167 of federal matching funds to the state. Of this amount, the state retained $1,445,117 to offset the administrative expenses of the program including paying a vendor to complete federally required cost reporting and compliance activities with no cost to the General Fund. Net reimbursement to public EMS providers for this period was $13,006,050. A detailed list of public EMS providers

and their supplemental payments for FY 2017-18 can be found on the Department's website at https://www.colorado.gov/pacific/hcpf/public-ems-supplemental-payment.

The Department implemented several targeted rate increases to the fee-for-service rates for both emergency and non-emergency medical transportation services in response to the Department's 2016 Medicaid Provider Rate Review Analysis Report and the 2016 Medicaid Provider Rate Review Recommendation Report. The Department estimates that the rates for these services overall rose from 30.74 percent of the rate comparison benchmark in FY 2014-15 to 38.97 percent of the rate comparison benchmark in FY 2019-20. Emergency Medical Transportation (EMT) services will be reviewed again by the Department in year one of the second five-year rate review cycle; evaluation will begin in 2020 and results will be published in the Department's May 1, 2021 Medicaid Provider Rate Review Analysis Report, which will include rate comparisons, as well as statewide and regional access evaluation results.

It is unclear how the minimum wage increases at the local level and statewide will impact emergency transportation providers. The Department is aware that increasing the wage in one county of a densely populated area creates significant issues for the entirety of a metropolitan area. Worker migration from providers in non-increased municipalities coupled with providers leaving that very same area may create significant access to care issues.

48. For the adjustments requested in *R10 Provider rates* please provide a summary table identifying the year the rate was reviewed by the Medicaid Provider Rate Review Advisory Committee.

RESPONSE

Rate	Year Reviewed in Rate Review Process	FY 2020-21 Budget Request Resulted from the Rate Review Process (Y/N)
Nursing Home	N/A	No, came from a separate policy rate change request
Personal Care and Homemaker	Year 2	Yes, follow-up to Year Two recommendations
Alternative Care Facilities	Year 2	Yes, follow-up to Year Two recommendations
Adult Day Programs	Year 2	Yes, follow-up to Year Two recommendations
Habilitation in RCCFs	Year 2	Yes, follow-up to Year Two recommendations
Anesthesia	Year 2	Yes, follow-up to Year Two budget request

Family Planning	Year 3	No, came from a separate policy rate change request
Ambulatory Surgical Centers	Year 4*	Yes
Fee-for-Service Behavioral Health	Year 4*	Yes
In-home Dialysis	Year 4*	Yes
Durable Medical Equipment	Year 4*	Yes

*Fiscal recommendations in the year four 2019 Medicaid Provider Rate Review Recommendation Report, submitted to the Joint Budget Committee November 1, were included in the FY 2020-21 budget request.

49. Please summarize the key findings and recommendations from the S.B. 15-228 rate review process for each of the adjustments proposed in *R10 Provider rates*.

RESPONSE

The chart below summarizes conclusions and recommendations from the Department's previously published Medicaid Provider Rate Review Analysis Reports and Medicaid Provider Rate Review Recommendation Reports.

Rate	Key Findings	Recommendation(s)
Personal Care and Homemaker	The Department's payments for personal care services range from 80.94% to 140.86% of the benchmarks. The Department's payments for homemaker services range from 80.95% to 133.65% of the benchmarks. In the 2017 Medicaid Provider Rate Review Analysis Report – Home- and Community-Based Services (HCBS) Waivers, the Department noted that utilization information derived from claims data was too limited to allow for robust access analysis.	The Department recommends increasing rates for other waiver services as identified through the ongoing rate setting process, with special attention to services: a. identified by stakeholders through the rate review process; and b. with the biggest gaps between current rates and rates developed via the new rate setting methodology.

	Stakeholders reported access barriers to personal care and homemaker services.	
Alternative Care Facilities (ACF)	The Department's payments for ACF services range from 27.12% to 89.52% of the benchmarks. In the 2017 Medicaid Provider Rate Review Analysis Report – Home- and Community-Based Services (HCBS) Waivers, the Department noted that utilization information derived from claims data was too limited to allow for robust access analysis. Stakeholders reported access barriers to alternative care facility (ACF) services.	The Department recommends increasing the rate for ACF services.
Adult Day Programs	The Department's payments for adult day services range from 58.00% to 88.25% of the benchmarks. This waiver service has the largest gap between the Department's rate setting methodology and the current rate. In the 2017 Medicaid Provider Rate Review Analysis Report – Home- and Community-Based Services (HCBS) Waivers, the Department noted that utilization information derived from claims data was too limited to allow for robust access analysis. Stakeholders reported access barriers to adult day services.	The Department recommends increasing rates for other waiver services as identified through the ongoing rate setting process, with special attention to services: a. identified by stakeholders through the rate review process; and b. with the biggest gaps between current rates and rates developed via the new rate setting methodology.

Habilitation in RCCFs	The Department's payments were 110.59% of the rate comparison benchmark. However, the results of the access analysis may indicate an access issue. Specifically, habilitation rates for RCCFs are currently much lower than DHS payments comparatively. In the 2017 Medicaid Provider Rate Review Analysis Report – Home- and Community-Based Services (HCBS) Waivers, the Department noted that utilization information derived from claims data was too limited to allow for robust access analysis.	The Department recommends increasing rates for other waiver services as identified through the ongoing rate setting process, with special attention to services: a. identified by stakeholders through the rate review process; and b. with the biggest gaps between current rates and rates developed via the new rate setting methodology.
Anesthesia	On average, the Department's payments for anesthesia services are 131.64% of the benchmark. Rate ratios for anesthesia services range from 116.23% to 1,162.30%. Unlike payments for physician services and surgeries, all anesthesia rates for individual services were above 100% of the benchmark.	The Department recommends a reduction in anesthesia service rates to 100% of the rate comparison benchmark, the 2016 Medicare conversion factor, and continued analysis thereafter to evaluate the appropriateness of reimbursement at that level.
Ambulatory Surgical Centers	The Department's payments for ASCs were 63.95% of the benchmark. Rate benchmark comparisons varied widely; payments for the ten ASC code grouping rate ratios varied between 29.71% and 139.02% of the benchmark. Analyses suggest that ASC payments were sufficient to allow for member access and provider	1. Add clinically appropriate procedure codes to the list of services that can be reimbursed in an ASC setting. 2. Eliminate the ASC grouping reimbursement methodology in favor of a more appropriate reimbursement methodology. 3. Re-evaluate each service rate relative to the benchmark and

	retention. However, additional research may reveal more information that could lead to a different conclusion. The Department recognizes that while analyses indicate that member access and provider retention are sufficient, there are ways in which access to ASC services could be improved.	evaluate individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[1] 4. Evaluate the potential for creating a Multiple Procedure Discounting reimbursement methodology. 5. Conduct additional evaluation of whether costs can be offset by incentivizing migration of appropriate procedures from the hospital to the ASC setting.
Fee-for-Service (FFS) Behavioral Health	The Department's payments for FFS behavioral health services were 94.67% of the benchmark. Rate benchmark comparison varied widely; payments varied between 22.71% and 231.23% of the benchmark. Analyses suggest that FFS behavioral health payments were sufficient to allow for member access and provider retention. The Department contracts with the Regional Accountable Entities (RAEs), which are the primary access point for behavioral health services.	Evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[1]
In-home Dialysis	Department's payments for dialysis and End-stage Renal Disease (ESRD) treatment services were 83.26% of the benchmark. Rate benchmark comparisons varied; payments varied between 73.46%	1. Evaluate potential reimbursement method changes for in-home Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis services, which

	and 90.02% of the benchmark. Analyses suggest dialysis and ESRD treatment services payments were sufficient to allow for member access and provider retention. Colorado Medicaid currently pays the facility rate for four extra days per week of Continuous Ambulatory Peritoneal Dialysis (CAPD) or Continuous Cycling Peritoneal Dialysis (CCPD) treatment than for patients receiving hemodialysis facility treatments, compared to Medicare.	would align more closely with the Medicare payment methodology. 2. Evaluate factors that impact utilization of in-home dialysis, including Medicare enrollment, and methods to improve access to in-home dialysis options where appropriate.
Durable Medical Equipment (DME)	Department's payments for DME not subject to Upper Payment Limits (UPL) were 104.84% of the benchmark. Rate benchmark comparisons varied widely by individual service; payments varied between 3.9% and 1,478% of the benchmark. Analyses suggest DME payments were sufficient to allow for member access and provider retention. Current data suggest that UPL DME rates are sufficient for provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.	1. Evaluate individual services not subject to the UPL that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[1] 2. Continue access to care evaluation of DME services subject to the UPL and work with state and federal partners to identify solutions to impacted services. 3. Evaluate the benefit of DME service component reimbursement.

50. There were strong and compelling arguments from advocates that influenced the Joint Budget Committee to reject previous Department proposals to reduce nursing home rates and anesthesia rates. Why is the Department requesting these changes again without any new information or new arguments to change the views of the Joint Budget Committee?

RESPONSE

Nursing Homes

The Department previously requested to eliminate the 3.0 percent rate growth for nursing homes one time since FY 2012-13, as part of FY 2018-19 R-9, "Provider Rate Adjustments." The Department proposed the reduction for one year only in that request. At the time, JBC staff noted that this single-year reduction may not have addressed the overall inequity.[1] This request will bring alignment to rate setting for all long-term services and supports.

Skilled Nursing Facilities are the only long-term care provider type that have a statutorily mandated provider rate increase. Very few other providers in the Medicaid program receive automatic rate increases, and other than nursing facilities, no other providers in the Medicaid program receive automatic rate increase as a result of state law. Other providers that receive automatic increases, such as pharmacies and Federally Qualified Health Centers, receive these increases because of requirements in federal law. Rate increases for other providers are subject to annual appropriation by the General Assembly. In FY 2020-21, the 3 percent increase would represent a rate adjustment that is more than 10 times greater than the proposed 0.29 percent across the board increase for all other long-term care providers. This discrepancy has occurred on an annual basis for the last decade and creates inequity in reimbursement amongst providers. This statutory change would provide consistency between nursing facilities and other provider types with respect to the process through which payment rates are proposed and adopted by the Governor and General Assembly.

While the budget request in FY 2018-19 regarding skilled nursing facility reimbursement was a single year adjustment related to a single year budget, the Department views the current budget request as a more long-term approach to nursing facility reimbursement. Nursing facilities would still receive the same across the board rate increases that are applied to other providers.

Finally, the Department is also seeking additional funding in R-17, "Program Capacity for Older Adults," to study potential alternative rate methodologies.

Anesthesia

The Department previously requested to reduce anesthesia rates to 100 percent of the benchmark rate in FY 2018-19 R-9, "Provider Rate Adjustments" and FY 2019-20 R-13, "Provider Rate Adjustments." The Department's 2017 Medicaid Provider Rate Review Analysis Report - Physician Services, Surgery, and Anesthesia showed that anesthesia services for Colorado Medicaid were at 131.64 percent of the benchmark. Individual rate ratios for anesthesia services ranged from 116.23 percent - 1,162.30 percent above the benchmark. Unlike payments for physician services and surgeries, all rates for individual anesthesia services were above 100

percent of the benchmark. The Joint Budget Committee approved a rate reduction to 120 percent of the rate comparison benchmark in the FY 2019-20 Long Bill (SB 19-207).

In the 2017 Medicaid Provider Rate Review Recommendation Report, the Department recommended a reduction in anesthesia services rates to 100 percent of the rate comparison benchmark, the 2016 Medicare conversion factor, and continued analysis thereafter to evaluate the appropriateness of reimbursement at that level. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) supported the Department's recommendation to reduce anesthesia service rates to 100 percent of the rate comparison benchmark. This recommendation was intended to bring further consistency to rates within the individual anesthesia service grouping **and** across service groupings reviewed within the Rate Review Process. The Department frequently recommends rebalancing or changing rates below 80 percent and above 100 percent of the benchmark. This recommendation is in line with recommendations for other service groupings. In past MPRRAC meetings, the Department and MPRRAC have expressed the importance of consistent approaches to recommendations across the services and years of rate review, as well as striving for rates for services to fall within 80 percent - 100 percent of the rate comparison benchmark, and for equity of rate ranges across services.

The Department does not believe that reducing anesthesia service rates to 100 percent of the rate comparison benchmark will adversely impact client access and provider retention. Anesthesia services will be reviewed again by the Department in year three of the second five-year rate review cycle; evaluation will begin in 2022 and results will be published in the Department's May 1, 2023 Medicaid Provider Rate Review Analysis Report, which will include rate comparisons, as well as statewide and regional access evaluation results.

51. In particular, why is the Department requesting eliminating the statutory provision allowing up to a three percent increase in nursing home rates before completing the study of nursing home rates proposed in *R17 Program capacity for older adults*?

RESPONSE:

The Department is pursuing the study of nursing facility rates separate and apart from the request to eliminate the statutory provision for a 3 percent provider rate increase. The elimination of the 3 percent annual increase is aimed at creating equity around how provider rates are reimbursed across the spectrum of long-term services and supports. At the same time, the Department is also proposing to give nursing facilities the same 0.29 percent across-the-board rate increase that is proposed for other providers. In the future, Nursing Facilities would get the same rate increase as all providers receive. The study is aimed at assessing a long-term strategic approach to financing nursing facilities in Colorado.

The study would include a review of existing rate reimbursement components, potential improvements to the existing structure, and a comparison to other state reimbursement systems. The Department requested funding to facilitate stakeholder meetings to review the options from the analysis. The Department would use the results of the contractor study and stakeholder feedback to propose a new reimbursement methodology that takes into consideration the case-mix of nursing facility residents, the acuity level of residents, and anticipated resources needed for a member. The Department expects this study to lead to better reimbursement policy, accounting for geographical differences, and incentives for serving members with more complex needs, while also incorporating quality metrics.

52. How does access to personal care and homemaker services differ in rural areas compared to urban areas? Do we need rate increases and regional variations in the rates to address inequitable access?

RESPONSE

The Department recognizes that there are geographical issues around access to these critical services in both rural and urban areas. Recently, the Department has undertaken efforts to recruit providers that are in adjacent service areas or that historically provided services to people with a different disability type to expand their service footprint to further meet the needs of rural communities. That said, the Department does believe that geographical rate variations may be worthwhile in addressing any issues of provider capacity and member utilization. The Department has updated the reimbursement methodology for long-term services and supports case management agencies. To better address the unique fiscal challenges of providing case management in rural and frontier regions, the proposed rates include a geographic modifier for the first time. The Department intends to conduct additional analysis on both rural and urban sustainability across services to better understand, and offer corresponding policy changes to reflect, unique differences that providers and members experience throughout Colorado.

Personal care and homemaker services were reviewed by the Department in year two of the first five-year rate review cycle. While the Department found that Colorado's rates for these services was between 81 and 141 percent of the comparison states, it did also outline a lack of multiple providers in rural and frontier counties. Personal care and homemaker services will be reviewed again by the Department in year one of the second five-year rate review cycle; evaluation will begin in 2020, and results will be published in the Department's May 1, 2021 Medicaid Provider Rate Review Analysis Report. This upcoming report will pay particular attention to regional access and adequacy of rates.

As another measurement of access, the Department recently analyzed the time to start receiving personal care and homemaker services for new HCBS members from their authorized start date during FY 2018-19:

Percent of New HCBS Members Starting Services within	Homemaker		Personal Care	
	Urban	Rural	Urban	Rural
30 Days	47%	51%	66%	44%
60 Days	58%	66%	74%	62%
90 Days	64%	73%	78%	69%

The Department will continuously monitor this data. Information collected from case managers and members via surveys and other channels indicates that the ultimate choice of a particular service provider is often dependent on a multitude of issues. As previously stated, the Department will continue to monitor issues of access to ensure that members are able to receive these services regardless of location.

53. How could/should the General Assembly minimize the workload for both providers and the Department to comply with the provisions of H.B. 18-1407, S.B. 19-238, and H.B. 19-1210 regarding expenditures on compensation, while maintaining the legislative intent that the specific rate increases be passed through to compensation?

RESPONSE

While HB 18-1407, SB 19-238, and HB 19-1210 are all legislation that require changes to provider reimbursement, there are important differences. HB 18-1407 and SB 19-238 are wage pass-through requirements that necessitate an in-depth financial review of fund accounting to identify the fund source and cost pool from which employees or workers are paid. By contrast, HB 19-1210 relates to minimum wage and only requires a base level of compensation, without regard to fund source. While verification of provider compliance with these requirements will draw on related skill sets, they are distinct approaches. A wage pass-through review will always be more complex to collect data and review than a minimum wage review.

There are two fundamental approaches to complying with the applicable legislative requirements of HB 18-1407 and SB 19-238 and all other compensation related legislation. One is to allow for self-reporting and self-certifying, while the other is to require external review and validation. The Department recommends external review in general and is using it for this legislation, as it removes the financial incentives for any organization to falsify reports. To ensure the law is followed, some form of external review is essential, and this generates a workload impact on providers and the Department.

For HB 18-1407 and SB 19-238, alternatives that would decrease this wage pass-through workload could include: fewer years of mandatory reporting; fewer restrictions on the eligible uses of funds; consistent language and definitions of compensation versus wage; requiring compensation compliance at the agency aggregate total level instead of at the individual staff level; broader eligible populations and services; and separate increased payments from rates.

A further discussion of the overlap of the legislation and workload factors affecting implementation is incorporated into the response to Question #56.

54. What is a reasonable amount of time to track whether providers maintain the compensation increases required by H.B. 18-1407, S.B. 19-238, and H.B. 19-1210? For example, should the compensation requirements of H.B. 18-1407 and S.B. 19-238 expire after FY 2020-21 when the statutory reporting requirements end, or maybe three years later to be consistent with the record retention requirements, or continue indefinitely?

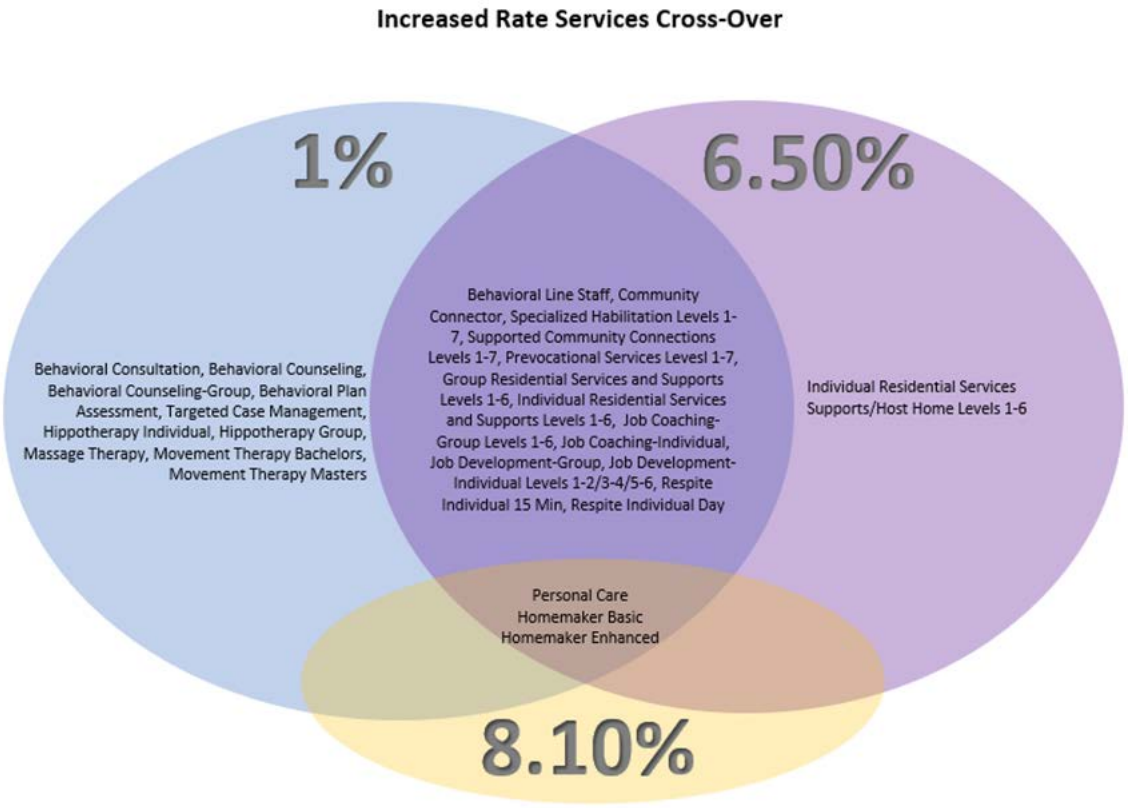
RESPONSE

For HB 18-1407 and SB 19-238, the Department must perform oversight activities for three years following each of the reporting deadlines. The Department supports a three-year window for provider compliance and related reporting, during which providers must submit data to the Department for review and audit. However, for similar post-payment reviews, the Department typically has six years to complete its work, through the records retention period. Hence, the Department would prefer to have three years of mandatory reporting followed by the Department-standard six-year window for post-payment review. This would allow the Department to recover incorrectly spent funds if uncovered by future audits. However, the provider agencies would not be required to submit annual reports beyond the three-year window.

Both HB 18-1407 and SB 19-238 allow provider agencies to challenge the Department's findings/determination, provide additional information to the Department demonstrating compliance, submit a plan of correction to the Department, file an informal reconsideration request, and pursue a formal appeal. These actions by a provider agency will require extensive administrative effort from the Department, including but not limited to: reviewing additional information, reviewing provider plans of correction, drafting and distribution of revised findings/determinations, and potential appeals to findings, drafting and issuing of notice of recovery if needed, and ensuring that recoveries are received by the Department in alignment with final determination timelines. Service providers can then appeal the final decisions made by the Department concerning compliance, which can add another 12-18 months to the final disposition of each reporting year.

The two laws have different language targeting different classifications of workforce members. HB 18-1407 identifies wage pass-through for "workers," whereas SB 19-238 identifies "employees." The term "workers" covers employees and contractors, while the term "employees" is synonymous with employment exclusively. During financial reviews, the Department will be required to ensure that classification of these workforce members was correct under each law. Because of this nuance, both laws require an in-depth financial review of fund accounting to identify the fund source and cost pool from which workers or employees are paid to ensure compliance. SB 19-238 will require additional Department scrutiny to ensure that the increases were passed through to "employees." If both laws were to apply to the same classification of workforce members, to include all "workers," there would be less complexity for providers responsible for reporting under both laws and for the Department in conducting financial reviews.

Additionally, some providers are covered by both laws, but are required to report separately for each, which creates complications regarding overlapping services, deadlines, workforce member definitions, and rate increases. The diagram below demonstrates the overlaps that could occur for providers during the financial reviews between rate increases (1 percent across the board) and affected service categories (6.5 percent in HB 18-1407 and 8.10 percent in SB 19-238) as an example. HB 18-1407 pass-through reporting deadlines are December 2019, 2020, and 2021, whereas SB 19-238 pass-through reporting deadlines are December 2020 and 2021.



Note that the response above discussed only HB 18-1407 and SB 19-238 as wage pass through legislation affecting over 900 service providers.

HB 19-1210 is minimum wage legislation that is not accounted for in the above outline. HB 19-1210 allows for government jurisdictions to establish their own minimum wage exceeding the statewide minimum wage. The bill also creates a minimum wage enhancement payment to reimburse nursing homes for increased employee compensation due to the minimum wage increase. Every year, the Department will collect payroll journal data from nursing homes located in government jurisdictions with a minimum wage exceeding the statewide minimum wage to verify the increased compensation and reimburse them for the increase. The Department will complete this process every year as long as the General Assembly appropriates money for the minimum wage enhancement payment.

55. **How could the General Assembly get more information about the approximate percentage of provider payments used for compensation in the least invasive and burdensome way? For example, could the Department include a survey of a representative sample of the categories of providers under review in a given year as part of the S.B. 15-228 rate review process?**

RESPONSE

While the Department performs in-depth rates analysis and calculations during rate setting, it does not require all providers to submit cost reports. For providers who are required to furnish cost reports, which often provide data about compensation, the percentage of reimbursement rates used for compensation can vary widely between providers and even within a single provider. The Department currently receives more specific compensation data from the following sources:

- Federally Qualified Health Center cost reports;
- Hospital cost reports;
- Long-term care provider cost reports; and
- Regional Accountable Entity (RAE) cost reports.

In addition, the Department will receive information about employee compensation associated with HB 18-1407 and SB 19-238. These wage pass-through bills require an in-depth financial accounting review to identify the fund source and cost pool from which employees or workers are paid.

Based on the Department's rate methodology for services, the average range of provider payments built into the rates related to compensation for providing direct and indirect client care ranges from 70.48 percent of the unit rate to 95.88 percent of the unit rate depending on the service. On average, 84.96 percent of the unit rate paid to providers accounts for wages for direct service providers, management staff, ancillary and administrative staff, and payroll taxes and benefits. This type of average compensation information could be used as a less invasive and burdensome proxy for the amount that providers use for compensation, but it provides a limited snapshot of the actual amount of provider payments used for compensation.

Implementing a survey or similar data collection method, which would provide more precise data, would likely be administratively burdensome for both providers and the Department. Any representative sample would have to include a mix of variables for providers such as: urban/rural, size of business, number of services provided, type of services provided, area of Medicaid served, and the like. Furthermore, provider participation could be impacted by concerns about the information becoming public, or potentially impacting employee retention or recruitment.

56. Is the S.B. 15-228 rate review process and the Medicaid Provider Rate Review Advisory Committee adding value, or should it be scrapped? If it adds value, how could the process be improved? Are statutory changes needed?

RESPONSE

The SB 15-228 Rate Review Process and the Medicaid Provider Rate Review Advisory Committee adds value and, as with any new process can also be improved. The Department considers both MPRRAC and stakeholder feedback to be equally important in informing the Rate Review Process.

Rate Review Process Value

The Rate Review Process outlined by SB 15-228 has contributed greatly to the Department's systematic review of provider rates. These rates did not have an existing review process prior to the Rate Review Process. This process provides a transparent, consistent, and evidence-based approach to comprehensively evaluate the sufficiency of provider rates for maintaining and improving provider retention and access to care. 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. 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 69.49 percent of the benchmark, with some rates ranging as low as 29.73 percent.
- Anesthesia rates were reduced to 120 percent of the benchmark, including rates that ranged up to 1,162.30 percent of the benchmark.
- High-value home and community-based services with rates well below the benchmarks received targeted rate increases.
- Several rebalancing projects have been completed for rates that bring rates within 80-100 percent of the benchmark, which has brought 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 rate 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 allows for elements of the rate setting process to be captured and to support standardized processes in how rates are set.

MPRRAC Value

The Medicaid Provider Rate Review Advisory Committee (MPRRAC) offers thoughtful and diverse perspectives that span numerous provider types. The representative of the related topic of discussion has tremendous insight and value to add, the conversations as a whole are fruitful within the entirety of MPRRAC. Additionally, stakeholders participate in each MPRRAC meeting and provide invaluable feedback to the Department on each service.[5]

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 will supplement the Department's data analysis.

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 both the MPRRAC or the JBC any time before December 1 each year, in general, and for the current year of review, for which the work has already begun. This can lead to schedule change requests that conflict with MPRRAC or JBC votes, as well as stakeholder feedback.[6] Sole authority for schedule changes by either the JBC or MPRRAC would prevent this possibility.

The changes outlined in R-8, "Accountability and Compliance Improvement Resources," will help properly resource the committee's work and improve the rate review process.

57. How can we achieve greater consensus between providers and the Department about rate setting priorities prior to presentation of the budget request to the Joint Budget Committee?

RESPONSE

The Department understands the value of stakeholder engagement and strives to engage with providers to share data, talk though information provided to the Department from outside sources, and address issues brought to the Department through solution-focused efforts. Stakeholder feedback, along with evidence-based data, largely informs Department initiatives for rate review and rate setting. The Department has many considerations to take into account when reviewing and setting rates, such as member access to care, compliance with state and federal regulations, fiscal responsibility, budgetary and legislative authority, federal authority, and incentivizing

[5] Stakeholders can share data and other information with the Department to help inform the Rate Review Process at any time, not only during MPRRAC meetings.

[6] The MPRRAC has substantial knowledge of how services and service groupings relate to one another, reviews all stakeholder requests tracked by the Department, and considers stakeholder feedback shared in MPRRAC meetings and with the Department.

increased quality of care and reduction of unnecessary costs, among others. In addition, the Department is unable to publicly share any proposals to change rates with a budget impact until the November 1 budget is released.

Stakeholders have the opportunity to engage with the Department through several channels. One example is the Rate Review Process outlined in SB 15-228, which functions as a comprehensive, systematic, evidence-based rate review process, informed by stakeholder and Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback. Providers and other stakeholders can share data and other information with the Department at any time, as well as make public comments to the Department and MPRRAC during quarterly MPRRAC meetings. Any data or information shared by stakeholders is taken into consideration when evaluating data analyses for the Department's Medicaid Provider Rate Review Analysis Report submitted to the Joint Budget Committee (JBC) May 1 of each year, as well as when developing recommendations for the Department's Medicaid Provider Rate Review Recommendation Report submitted to the JBC November 1 of each year.

There are also other means for providers to engage with the Department. For example, hospitals, Federally Qualified Health Centers (FQHCs), and their respective associations have regularly scheduled meetings with the Department to discuss a variety of topics, including rate setting methodologies. Additionally, providers have opportunities to participate in Department rate setting stakeholder engagement, which is designed to help inform the rates. The Department believes existing opportunities provide systematic, formal channels for stakeholders to inform rates set by the Department.

58. Why do we need more administrative resources to implement *R9 Bundled payments*? It seems like something straightforward that the providers could figure out. What are the anticipated cost savings?

RESPONSE

Creating bundled payment methodologies is an administratively complex endeavor which requires frequent, detailed claims analysis, constant interaction with stakeholders, and detailed financial modelling to ensure that payments are sufficient and accurate. Without additional staff, the Department would be unable to absorb the workload associated with creating payment bundles.

Traditionally, Medicaid makes separate payments to providers for each of the individual services they furnish to beneficiaries for a course of treatment also known as an episode. This approach can result in fragmented care with minimal coordination across providers and health care settings. This payment structure rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospitals, physicians, and other practitioners – allowing them to work closely together across all

specialties and settings. Under a bundled payment model, providers involved in an episode have a specific pre-agreed upon target budget for the expected care based on trended historical utilization. Participating providers hold limited risk for staying within the target budget and are eligible for shared savings when the budget is not exceeded.

Administrative resources are necessary to operationalize bundled payment methodologies. Implementing new bundled payment methodologies will require extensive analysis of claims data to identify episodes with high potentially avoidable costs. Once episodes are identified in claims, the data needs to be analyzed to inform policy decisions to shape the program to ensure it will incentivize high quality care while containing costs. The requested staff would work with the Department's actuarial contractor to develop a risk adjusted budget for the proposed bundle to ensure that high acuity episodes are properly accounted for in the model so that providers are not penalized for sicker patients. For example, a provider who has a group of patients who are sicker than average must have their payment bundle adjusted to ensure that their financial success is not based on a comparison group of healthier people.

After the bundled payment is designed there will be an extensive stakeholder engagement process to get public input on the design and build trust with potential participants. The Department will also engage with the Centers for Medicare and Medicaid Services to determine federal authority for implementation of the bundle. After stakeholder and federal authority are received the Department will need to promulgate rules and negotiate with entities willing to participate in the model.

After the bundled payment is implemented participating providers will submit fee-for-service claims throughout the fiscal year. In year one, episodes submitted during the fiscal year will be retrospectively reconciled against the risk adjusted budget. In years two and beyond episodes will be reconciled on a rolling semi-annual basis. The reconciliation process will require extensive claims analytics to see if costs stayed within the budget and if providers met quality goals to ensure appropriate care is being provided. If an episode stayed within the budget and quality goals were met, the providers are eligible to receive shared savings. In years two and beyond providers who do not stay within the budget will be liable for partial risk of the success of the episode. The reconciliation process in all years is expected to require an extensive amount of technical assistance and communication with participating providers and take approximately six months to fully complete. Having these additional resources will ensure the implemented program is of value to participating providers.

The anticipated costs savings of the maternity episode of care program is $138,736 in FY 2020-21. The Department anticipates that limited providers with sufficient delivery volume will be willing to participate in the pilot initially but anticipates the program will grow over time. The savings are estimated based on a target reduction in potentially avoidable costs for maternity

episodes for the limited number of participating providers each year, which is assumed to grow from 10 percent in FY 2020-21 to 20 percent by FY 2022-23. A share of realized savings will be paid to participating providers as incentive payments.

59. What is the rationale for submitting the cost containment strategy proposed in R9 Bundled payments when rates for maternity services are not sufficient?

RESPONSE

The 2018 Medicaid Provider Rate Review Advisory Committee reviewed maternity services and found access to care was sufficient. However, since Colorado's rates were lower than the average of the other state Medicaid rates, the Committee requested to increase rates to 90 percent of the benchmark. The Department requested an increase to 80 percent of the benchmark in its November 1, 2018 request. In its response to the Committee, the Department said that rather than increasing payment rates to 90 percent of the benchmark, the best long-term approach to increasing reimbursement for maternity services is through a quality incentive and value-based payment lens. Bundled payments are a value-based payment methodology and are a way to increase reimbursement for high quality, efficient providers without needing to increase the fee schedule payment for everyone. Bundled payments present an opportunity for providers to potentially earn more than they otherwise would with fee-for-service payment by coordinating care, finding efficiencies, and delivering high quality care.

60. Bundled payments sound a lot like managed care and service level capitation strategies that the industry moved away from after experiences in the 80s with adverse incentives to ration care. Why does the Department believe bundled payments are a good option and will provide incentives for quality care?

RESPONSE

Bundled payments are separate and distinct from managed care fully capitated rates of the 1980s. Bundled payments are an alternative payment methodology used for appropriate episode of care payments such as a hip replacement, delivery, and removal of the gall bladder. Bundled payments are currently gaining favor with commercial payers and employer-sponsored health plans which have recognized the ability of this alternative payment methodology to contain costs and incentivize high quality care. United Healthcare recently switched to a bundled payments model for maternity care and stated the program is meant to incentivize better care coordination across the entire episode of maternity care. Boeing, GE, Lowes, and Walmart have also adopted bundled payments for their employer-sponsored health plans to reduce costs and improve outcomes for their employees.

A core component of bundled payments is a quality threshold to access financial reward payments to help ensure that appropriate care is not being inappropriately withheld. Bundled payments, as the Department is currently envisioning them, unlike historical capitated programs, do not require providers to assume full risk for the services being provided. Under this model, providers are only responsible for outcomes of the episode and not the management of the population with an illness.

The Department has analyzed independent peer reviewed research and has come to the conclusion that bundled payments encourage coordination and cooperation among providers, which decrease silos in a member's care experience, reduce cost, and also create efficiencies that can lower the cost of the bundle vs. the fee-for-service alternative. This improves the quality of care a member receives throughout the episode and ultimately leads to better health outcomes.

GENERAL FINANCING AND MISCELLANEOUS

61. Are the Department's current utilization management procedures overturning decisions by Administrative Law Judges? What assurances can the Department provide that the enhanced utilization management procedures will not overturn decisions by Administrative Law Judges, requiring a client to redispute the case?

RESPONSE

The Department's utilization management procedures do not overturn decisions by Administrative Law Judges (ALJs). The Department's Appeals Officer, who is also an ALJ, reviews each ALJ Initial Decision for accuracy, evidentiary bases, and consistency with the Department's regulations, state statutes, and federal law. The Appeals Officer then issues a Final Agency Decision, in most cases upholding ALJs' Initial Decisions and, in some cases, overturning them if there is a legal or evidentiary issue. None of the Appeals Officer's overturned cases are related to utilization management procedures. If the Appeals Officer overturns an ALJ's Initial Decision, which results in an adverse action, the member may appeal the Appeals Officer's Final Agency Decision in district court, also called judicial review. See section 24-4-106, C.R.S. The Appeals Officer does not have any contact with the Department's utilization management vendors during the review process, or at any other time.

62. Please describe the web and mobile technology to manage high cost conditions that is proposed in *R14 High cost condition management*. How does it help people manage their conditions? What evidence is there to indicate that it will work for the Medicaid population?

RESPONSE

The technology proposed in the Department's budget request R-14, "Enhanced Care and Condition Management," is commercial off-the-shelf software that helps members manage conditions such as chronic pain, anxiety, or depression along with other conditions, such as maternity, diabetes,

and cardiovascular disease. The software would be provided to members with one or more of these conditions, and members would access the software either on their computer through a web browser or on their phone as a mobile application. The software would provide members with numerous, evidence-based tools that help manage their condition. It would also be responsive to the individual member, tailoring their experience based on clinical needs, emotional health goals, and current motivation. The software tools would include:

- Interactive programs that teach mood management techniques based in cognitive behavioral therapy and that help overcome depression
- In-the-moment instruction on coping strategies that help reduce out-of-control anxiety and are based in mindfulness and cognitive behavioral therapy
- Peer-led programs that provide advice, inspiration, and community support for coping with chronic pain
- Tracking programs that track a member's sleep, mood, or other indicators and help plan for improvement, provide motivation, and reinforce habit change
- Tools and evidence-based strategies for managing pregnancy and the post-partum period, improving outcomes and encouraging appropriate prenatal care and mental health screens
- Tools and evidence-based strategies to support multi-morbid conditions and improve outcomes across medical and behavioral support services

The Department is aware of evidence that similar technology has reduced depression symptoms with an effect size comparable to that of traditional psychotherapy among a commercially-insured adult population and expects that the proposed software would also have favorable clinical impacts on Medicaid members seeking care for depression. This evidence comes from an October 2017 study called "Real-World Outcomes Associated with a Digital Self-Care Health Platform[7]" and is discussed in more detail in the request. Additionally, the Department is aware of evidence that similar technology has reduced the total cost of care for behavioral health conditions among the Missouri Medicaid population. This evidence comes from a November 2018 study called "Quantifying the Economic Impact of a Digital Self-Care Behavioral Health Platform on Missouri Medicaid Expenditures[8]" and is also discussed in more detail in the request. Based on this evidence, the Department anticipates that the software would offset use of more expensive care settings such as outpatient psychotherapy and help prevent chronic conditions from worsening to costly acute care needs such as emergency room visits.

[7] Schladweiler, K., Hirsch, A., Jones, E., Snow, L.B. (2017). Real-World Outcomes Associated with a Digital Self-Care Behavioral Health Platform. Annals of Clinical Research and Trials, 1(2), 007.
[8] Abhulimen, S and Hirsch, A. (2018). Quantifying the Economic Impact of a Digital Self-Care Behavioral Health Platform on Missouri Medicaid Expenditures. Journal of Medical Economics, Vol. 21:11.

Forty five percent of all births in Colorado were covered by Medicaid in 2018. Behavioral health care in pregnancy is a particular area of concern and one that is very amenable to digital solutions. Colorado Medicaid's preterm birth rate is 10.3 percent.[9] There is a high correlation between anxiety and depression and preterm births. In Colorado, between 2009 and 2013, forty-one women died in the perinatal period due to mental health issues (suicide and drug overdose)[10], making mental health the leading cause of death in the perinatal period. Seventy-two percent of those were covered by Medicaid. A review article published in June 2018 (eHealth as the Next-generation Perinatal Care: An Overview of the Literature) summarized 71 articles on maternity in the mobile health space.[11] This is a new and evolving area but overall, especially in gestational diabetes and mental health, the study found that digital applications were effective and efficient enhancements to standard practice, enabling the shift from hospital-centered to patient-centered care. Evidence from a study of a mobile application for pregnant women enrolled in Medicaid in Wyoming found that users of the app were more likely to complete a six month or more prenatal visit and less likely to give birth to low birth weight babies.[12] The digital applications also increase access to care, especially in rural and frontier regions.

63. In *R8 Accountability and compliance resources* the Department proposes, among other things, an additional FTE for redesigning the benefit and managed care network for the Children's Basic Health Plan (marketed as the Child Health Plan Plus or CHP+). What changes is the Department considering? How will these changes impact clients, providers, and the state?

RESPONSE

The Department's purpose for requesting an additional FTE for a Child Health Plan *Plus* (CHP+) Benefit Specialist is to improve oversight of the current managed care organizations; and identify opportunities to support the long-term affordability and sustainability of the CHP+ program. This work is designed to align with the state's Office of Saving People Money on Health Care.

With increased federal and state regulations, the Department requires an additional FTE to more effectively oversee compliance by the five existing managed care contracts and to transition to an outcomes-based management strategy. This work includes updating the Department's contracts with the managed care organizations to be more consistent with those for the Medicaid Regional Accountable Entities. This position would also be responsible for identifying opportunities for containing costs while expanding access to quality care.

[9] 2019 March of Dimes Report Card
[10] Data request from the Colorado Department of Public Health and the Environment.
[11] Van Den Heuvel et al. (2018). "EHealth as the Next Generation Perinatal Care: An Overview of the Literature" Journal of Medical Internet Research, 20:6.
[12] Bush, et al. (2017). "Impact of Mobile Health Application on User Engagement and Pregnancy Outcomes Among Wyoming Medicaid Members." Telemedicine and eHealth, 23:11.

In building in this increased oversight and alignment, the Department does not have any intention to redesign the basic components of the CHP+ benefit or managed care networks. The one change is to eliminate the Administrative Service Organization contract for what is known as the State Managed Care Network (SMCN). The SMCN currently administers fee-for-service reimbursements for any services delivered to members prior to their enrollment with a managed care organization (MCO). Instead of contracting out this work, the Department will implement automatic enrollment of members with an MCO, thereby eliminating any time a member is not enrolled with an MCO. This new position would also be accountable to ensure the changes are implemented and to oversee the new processes to make sure things are functioning properly.

The changes to CHP+ will allow for greater continuity of care for members, as they will have real time assignment into a plan, similar to the way Medicaid members are enrolled into the Medicaid Regional Accountable Entities. This change will also mean one fewer transition for members who move from Medicaid to CHP+ (e.g. they will move from the Regional Accountable Entity to a CHP+ MCO without the interim step in the CHP+ SMCN). For providers, the change means that providers that used to contract with the SMCN only will have to contract with the MCOs. For the state, making these changes will lend to greater program efficiency which will reduce administrative burden and cost in future rate setting cycles.

64. **What makes the Department believe the additional resources requested in *R15 Medicaid recovery and third party liability* will be effective in reducing Medicaid expenditures? How will the Department track performance and demonstrate the cost effectiveness of the additional resources?**

RESPONSE

The Department recovered $69.85 million last fiscal year through collections related to third party liability (TPL). The understanding that additional TPL staffing can further reduce Medicaid expenditures is predicated on analysis of a wide variety of information, including performance related to prior budget requests, assessment of daily operations, best practices from other states, and the knowledge and expertise of its TPL vendor. For example, in FY 2018-19, the Department requested and received an additional $151,426 total funds and a General Fund reduction of $1,323,461 for two FTE to review trust compliance issues and identify additional trust recoveries. After this request was approved, trust recoveries in FY 2018-19 totaled $8.17 million, or an increase in recoveries of $3.53 million (compared to recoveries in FY 2017-18 of $4.64 million).

The Department's budget request, R-15 "Medicaid Recovery and Third Party Liability Modernization," encompasses tort and casualty program resources and enhanced data collection of commercial health information. Current reporting and data analyses demonstrate that program enhancements can and do improve performance and recoveries. Currently, there are more than

15,000 open tort and casualty cases. Additional FTE working these cases would increase recoveries and the effectiveness of the program.

Within the Department, several processes are in place to identify fraud, waste and abuse, as well as identify and recover improper payments and overpayments. Recoveries and overpayment processing can be a lengthy process requiring many steps to ensure that Colorado law is being followed, and the Department works closely with providers and attorneys throughout the process. After determining a credible allegation of fraud, the Department also refers cases to the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office when fraud is suspected. In the last fiscal year, the Division recovered approximately $19.7 million in overpayments and identified an additional $21.8 million in improper payments. Additionally, the Department took in and reviewed approximately 572 provider and member fraud referrals, 33 of which were referred to the MFCU for investigation.

The Department currently uses software technologies that have not significantly changed over the last 25 years. The addition of software that uses machine learning, natural language processing, and/or other artificial intelligence technologies could greatly enhance the Department's ability to identify and recover improper payments that are not as straightforward as most of the current analysis identifies. It is the Department's position that, if approved, a software vendor would be held to benchmarks for identifying recoverable funds tied to funding levels. This would ensure that Medicaid expenditures for this request would only go to successful projects that reduce total expenditures.

The Department requested funding for additional FTE to assist in the identification and detection of fraud, waste and abuse referral cases, as well as a contract manager to oversee a recovery of overpayment vendor contract—all of which would lead to increased recoveries and deter other providers from billing in a way that would lead to fraud, waste, and abuse. Current FTE and contractors working in overpayments average $8 million identified overpayments with $800,000 recovered each year on average per person/vendor. The Department would track performance of the new FTE and vendor based on the number of overpayments identified, the number of those identified and recovered, and by calculating the cost avoidance achieved by those recoveries. Because of the lengthy and complicated legal process, the Department would use both identification and actual recoveries in each year as metrics being tracked for performance.

65. Please discuss the concerns raised by hospital leaders in the November 2019 letter to Governor Polis and Director Bimestefer that relate to access to care and how the Department is responding. The concerns related to access to care include:

a. New prior authorization and concurrent review requirements

b. Denied claims for patients in observation over 48 hours

c. Refused bills for behavioral health

RESPONSE

The November 21, 2019 letter from several Medicaid hospital providers raised a number of concerns about HCPF's administration of Medicaid. The Department takes all feedback and concerns seriously. The Department does not have any data that these issues are creating a barrier for Medicaid members to access appropriate health care. When a formal response to the letter is available, the Department will share the entirety of the response with the Joint Budget Committee.

Background: The Department received a letter from the Colorado Hospital Association (CHA) in September. We responded in writing on October 20, created workgroups to address the issues raised, scheduled a standing meeting with CHA staff on the issues, and the Department's executive director met in person with CHA leadership on October 21, 22 and 25, with the letter in hand ready to review and discuss. At those meetings, CHA leadership indicated they did not need to discuss the October 20 letter, the items in the letter, or the workstreams and preferred instead to discuss other matters. The Department was, therefore, surprised by the November 21 letter directed to the public. After all, that public communication pathway was chosen in lieu of any email, letter, or telephonic response directly to the Department in response to our October 20 correspondence. It was also inconsistent with the communications and collaboration with CHA. Below, the Department addresses the specific claims raised in the letter:

- *The Department's new system for prior authorizations and concurrent reviews, including the use of the national standard of 278 Hospital Admission Notification required manual upload or faxed information and incorrect denials of the hospital's claims for payment.*

The Department has a Joint Operating Committee with the hospitals across the state, which meets monthly and includes CHA participation. Additionally, the Department meets regularly with hospitals' staff to support any questions and issue resolution. The Department is working collaboratively with hospitals and collecting feedback on this program, which has been employed by commercial payers for decades. On December 5, CHA provided a list of portal upgrades from their hospital members. The Department is in the process of comparing that list to our existing plan for portal upgrades. By the end of the month, the Department will provide CHA feedback on if those proposed upgrades are feasible and if so, when they could occur.

Regarding the new process of prior authorizations and concurrent reviews delaying patients' surgeries and admissions, there is a one business day turnaround to process prior authorizations and same day for expedited requests. The Department encourages use of the national standard[1] format for electronic transactions for Hospital Admission Notification (ASC X12N 278) and Clinical Submissions (ASC X12N 275) to simplify the process, but currently only nine hospital systems have chosen to implement this approach and no hospitals have chosen to support the 275 clinical submission.

The alternate modes of clinical data submission are through the Department's electronic portal. All hospitals not utilizing an automated electronic submission integrated with the electronic health records are required to utilize this electronic portal. Through the Joint Operating Committee, the Department is working with hospitals to make this process as efficient as possible. Hospitals which use both the standard transactions would not need to submit additional information via the Department's electronic portal.

- *Payments for observation days over 48 hours.*

The Department fully understands this concern and is working to systematize a new payment methodology for these claims. A system change to the Department's claims processing system has been opened and the Department's vendor is evaluating other states' policies that match the Colorado policy to assist in implementing the new payment methodology. In the Department's legacy claims processing system, the Department was inappropriately paying for observation days. The Department is working to implement the correct policy, so it does not overpay for observation days. Note that the Department currently is paying claims properly when the observations days are under two days. The Department expects the system change will be implemented in the first quarter of 2020. The Department has received data from two hospitals (UCHealth and Centura) regarding unpaid claims that account for 650 claims over two years. The Department is continuing to research these claims and working to provide a resolution to the impacted hospital providers.

- *Billing responsibilities for behavioral health patients*.

As of July 1, 2018, the Department contracted with Regional Accountable Entities (RAEs) instead of Behavioral Health Organizations (BHOs) to administer the capitated behavioral health benefit. Starting in March 2019, the Department initiated the Behavioral Health Hospital Engagement Forum in collaboration with CHA to help the hospitals work through their behavioral health billing concerns. Representatives from the acute care hospitals, the Department and the RAEs attend this forum. To date, this forum has provided an opportunity for the hospitals to bring forth their system concerns. In response to issues brought forward in this forum, the Department has modified RAE contract language and has issued formal billing guidance to help hospitals to understand when they should bill the RAEs versus fee-for-service Medicaid. The Department has also collaborated with its fiscal agent to set up a streamlined process to have specific behavioral health billing concerns resolved. Finally, this forum has provided hospitals and RAEs the opportunity to collaborate and engage in joint problem-solving efforts. The Department remains committed to maintaining this forum to discuss issues and solutions with our hospital partners.

The Department has held an additional forum with the free-standing psychiatric hospitals since fall 2018. These hospitals are considered Institutions for Mental Disease (IMDs) and have unique

billing limitations pursuant to federal law. In July 2018, the Department operationalized a managed care regulation that stipulates federal financial participation dollars cannot be utilized to fund stays in an IMD that are over 15 days in a month. Coming into compliance with this regulation has required the IMDs to work in collaboration with the Department and the RAEs to develop new payment strategies that encourage members to be effectively served using shorter lengths of institutional stays. This will mitigate inappropriate admissions and use more effective, intensive community-based services. This forum has determined there are several utilization management related processes they would like to address collaboratively. The Department is in the process of hiring a vendor to assist with this work and anticipates securing this vendor within the next 90 days. Additionally, the Department has facilitated weekly data collection and check-in calls between one free-standing psychiatric hospital system and one RAE when concerns were raised that denial rates were not in alignment with the overall program/other RAE rates. This effort has been helpful in resolving problems and ensuring that denial rates are in alignment with overall program rates.

- *The Department's reimbursement policy for high-cost drugs administered by a hospital.*

The Department shares the concern regarding the rising cost of specialty drugs. The Department will continue its work through the existing bi-monthly meetings with hospitals and CHA to find a solution that balances the need to adequately reimburse drugs administered by hospitals while remaining within the spending authority appropriated by the General Assembly.

When the Department converted to a new outpatient hospital reimbursement methodology in 2016, the Department was required to maintain annual total expenditures within the historic reimbursement amounts at 72 percent of costs. The Department cannot unilaterally increase payments to any provider group or for services without approval from the General Assembly.

The Department, through the Medicaid Provider Rate Review Advisory Committee (MPRRAC), received information from The Children's Hospital that has select information on 10 states regarding their reimbursement policy for reimbursement of 340B drugs at 100 percent of acquisition costs. If hospital organizations have detail on other Medicaid programs that reimburse hospitals at 100 percent of the 340B acquisition costs, the Department is willing to review those materials as the Department has not found consistency across state Medicaid programs in its research. That information can be shared directly with the Department or through CHA.

Regarding the actions since implementing the new outpatient hospital reimbursement methodology, the Department has already made payment adjustments within its spending authority. The Department changed the 340B discount percentage from 50 percent to 20 percent and has carved out several specialty drugs from the new outpatient hospital reimbursement methodology to pay these drugs at 72 percent of net invoice. The 72 percent of net invoice

reimbursement is what the Department would have paid historically, but now the payment is received on a prospective basis without a cost reconciliation occurring several years following the initial claim. These changes have a positive impact on hospital payments. Payments, including the CHASE Fee addition total about 84 percent of invoice.

The Department has never attempted to reimburse at the 340B acquisition costs as this information is not currently available to the Department. To assist the Department in determining a better reimbursement policy for drugs, the Department has proposed a new acquisition cost methodology for physician administered drugs in its FY 2020-21 budget request R-7, "Pharmacy Pricing and Technology." Working with hospitals, this methodology, if approved, could be applied to the outpatient hospital setting to create a database on the acquisition costs of drugs across all Colorado hospitals. The Department looks forward to working with hospitals and CHA on this approach to create a better reimbursement methodology.

66. What has happened to the Primary Care Fund (Amendment 35 tobacco tax) over time in terms of total funds and funding per uninsured patient?

RESPONSE

The Primary Care Fund receives 19 percent of the increased tobacco tax revenue pursuant to Section 21 of Article X of the State Constitution. The Primary Care Fund is allocated to qualified health care providers who provide comprehensive primary care to persons of all ages based on their portion of medically indigent patients compared to all qualified providers. Medically indigent patients are those below 200 percent of the federal poverty level who are uninsured and not eligible for Medicaid, the Child Health Plan *Plus*, or other governmental health care coverage.

See the chart below. Tobacco tax revenue has declined as the use of tobacco products has declined. This has resulted in a $2 million decline of Primary Care Fund payments to providers of $27.2 million in FY 2012-13 to $25.2 million in FY 2018-19. However, due to Colorado's implementation of the Medicaid expansion pursuant to the federal Affordable Care Act, the number of medically indigent patients served by Primary Care Fund providers has declined over the same period from 211,876 to 123,229 patients, resulting in increased funding per patient of $105 from $128 in FY 2012-13 to $233 in FY 2018-19.

Table 1 - Primary Care Fund

State Fiscal Year	Total Appropriation	Total Payments	Patient Count	Payment Per Patient	Total Payments Change (%)
2012-13	$27,968,000	$27,202,137	211,876	$128	
2013-14	$27,759,000	$26,684,598	210,966	$126	-1.90%
2014-15	$26,828,000	$26,827,999	188,579	$142	0.54%

2015-16	$26,778,000	$26,778,000	116,052	$231	-0.19%
2016-17	$27,276,358	$27,110,350	110,382	$246	1.24%
2017-18	$27,767,192	$26,709,204	107,999	$247	-1.48%
2018-19	$28,669,326	$25,168,168	107,936	$233	-5.77%
2019-20*	$27,983,568		123,229		
*Estimated figures based on current appropriation					

67. What has happened to the Colorado Indigent Care Program (CICP) clinic-based line item over time?

RESPONSE

The appropriation for the Clinic Based Indigent Care line item (i.e., CICP clinic-based care) was $6,119,760 from FY 2002-03 through FY 2017-18. This line item includes federal funds matched under upper payment limit (UPL) financing. From this funding, $60,000 is paid to Children's Hospital Colorado for the administration of CICP clinic-based care.

Pursuant to approval of the Department's FY 2018-19 budget request R-14, "Safety Net Provider Payments," a portion of the General Fund previously appropriated to the CICP clinic-based care line item is appropriated to the Department's Professional Audit Contracts line item to conduct compliance audits of participating CICP clinics. Contractor funding was $57,728 for a partial year's work in FY 2018-19 and is $80,374 for the full year's work beginning in FY 2019-20 and ongoing. This resulted in a corresponding decrease in funds for CICP clinics compared to earlier years.

Annual payments to CICP clinics from FY 2002-03 through FY 2017-18 were $6,059,760. Following the approval of the Department's FY 2018-19 R-14 budget request, payments to CICP clinics were $6,002,032 in FY 2018-19 and will be $5,979,386 beginning in FY 2019-20.

68. Are there any opportunities to increase funding in either of these funds/line items? If so, what are those options?

RESPONSE

The General Assembly could appropriate additional General Fund to the Primary Care Fund Program and/or the Clinic Based Indigent Care (Colorado Indigent Care Program clinic) line items. However, because the portion of tobacco tax revenue assigned to the Primary Care Fund is established in the the State Constitution, the General Assembly cannot appropriate additional revenue from the Tobacco Tax Cash Fund to the Primary Care Fund.

69. How are we measuring the effectiveness of policies designed to reduce expenditures, such as the initiatives in S.B. 18-266, mandatory enrollment in the Accountable Care

Collaborative, and integrating physical and behavioral health? Do we have standardized measures to determine if we actually achieve the expected savings?

RESPONSE

The Department has developed a variety of measurement strategies – both qualitative and quantitative – to assess the effectiveness of its policies to improve quality and reduce expenditures. Additionally, the Department completed the implementation of the Business Intelligence & Data Management (BIDM) project, which consolidated medical, behavioral and pharmacy claims, eligibility, and other external data sources creating a platform to allow advanced analysis on performance, expenditure and trends to drive quality and cost improvements.

Initiatives in SB 18-266

As reported to the Joint Budget Committee in "The Controlling Medicaid Costs Annual Report" on November 1, 2019, the Cost Control and Quality Improvement (CCQI) Office in the Department was established July 1, 2018 in response to SB 18-266 "Controlling Medicaid Costs."

SB 18-266 directs the Department to provide information to providers participating in the Accountable Care Collaborative (ACC) regarding the cost and quality of services. This work is in process. For example:

- The Department has shared tools and reports with RAEs to identify opportunities for improved care delivery and reduced expenditures across their respective regions. RAEs have been evaluating these reports and developing delivery system interventions that project a positive return on investment (ROI) and reduction in expenditures. The improvements are expected over the next one to three years. The Department monitors the RAEs' performance on quality and outcome-based metrics.
- The Department has also conducted an analysis of the clinical needs of its membership and a review of` the RAEs' existing care management and coordination efforts to develop a statewide but regionally-adapted approach for members with the most complex needs. RAEs report quarterly on the implementation and progress of their efforts, and the Department uses clinical and expenditure measures to ensure their effectiveness in improving quality and reducing expenditures.

Mandatory Enrollment in the Accountable Care Collaborative (ACC)

Through Accountable Care Collaborative (ACC) Phase II, the Department implemented mandatory enrollment into the program for all full-benefit Medicaid members, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). This resulted in a 20 percent increase in program enrollment and, more importantly, immediately connected members to their respective RAE for further connection to a primary care provider and other

services. Health care research shows that patients who are engaged with their health care provider achieve better health outcomes and lower costs. This finding comes from a growing body of evidence summarized in the February 2013 Health Affairs brief "Patient Engagement."

Integrating Physical and Behavioral Health

ACC Phase II also allowed the Department to join physical and behavioral health administration under one entity, the RAE. During the first year of ACC Phase II, RAEs have consolidated provider and member service systems across behavioral and physical health, eliminating unnecessary administrative costs and creating streamlined processes that can reduce expenditures over the long term. More information can be found in the annual legislative report "Accountable Care Collaborative FY 2018-19" released in December 2019, which notes that members appear to have greater access to behavioral health services during the first nine months of Phase II as evidenced by the behavioral health engagement measure.

Standardized Measures to Determine Savings

In addition to the measure strategies cited above, the Department has developed an overall total cost of care metric that holds RAEs accountable to their respective region's expenditure trend and allows the Department to assess the overall effectiveness of policies and initiatives. The total cost of care metric is available on a dashboard accessible by Department and (eventually) RAE staff. The total cost of care metric is person-centered, meaning it includes all behavioral, physical health and long-term services and support (LTSS) expenditures for each enrolled member. The dashboards offer the ability to drill-down to individual expense categories and to the subpopulation level. Subpopulations include eligibility category (e.g., foster care), demographics (e.g., age group), clinical risk status, among others. Using this drill-down feature, initiatives that target a particular population may be monitored over time to determine whether projected short- and long-term savings accrue as expected and whether there are unintended consequences. The dashboard is refreshed on a monthly basis and is aligned with the Governor's overall health care agenda.

70. Which initiatives in the Department's FY 2020-21 request, if any, came out of the exercise required by the Office of State Planning and Budgeting that asked agencies for potential budget reductions?

RESPONSE

All of the Department's budget requests were developed with the understanding that discretionary funding for decision items was limited for FY 2020-21. As in prior budget cycles, the Department focused its budget development efforts on cost control initiatives with immediate savings and long-term savings potential. These efforts are consistent with OSPB's budget instructions for FY 2020-

21. Medicaid cost control is a critical component of the Department's Performance Plan and is listed as one of the Department's "pillars" for the current fiscal year.[13]

71. What is the administrative entity considering the dispute concerning federal bonus payments for meeting goals for the retention and recruitment of children in Medicaid and CHP+? Please provide an update on the status of the dispute and the likely timeline for resolution.

RESPONSE

The administrative entity considering the CHIPRA Performance Bonus dispute is the Departmental Appeals Board (DAB), established within the federal Department of Health and Human Services (DHHS). Federal law provides that a state may appeal the disallowance of a claim for federal financial participation (FFP) to the DAB, which is an administrative tribunal. 42 U.S.C. § 1316(e)(2)(A). Once the DAB has heard a case, a state can seek judicial review through a federal district court, after which a case enters the normal federal appellate process. 42 U.S.C. § 1316(e)(2)(C). More information about the DAB is available at https://www.hhs.gov/about/agencies/dab/index.html.

Colorado is aligned with seven other states related to CHIPRA appeals and is working cooperatively with these states. The Department is currently in the middle of the briefing process and has submitted its opening appeal brief. The brief in response from the Centers for Medicare and Medicaid Services is due December 13, 2019, after which Colorado will have a final reply brief. Unless requested by the DAB, appeals are reviewed on the record without live testimony or argument. The DAB does not have a set timeframe for issuing a response. Given that briefing is not complete, and that Colorado would likely pursue judicial review and available appeals if the DAB issues an unfavorable response, it is likely that any recovery from the state is at least two or more years in the future.

72. Is information concerning a student's eligibility for Medicaid retained as part of a student's school record? Would implementation of *R18 Public School Health Services expansion* change the information retained at the school about Medicaid eligibility? How do the requirements of HIPAA and FERPA align and relate to this issue?

RESPONSE

It is up to each school district whether they collect student health insurance information including Medicaid enrollment and the Department does not know the districts' policies. In administering the Public School Health Services Program, the Department does not receive student Medicaid enrollment status from participating school districts. Rather, the Department determines the

[13] https://www.colorado.gov/pacific/sites/default/files/HCPF%202019-20%20Performance%20Plan.pdf

Medicaid eligibility rate for participating districts. The Department receives basic student information from the Department of Education for participating districts through a data sharing agreement then matches the student information to a Medicaid eligibility file to determine the district's Medicaid eligibility rate.

As stated in a joint guidance document on the application of Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) by the U.S. Department of Health and Human Services and the U.S. Department of Education, available at https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf, FERPA protects the privacy of student educational records including records that are directly related to a student and maintained by an educational agency or institution or by a party acting for the agency or institution. HIPAA protects individuals' health records. Prior to implementation, the Attorney General reviewed the data sharing agreement between the Department and the Department of Education and determined it was compliant with both FERPA and HIPAA.

If approved, the implementation of the Department's R-18 budget request would not expand or change the current process or the amount of information retained by school districts regarding Medicaid eligibility.

BEHAVIORAL HEALTH - GENERAL

73. Summarize the performance of the Rocky Mountain Health Program Prime pilot integrating physical and behavioral health care. How are the findings from the pilot informing policies statewide?

RESPONSE

The Department submitted a formal report on the FY 2017-18 performance of Rocky Mountain Health Plans Prime (RMHP Prime) to the General Assembly on June 30, 2019.[1] For the time period covered by this report, Rocky Mountain Health Plans received capitated physical health payments. Behavioral health services were not included in the capitation and were paid for by the Behavioral Health Organization.

In this report, the Department provided a comparison of the estimated costs of the population enrolled in RMHP Prime to estimates of what the population would have cost had they not enrolled in the program. The results of this analysis showed that for FY 2017-18, RMHP Prime reduced the total cost of care for members by a small margin (less than two percent), or approximately $3 million. The analysis indicates that the program was more successful in generating cost savings among individuals with disabilities and individuals older than 64 years of age, but experienced cost increases for Adults without Dependent Children.

The Department also looked at RMHP Prime's performance compared to a similar population of members enrolled in the statewide Accountable Care Collaborative overall and found higher performance for the percent of members who had at least one visit to a primary care medical provider and for all-cause readmission rates yet worse performance for emergency department visits. The behavioral health penetration rate was very similar. The Department's overall assessment was that RMHP Prime is delivering similar performance to the statewide Accountable Care Collaborative, while providing some cost savings with higher rates of member experience and utilization of primary care.

Some specific examples of lessons learned from RMHP Prime that have informed the statewide Accountable Care Collaborative are:

- Payment flexibility is critical for provider and system success. In Phase II of the Accountable Care Collaborative, the Regional Accountable Entities are responsible for creating flexible, value-based administrative payments that best meet the needs and goals of their contracted Primary Care Medical Providers to fund coordinated, comprehensive models of care.
- Behavioral health providers can provide care coordination for members. RMHP provided support to behavioral health providers, and this has been applied across the Accountable Care Collaborative.
- Governance structures and member advisory councils are more effective when behavioral health and physical health providers and stakeholders participate. Many RAEs are moving in this direction and the Department has required that the regional Program Improvement Advisory Councils be comprehensive.
- Moving providers to greater use of outcomes-based metrics (for example clinical quality measures) can be difficult but with financial incentives it is possible. RMHP has been doing this with a limited set of providers and the Department is incentivizing providers to move in this direction as part of its alternative payment models.

74. In terms of the behavioral health system, how does spending on the front end (prevention and providing services early, when issues initially arise) relate to individuals' interactions with the criminal justice system, competency, and higher cost services? How does the Department think about systemic issues, ensuring that sufficient resources are allocated for prevention and front-end services to limit the need for high end, intensive services?

RESPONSE

In Colorado, the Department works in concert with the Office of Behavioral Health (OBH) and commercial health plans to finance and build a behavioral health system for the state's citizens. Within the system, the respective players implement strategies that encourage prevention and address emerging issues when they initially arise in hopes of preventing interactions with higher cost services or alternative systems, like the criminal justice system. These strategies include Crisis Services System, diversion programs with law enforcement, transitional programs across service settings, intensive community-based supportive services, and integration between primary care and behavioral health providers. Currently, the Governor's Behavioral Health Task Force is working to ensure the disparate behavioral health systems are working coherently and is leveraging a population-in-need (PIN) study to identify potential opportunities for improvement. The PIN study will specifically investigate access to providers and services at the county and regional levels in order to consider and prioritize behavioral health investments and services across the continuum. The Department has been an active participant in the Task Force and is committed to developing collective solutions regarding workforce development, system and care continuum alignment, regulatory change, and provision of preventive services.

When an individual is eligible for Medicaid, the Regional Accountable Entities (RAEs) provide a continuum of behavioral services that are designed to move individuals across needed levels of care. These services include traditional outpatient and inpatient services as well as alternative services, such as respite services, targeted case management, and vocational supports, that help ensure an individual receives care in the least restrictive setting possible. Additionally, with the implementation of RAEs, the Department began reimbursing for six short-term behavioral health visits in primary care as a means to increase access for low-acuity behavioral health challenges.

The Department is committed to addressing systemic issues with its respective partners by ensuring that sufficient resources are allocated for prevention and front-end services. In particular, the Department is collaborating closely with its partners at OBH, the Department of Corrections, and county offices to carry out its commitment to systemic solutions for the following specific populations: children and families in the child welfare system and individuals involved in the justice system. The collaborations have yielded delivery system interventions such as financial incentives, contractual requirements, and systemic care models that ensure all actors are working in concert with one another to provide services early and to collectively mitigate issues when they arise. The Department is currently monitoring the impact of each of these collaborations through internal dashboards and programmatic performance measures.

75. Can funding that will not be utilized in FY 2019-20 or FY 2020-21 (such as the substance use disorder treatment funding), be allocated to address other unmet behavioral health needs? If so, what would be the Department's recommendation for the use of these funds?

RESPONSE

The Governor's Office submitted a balanced budget for FY 2020-21. The Department's priorities for additional funding are included in the R-1 through R-20 budget requests as part of that budget submission.

The Department projected costs for the behavioral health community programs through two requests: R-2, "Behavioral Health Community Programs" and R-11, "Patient Placement and Benefit Implementation- Substance Use Disorder." The requested reduction in funding for the new residential and inpatient substance use disorder treatment benefit is a technical true-up of anticipated costs for the benefit during the first year of utilization ramp up and is not due to a change in the benefit design or service delivery. The Department is federally required to pay for covered services incurred by members, which will include the new benefit starting July 2020. If expenditures for the program are higher than projected, the Department would use statutory over-expenditure authority to continue to cover members.

76. Safety net providers have described challenges they face regarding administrative burden. For example, one provider shared that they have up to 13 unique forms required to enroll a client in services, depending on their diagnosis and who is referring them. Often, different forms are required by different agencies, making the task of trying to automate and streamline the process very difficult. This provider also reports that they must complete 139 individual reports (due at various intervals) to show that they are following what they need to for their various public funders. The break down is that 95 of the reports are for OBH, 30 are for the RAE, and 12 are for the MSO. On top of all that, they must stay in good standing with CDPHE for their facilities and disaster response services, with DORA to ensure their clinicians are in good standing, and locally for various programs.

How are state agencies working together to reduce administrative burden for behavioral health providers to increase the amount of time clinicians spend providing direct care and expanding access to more people? What efforts are underway to unwind some of the complexity that is built into the system? Will the Governor's Behavioral Health Task Force address these issues?

RESPONSE

The Department and its sister agencies share the goal of reducing the administrative burden on providers to enable them to spend more time providing direct care and expanding access. That said, as providers of publicly-funded services there is a level of reporting required to ensure

accountability, transparency, and compliance. The Department is working in three major areas to help achieve the appropriate balance of reducing the administrative burden while still ensuring accountability to our federal partners and Colorado residents.

1. Joint work with the Office of Behavioral Health (OBH).

As the state's Substance Abuse and Mental Health Authority, OBH must ensure compliance with federal and state requirements for publicly funded behavioral health services. To do so, OBH must receive information and data from providers. The Department and the Regional Accountable Entities (RAEs) have been working with OBH on the implementation of its new behavioral health treatment data collection system known as COMPASS. Once implemented, COMPASS will save providers' time by substantially reducing data entry requirements.

The Department also meets with the OBH regularly and explores opportunities for better alignment across their respective pieces of behavioral health systems, including RAE collaborations with Crisis System contractors and Managed Service Organizations (MSOs).

2. Department work on streamlining deliverables and other administrative processes.

The Department does not require reports from behavioral health providers beyond OBH's requirements articulated above. However, the Department does have reporting requirements for the RAEs to ensure members are receiving appropriate services, to ensure the RAEs are meeting their contractual requirements, and to evaluate whether state and federal dollars are being used appropriately. Some providers have contracted with RAEs to provide care coordination or other services to members. For this work, the providers receive additional reimbursement and also commit to providing data and information to the RAEs so the RAEs can provide comprehensive reports to the Department. The Department is engaged with the RAEs to assess and redesign certain reporting requirements to reduce the administrative burden. Additionally, the Department is working with the RAEs to see if there are opportunities to improve the provider credentialing process and reduce the burden on providers.

3. Tri-agency collaboration on the Behavioral Health Entity and the Governor's Behavioral Health Task Force.

With OBH and the Department of Public Health and Environment, the Department is engaged with the Behavioral Health Entity Implementation and Advisory Committee meetings established under HB 19-1237. This committee has adopted the following guiding goals: to provide a single flexible license category; to provide a regulatory framework for innovative behavioral health service delivery models; to increase parity in the oversight for both mental health and substance use disorder treatment providers; and to streamline and consolidate the current regulatory structure.

The Department is also an active participant on the Governor's Behavioral Health Task Force and each of its subcommittees. These committees have highlighted the burden that is created for providers who receive funding from more than one source and are working on possible joint solutions.

77. Colorado is among a handful of states that have not moved Medicaid from fee-for-service to full risk managed care. Is the Department contemplating such a move? If so, how and when? If not, why?

RESPONSE

In Colorado, Medicaid behavioral health services are provided under a full risk, managed care model administered by the Regional Accountable Entities. While most physical health services are covered under fee-for-service, there are some counties in which there is a managed care capitation option for physical health services.

The Department is not considering moving to full-risk managed care statewide because the current model enables tailoring to local needs and assets; stakeholders have indicated broad support for the Accountable Care Collaborative; and, there would be a substantial negative impact on the hospital provider fees collected due to federal restrictions on assessing fees on inpatient days paid for under capitation. Additionally, the current model allows for insights into quality, utilization and costs in a way that full-risk managed care does not.

78. Colorado's decline in Medicaid enrollment seems to be more significant than other states. Why is this the case? Are citizens being negatively impacted by this decline?

RESPONSE

Information from the Kaiser Family Foundation indicates that Colorado is not an outlier among states that have experienced enrollment declines. Out of 35 states with enrollment declines, Colorado has the 13th largest decline between December 2017 and July 2019.[14] It is not possible to determine why Colorado's decline in enrollment is different than other states' rates because every state Medicaid program has different eligibility rules, covers different populations, and has different income thresholds. Further, policy changes in other states may also be contributing to the change in enrollment; for example, Virginia experienced a 30 percent increase in caseload during this same period because it expanded Medicaid eligibility effective January 1, 2019.

[14] https://www.kff.org/medicaid/fact-sheet/analysis-of-recent-declines-in-medicaid-and-chip-enrollment/

For additional information about the reasons for caseload declines, see the response to Question #10. Because Colorado has the strongest economy in the nation, with an historically low unemployment rate of 2.6 percent in October 2019, many Coloradans have experienced a positive impact through increased wages and increased working hours. The Department celebrates the fact that Coloradans are rising out of poverty, which is a major contributor to a reduction in Medicaid enrollment of 2 percent in FY 2017-18 and 4 percent in FY 2018-19.

PROVIDER RATES

79. In FY 2019-20, the General Assembly allocated a 2% targeted rate increase for behavioral health providers, including a 2% increase through HCPF's Medicaid behavioral health program. Those increases were to be passed directly to providers for salary increases. Were those dollars passed on to providers by the Regional Accountable Entities (RAEs)? If not, what steps is the Department taking to ensure that this happens as intended?

RESPONSE

On August 15, 2019, the Department distributed formal guidance to all of the Regional Accountable Entities (RAEs) regarding the General Assembly's allocation of the 2 percent targeted rate increase for behavioral health providers. To enable the RAEs to pass the funds on to providers as stated in the Long Bill, the Department incorporated the rate increase as a "public policy adjustment" in the RAEs' behavioral health managed care rates for FY 2019-20. This adjustment added sufficient funding to increase all eligible provider rates by 2 percent above and beyond the underlying historical pricing and trend.

The Department directed the RAEs on how they needed to process this rate increase with the following guidance:

- The funding must be passed through to eligible providers in its entirety.
- The funding must be used in a manner that is consistent with the legislative intent as stated in the FY 2019-20 Long Bill.
- The RAEs must be able to demonstrate that the funding has been passed on to eligible providers and provide documentation of its distribution strategy to the Department upon request.
- The RAEs have autonomy to determine how best to disseminate the funds; however, the Department expects the RAEs to consider the context and stated intent of the statute when determining how to distribute the increase to providers.

All of the RAEs have reported that they incorporated the 2 percent increase into their reimbursements for behavioral health providers in accordance with the Department's direction and the intent of the General Assembly.

SUBSTANCE USE DISORDER TREATMENT

80. The Department of Human Services has requested a reduction in the appropriation for the Special Connections program, which originates as Medicaid funding appropriated to HCPF. How would such a decrease affect access to behavioral healthcare for Medicaid-eligible pregnant women?

RESPONSE

The Department of Human Services requested the reduction to the appropriation for the Special Connections program based on the historical trend of under expenditures of the line item. The reduction would not lead to any change in Medicaid eligibility for the benefit or access to Medicaid services covered under the benefit. If utilization of the benefit increased beyond the revised appropriation, the Department would use over-expenditure authority to continue to pay for Medicaid services rather than imposing any limits on the benefit.

Per HB 19-1193, any unspent General Fund from this line item is transferred from the Department to the Office of Behavioral Health (OBH) to spend on state-only supportive services, as administered by OBH, for high-risk pregnant women. A reduction in the appropriation would result in less potential reversions from the line item to be transferred and used for this purpose.

Special Connections was reviewed during year four of the Rate Review Process; considerations and recommendations to improve access were included in the Department's 2019 Medicaid Provider Rate Review Recommendation Report, submitted to the JBC, and published, on November 1, 2019. Analyses are inconclusive to determine if Special Connections payments were sufficient to allow for member access and provider retention.

81. Regarding substance use disorder treatment capacity, please respond to the following:

- **What is the existing treatment capacity across the state? Are shortfalls in particular regions of the state? For certain types of clients? For certain types of services?**
- **What are the barriers to building additional capacity?**
- **Are capacity concerns based solely on a shortage of total providers in the state, or is capacity further limited by the number of Medicaid providers?**

RESPONSE

The Department is actively engaged in multiple efforts to monitor capacity for substance use disorder treatment and is working with its sister agencies and stakeholders to continue to improve the availability of services. As with all states, the Department faces challenges with shortages of substance use disorder providers, and these shortages apply across all payers. While the Department is not solely responsible for supporting treatment capacity, the Department acknowledges the important role it plays in covering and reimbursing services for Medicaid members.

The Department is engaged in multiple activities to better understand the existing capacity and any shortfalls.

- The Department is collaborating with its state partners to accurately assess substance use disorder (SUD) treatment capacity across Colorado and will leverage the Office of Behavioral Health's (OBH) Population-In-Need (PIN) study to identify potential opportunities for improvement.
- As part of the requirements for the Section 1115 SUD Demonstration Waiver recently submitted to the Centers for Medicare & Medicaid Services, the Department is developing a formal implementation plan. This plan will include an assessment of provider availability at all levels of care and a description of the planned improvements to provider availability and capacity. The Department is holding Capacity Building Workgroup meetings with the RAEs, OBH and the Managed Service Organizations (MSOs). The Department has also held several stakeholder meetings and has ten more scheduled throughout the state in early 2020.

Through these efforts, the Department has initially identified the following shortages:

- Medication-assisted therapy (MAT) providers across the state;
- Intensive outpatient program (IOP) in rural areas of the state;
- Inpatient and residential beds, in particular in regions outside of the I-25 corridor; and
- SUD treatment for youth and pregnant and parenting women.

The Department, along with OBH, has identified the following barriers towards adequately addressing these service shortfalls:

- A shortage of qualified workforce, particularly in rural and frontier regions of the state;
- A lack of financial flexibility for capital investments to build and expand existing programs; and
- Reimbursement rates that do not always cover the full costs associated with treatment programs.

The Department is committed to working with OBH and other stakeholders as the PIN study and 1115 waiver are implemented and to developing constructive solutions that resolve identified capacity shortfalls. In addition, the Department is working to develop rates that cover the entire cost of providing services so that programs will be sustainable and serve Medicaid members.

REGIONAL ACCOUNTABLE ENTITIES

82. Has hospital utilization increased in the first year of the RAEs? If so, by what percentage and what has been the cost to the state?

RESPONSE

Below are statistics for behavioral health inpatient utilization for the last three fiscal years.

	FY 2016-17 BHO	FY 2017-18 BHO	FY 2018-19 RAE
Average Members Per Month	1,311,547	1,267,150 (-3.39%)	1,201,460 (-5.18%)
Total Number of Inpatient Days	61,840	67,465 (+9%)	79,162 (+17%)
Average Number of Inpatient Days per Thousand Members	47	53	66

There has been an increase in inpatient utilization over the last three years. During the transition from the Behavioral Health Organizations (BHOs) to the Regional Accountable Entities (RAEs), the increase was more significant. A month-by-month analysis shows that several RAEs had an atypical peak in inpatient days for the first few months of program implementation, which appears to indicate the difficulty switching to a new program. Since the spike in the transition months, the Department is seeing a stabilization of the rate. RAE implementation is not the only factor because the trend toward higher utilization began in FY 2017-18, prior to RAE implementation in July 2018. Additionally, the Department is investigating whether documented enrollment increases in higher acuity members is a partial explanation for observed increases.

The Department is refining an internal dashboard to further monitor behavioral health outcomes, and in particular, inpatient hospitalizations. In addition, the Department has begun conducting working sessions with the RAEs to more closely analyze their trends in inpatient utilization, as well as overall behavioral health service management. These efforts, coupled with the Department's new approach in managing members with complex conditions and preventing

disease progression, should provide a comprehensive picture of service utilization and member needs and help the Department identify whether program and policies changes need to be made.

If these trends continue, the increases in utilization may need to be accounted for in future year behavioral health rates as there is a lag between when utilization increases and when capitation rates are developed. Whether the rates increase in the future will be dependent on other factors, such as changes in utilization in other services.

83. The Department has communicated to RAEs that the Department will be taking a different direction. Please describe these changes, the reasons for the changes, and the outcomes the Department hopes to achieve by making these changes.

RESPONSE

The Accountable Care Collaborative (ACC) is designed with the understanding that delivery system change must be iterative to keep pace with an evolving health care system and to best meet the complex health needs of members. While implementation of ACC Phase II was a significant innovation of the Medicaid delivery system, the Department continues to evolve the program in collaboration with Regional Accountable Entities (RAEs), Federally Qualified Health Centers and other Primary Care Medical Providers, behavioral health providers, advocates, members and other stakeholders. In alignment with the Governor's health care affordability objectives, the Department's Medicaid cost control goal, and the Department's focus on member health improvement, the Department is refining its ACC program. Specifically, the Department has developed a statewide approach to address the health care needs of high-cost, complex populations and prevent disease progression of conditions impacting the Medicaid population.

In alignment with this evolution and in accordance with the RAE contract requirements, the Department has begun shifting how it monitors and supports the RAEs in managing complex patients. The Department has implemented the Clinical Risk Stratification Dashboard to provide RAEs with information on targeted populations to facilitate more effective interventions. Furthermore, the Department is working with the RAEs to ensure the consistent application of evidence-based and proven programs that will improve health and better manage costs for targeted conditions and populations. To support these activities, the Department has requested that the RAEs reallocate their ACC resources to invest in more effective programs.

Lastly, RAEs will be accountable for cost trend and quality outcome metrics for the identified targeted populations provided by the Department, for the overall health and expenditure for all enrolled members, and for ensuring members have access to medically necessary services. Moving forward, the Department will partner with the RAEs to implement payment strategies that reward the RAEs for achieving total cost of care goals and clinical quality outcome metrics. The

Department will continue to utilize Key Performance Indicators and Performance Pool measures to incentivize progress on the outcome measures and targets.

84. The Department's new direction with the RAEs places a focus on primary care. Has this shift negatively impacted the behavioral health services that were delivered under the Behavioral Health Organizations (BHOs)? Have outcomes improved under the RAE structure? How are outcomes measured? Can these outcomes be provided by RAE region?

RESPONSE

Primary care has been the focus of the Accountable Care Collaborative since it was implemented in 2011. With Phase II and the implementation of the Regional Accountable Entities (RAEs), the Department combined responsibility for primary care with the management and coordination of a comprehensive system of behavioral health services, previously managed by separate Behavioral Health Organizations (BHOs). This combined accountability enables the RAEs to more effectively coordinate care and offer interventions for members with complex health needs and chronic conditions and prevent disease progression of conditions impacting the Medicaid population in accordance with the Department's direction. Many of these individuals have co-occurring physical and behavioral health conditions, including serious mental illness and substance use disorders.

As the RAE structure is new, the Department is just becoming able to review a full year of data and identify any shifts from the BHOs' performance. Initial indicators do not show a negative impact on the number of people accessing services; in fact, there has been an average statewide increase of 2.5 percent of individuals who are receiving behavioral health services and an expansion of the provider network. That said, the Department is aware of challenges that have occurred during the transition such as delays in provider contracting and credentialing, and challenges with billing and claims processing. To ensure continued understanding of operational challenges and to identify opportunities for improving the delivery of behavioral health services, the Department is actively participating in a variety of stakeholder processes, including the Behavioral Health Task Force, aimed at resolving workforce, care continuum, delivery system, regulatory and other barriers within the larger behavioral health system.

In addition to looking at the percent of people accessing services and the provider network, the Department has several mechanisms it will be implementing over the next few months to monitor behavioral health outcomes now that a full year of data is available. These mechanisms include the Behavioral Health Incentive Program, the Department-created risk stratification tool, and the Healthcare Effectiveness Data and Information Set (HEDIS) measures. Examples of measures that are reportable statewide and by individual RAE include inpatient hospitalizations, emergency department utilization, outpatient follow-up treatment after a hospitalization, and engagement in treatment subsequent to a positive result on a screening tool. Additionally, the Department is

refining an internal dashboard to further monitor behavioral health outcomes. These outcomes will be monitored by Department staff and individual RAE regions.

85. Does the Department view the current RAE structure as the ideal model for managing Colorado's Medicaid benefit? If so, why? If not, what would be a preferable model?

RESPONSE

The Department is confident the current Regional Accountable Entity (RAE) structure is the appropriate model for managing Colorado's Medicaid benefit. The Accountable Care Collaborative (ACC) is the result of many years of stakeholder engagement and incorporates lessons learned within the state and nationally.

The RAE structure is the preferred model for Colorado for the following reasons:

1. **Combines strengths of different models.** The hybrid nature of the RAE structure leverages the best components of managed care and fee-for-service. Using managed care to administer the Department's behavioral health benefit enables to the Department to offer a broader range of services, particularly inpatient and non-traditional services not allowed by the Centers for Medicare & Medicaid Services (CMS) under a fee-for-service arrangement. Retaining fee-for-service for physical health services allows for insights into quality, utilization and costs in a way that has often proved difficult under managed care. Bringing these responsibilities together under the RAE promotes greater accountability for members' overall health and incentivizes comprehensive coordination of care across the health care system.
2. **Regional.** The RAE has also been designed around the central premise that health care is local. Regional communities are often best positioned to leverage local assets and make the changes that will cost-effectively optimize the health and quality of care for members. The regional model provides greater opportunities for local stakeholders to be actively involved in guiding and overseeing programmatic activities. This aligns with evidence-based research on regional-based health care systems and honors the unique differences of Colorado's rural and frontier communities. The Department's data analysis has also confirmed different cost, utilization and quality trends present in each of the regions. Finally, a regional approach accommodates differences in local readiness for advanced payment models.
3. **Iterative.** This hybrid model provides the state with more control and the flexibility to keep pace with an evolving health care system and to best meet the complex health needs of our members. It allows the Department to more easily incorporate new priorities and directions, such as moving toward more outcomes-focused performance measurement. It also provides structure to support the gradual evolution of provider networks to value-based

payment and care models. While there is no ideal model for health care delivery, as all models have their strengths and weaknesses, the Department has actively collaborated with stakeholders over many years to build a model that best advances the health of members and supports Colorado providers in delivering high-quality care in a cost-effective manner. The Department is committed to partnering with members, RAEs, providers, and other stakeholders to continue to evolve the program so that it best serves Colorado.

86. Some behavioral health providers are indicating that they are not being paid by the RAEs. Please provide the following:

- **A description of the Department's process for monitoring timely payment by RAEs to behavioral health providers.**
- **A list of outstanding balances owed to behavioral health providers by RAE, including any claims in dispute.**

RESPONSE

With Phase II of the Accountable Care Collaborative (ACC) and implementation of the Regional Accountable Entities (RAEs), responsibility for payment of behavioral health claims under the capitated behavioral health benefit switched from Behavioral Health Organizations (BHOs) to the RAEs. One of the Department's primary concerns upon implementation of the RAEs was to ensure that there was access to behavioral health services and timely claims payment. To monitor this transition, the Department implemented two processes. One process was to require the new RAEs to submit weekly information on claims submission and payment for the first quarter of the program, and the other process was the implementation of an issues triage center. Through these two processes, the Department was able to ensure that members were getting services and that claims were being paid, while also identifying specific member or provider challenges and intervening quickly with the RAEs.

Once the Department established that all RAEs had functioning claims payment systems and members were accessing services, the Department suspended the triage center and weekly reporting and shifted to standard monitoring and operations. One mechanism to ensure the RAEs are processing claims regularly is the monthly encounter data submission. The RAEs are incentivized to process and pay claims in a timely manner so that the encounter data can be factored into the rate-setting process. The Department also uses the RAEs' monthly encounter data to monitor the average percentage of members utilizing behavioral health services. Initial indicators show there has been an average statewide increase of 2.5 percent of individuals who are receiving behavioral health services and an expansion of the provider network.

Medicaid managed care regulations also require that the Department contract with an External Quality Review Organization to perform annual site visits of the RAEs and ensure compliance

with contract requirements. While initial reviews of the RAEs evaluated systems readiness and ability to pay claims, future reviews will focus on timeliness of claims payment.

The Department is aware of challenges that have occurred during and after the transition that have resulted in payment delays. Examples include delays in provider contracting and credentialing and system programming and billing challenges. As these issues have been identified during the Department's standard oversight processes or in conversations with providers and their professional organizations, Department staff have been able to intervene and assist in resolving issues. During the first year, the Department encouraged the RAEs to use interim and/or expedited payments to providers to compensate for claims processing delays. In addition, the Department provided education and clarification to providers, professional organizations, and the RAEs on proper billing and other targeted issues.

Under a capitated payment arrangement, the responsibility for processing claims is with the managed care entity, in this case the RAE. Each of the RAEs have their own claims processing systems separate from the Department. As a result, outside of the monthly encounter data received from the RAEs, the Department does not have access to individual claims payment status, such as denied or pending payment.

The Department does regularly check in with the RAEs to monitor outstanding claims processing issues. Based on the most recent information received for December 2019, the RAEs reported the following known claims processing/provider payment issues:

- Two RAEs do not have any outstanding issues.
- There are a small number of providers with outstanding payment issues, primarily community mental health centers (CMHCs).
- The RAEs are working closely with these providers and the Department to monitor and resolve issues as quickly as possible. In some instances, the RAEs have created action plans for greater transparency with the Department.
- Some RAEs continue to have system configuration issues, but most have been resolved.
- All outstanding issues are expected to be resolved by the end of January 2020

Since the Department does not have access to individual claims payment status, the Department cannot provide a list of outstanding balances owed to behavioral health providers, including claims in dispute. If the Joint Budget Committee desires more detailed information than the summary provided here, then the Department can request an ad hoc report from the RAEs with detailed claims information (excluding Protected Health Information).

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUSTED

1. **Provide a list of any legislation that the Department has: (a) not implemented, or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented 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 2008-2019: 265

Not Fully Implemented 2008-2019: 11

The Department has records of the status of implementation for legislation dating back to 2008. Over the last 11 years, the Department has successfully implemented over 230 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**	**FTE**
SB 19-235 Automatic Voter Registration (Fenberg/Danielson; Esgar/Mullica)	The bill requires the Department to give records to the Secretary of State's office for each eligible elector that applies for Medicaid. The member will then be automatically registered to vote.	The Department received guidance from the Centers for Medicare and Medicaid Services (CMS) that sharing member information for this purpose is not permitted. CMS requires that there be active consent from applicants instead of passively sending data for automatic voter registration. The Department is engaged in ongoing conversations with the Governor's office, stakeholders from America Votes, the Secretary of	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		State's office and advocates from the Center for Secure and Modern Elections to find solutions to these issues.	
SB 19-238 Improve Wages and Accountability Home Care Workers (Danielson/Moreno; Kennedy/Duran)	The bill requires the Department to request from the federal government an increase of 8.1% in the reimbursement rate for personal care and homemaker workers within 90 days of the effective date. The bill requires the Department to increase the hourly minimum wage for these services by July 1, 2020.	The Department has requested CMS approval of the rate increases associated with SB 19-238. HCBS waiver amendments were submitted on September 18, 2019. The amendments included the SB 19-238 associated rate increases, as well as other across the board increases and programmatic changes. The Department is on track to receive CMS approval of these amendments. CMS regulations require a minimum of 120 days for substantial HCBS waiver amendments. This time span includes a 30 day public comment period and a 90 day period for CMS review. This time span does not include the time it takes to develop the amendment application (calculate cost projections, develop language, and prepare public noticing documents). Additionally, this time span cannot begin until any prior HCBS waiver amendments have become effective.	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		During the spring of 2019, the Department was implementing programmatic and policy changes related to 10 other HCBS waiver renewals and amendments. When these actions went into effect on July 1, 2019, the Department began the process of creating the waiver amendments related to SB 19-238. The Department is on track to meet the other deadlines in the bill.	
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	SB 16-120 has not been fully implemented. Though the Department has been unable to launch the Medicaid Explanation of Benefits on July 1, 2017 due to system, policy and operational issues, the Department has completed the development of the Explanation of Benefits Letter and Member Educational Messaging, which includes legislatively required stakeholder feedback and member testing. The SB 16-120 EOBs will be available once the projects are implemented into the system. The Department does continue to send Medicaid members the federally required	0.5

Legislation	Legislation Summary	Barriers to Implementation	FTE
	name of the service providers, a description of the service provided, the billing code for the service, and the date of the service.	Explanation of Benefits as defined by 42 CFR 433.116.	
HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.	The Department has not yet implemented 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 revise drafts of services proposed for a consolidated waiver. The Department's actuarial findings from this work reveal a significant fiscal impact of a redesigned consolidated waiver. In addition, there is a need for the complimentary initiatives of Conflict-Free Case Management, the new Long-Term Services and Supports (LTSS) Assessment Tool, Person-Centered Support Planning, and compliance with the Home- and Community-Based Services (HCBS) Final Rule to properly redesign the system	3

Legislation	Legislation Summary	Barriers to Implementation	FTE
		in an efficient, coordinated, and thoughtful manner. Due to the significant fiscal impact to implement a consolidated waiver 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 is to build from the significant amount of completed work and begin to align services. The second approach is to perform further work and analysis on service unit and overall authorization limits. This would allow for a more individualized approach that would meet each member's individualized needs. The Department believes that this will allow the Department to align services and reach the ultimate goal of a consolidated waiver.	
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient	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	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	hospice facilities for room and board	for all services and 'passthrough' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through State Plan or waiver to reimburse class I nursing facilities directly for room-and board, or to pay a provider licensed as a hospice as if they were a licensed class I nursing facility. Although licensed inpatient hospice facilities are a hospice provider type recognized by the Colorado Department of Public Health and Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.	
HB 09-1103 Presumptive Eligibility Long-Term Care (Riesberg/Newell)	Persons in need of long-term care who declare all of the information necessary to determine eligibility under the Medicaid program shall be presumptively eligible for benefits.	The bill authorized the Department to seek federal approval to allow people who are in need of long-term care to be presumptively eligible for Medicaid. The bill directed the Department to seek federal approval from CMS, which was denied. Without federal approval, the	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		Department was not able to implement the legislation.	
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 regardless of a preexisting condition.	2
SB 08-003 Medicaid Family Planning (Boyd/Riesberg)	This bill provides flexibility in the income eligibility level for the Family Planning Pilot Program. Currently, the income eligibility level is set in statute at 150 percent of the federal poverty level (FPL), but this bill allows the level	The Department worked extensively with CMS and stakeholders to submit a waiver in order to implement the program. In December 2011, the Department withdrew its application for a waiver after learning that it would cost over $800,000 to make system changes to the	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	to be established in the federal waiver sought for the program.	MMIS and the earliest the changes could take effect would be January 1, 2014 due to national code freezes. As of January 1, 2014, this population would be covered under the expansion or could access subsidized private insurance through Connect for Health Colorado.	
SB 08-214 Local Government Medicaid Provider Fees (Shaffer/Frangas)	This bill made changes to legislation enacted in 2006 via SB 06-145, which authorized local governments to implement a provider fee on hospital and home health care agencies to draw federal matching funds to increase reimbursement for services provided to Medicaid members.	As noted in both bills, imposition and collection of a provider fee by a local government is prohibited without federal approval of a Medicaid State Plan Amendment (SPA) authorizing federal financial participation. The Department filed two SPAs with the federal Centers for Medicare and Medicaid Services (CMS) in 2006 and worked with CMS for more than two years for approval. Ultimately, CMS denied the Department's SPAs, concluding that the Department's reimbursement methodology did not meet the requirements of federal regulations [42 CFR §433.68 (f)] addressing hold harmless arrangements.	0
HB 05-1243	This bill extends the option of receiving Home and Community-Based	The legislation authorized the Department to seek federal approval to expand	0.5

Legislation	Legislation Summary	Barriers to Implementation	FTE
Consumer Directed Care Under Medicaid* (Jahn/Johnson)	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 the person's current HCBS waiver to receive services through the consumer-directed care service model.	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 to expand consumer direction into additional waivers and services.	

*While the Department does not have 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 as identified in the "Annual Report: Status of Outstanding Audit Recommendations" that was published by the State Auditor's Office and dated June 30, 2019 (link below)? What is the Department doing to resolve the high priority outstanding recommendations? Please indicate where in the Department's budget request actions taken towards resolving HIGH PRIORITY OUTSTANDING recommendations can be found.**

   http://leg.colorado.gov/audits/annual-report-status-outstanding-audit-recommendations-june-30-2019

RESPONSE

In reference to the outstanding audit recommendations identified in the Office of the State Auditor's "2019 Annual Report of Audit Recommendations Not Fully Implemented," the Department of Health Care Policy & Financing (the Department) has four recommendations that are considered "high priority."

1. Recommendation 2018-044A relates to the Department strengthening internal controls over, and ensuring compliance with, state and federal regulations for the Medicaid program by providing adequate training to the counties and Medical Assistance (MA) sites.

Implementation Status Update
Partially Implemented. Estimated completion date: December 31, 2019

In order to provide adequate training to the counties and Medical Assistance (MA) sites, the Department has released 17 Web-Based Trainings (WBT) and has facilitated seven Instructor-Led Trainings (virtual and in-person) which are available/accessible as recorded webinars through the Staff Development Center's (SDC) Learning Management System, COLearn.

Through July 15, 2019 there have been 17,767 individuals who completed these trainings and 2,462 individual end-users.
Additionally, the training team switched to a Process-Based Training (PBT) model. This will provide consistent Colorado Benefits Management System (CBMS) data entry training, regardless of the program area. The training will cover necessary policy and eligibility information for each program area affected by the process. The first phase of PBT was completed in August 2019. The second phase of Process Based Training is still on track to be completed by December 2019. The courses are required for all Medical Assistance eligibility workers. To date, the training team has updated the income section of current training (Expanding Foundations) to be PBT; the other modules are in the queue for updates.

The Income module includes 3 WBTs, 3 desk aids, and an Instructor-Led portion which includes hands on data entry practice. The content is income as it relates to the Modified Adjusted Gross Income (MAGI) course.

2. Recommendation 2018-044B relates to the Department strengthening its internal controls and ensuring it complies with state and federal regulations for the Medicaid program by monitoring local counties and MA sites by performing Medicaid eligibility reviews.

Implementation Status Update
Partially implemented. Estimated completion date: January 2020.

The Department is in the process of hiring an eligibility vendor to review the accuracy of Long-Term Care eligibility determinations. The Department will have a vendor procured by January 2020. The Department has drafted the scope of work to audit the Express Lane Eligibility (ELE) cases. Eliciting a vendor for this work is on hold until final guidance is received from the Centers of Medicare and Medicaid Services (CMS) to ensure the work is in compliance with CMS guidance.

In addition to this work, the Department is implementing a robust county oversight and accountability model for eligibility. The model is based on a partnership with the Colorado Department Human Services and leveraging their processes for oversight and accountability. This includes the following initiatives:

- Enhancing county administration rules to improve county accountability;
- Improving quality/performance metrics and information sharing through scorecards;
- Implementing management evaluation reviews and providing technical assistance to address issues; and
- Implementing changes to quality control processes as dictated by the federal government

This county oversight and accountability model is targeted to be implemented by July 2020.

3. Recommendation 2018-044C relates to the Department strengthening its internal controls over, and ensuring it complies with, state and federal regulations for the Medicaid program by researching and resolving CBMS system issues identified in the audit.

Implementation Status Update
On track. Estimated completion date: July 31, 2020.

The Department researched, investigated, and is on track with making system changes that were identified during this CBMS audit. Two projects were identified and prioritized to ensure that CBMS functionality is in compliance with state rules and federal regulations. Due to the prioritization of these projects amongst other high priority projects, the completion date was set to no later than July 31, 2020.

4. Recommendation 2018-058 relates to the Department developing and implementing interim policies and procedures to ensure that personnel costs charged to federal grant programs are compliant with federal cost regulations while it awaits the implementation of the state's new timekeeping system.

Implementation Status Update
Partially implemented. Estimated completion date: March 31, 2020.

Due to delays in the statewide implementation of the Human Resources Information System (HRIS), the Department identified an interim procedure to ensure personnel costs charged to a federal grant were compliant with federal cost regulations. The Department implemented semi-annual time certifications for staff dedicated to one federal award or state program. This interim procedure is compliant with federal cost regulations and moves the Department closer to full compliance with federal cost regulations. The Department does not anticipate being fully compliant until HRIS is deployed.

3. **If the Department receives federal funds of any type, please respond to the following:**
    a. **Are you expecting any changes in federal funding with the passage of the FFY 2020-21 federal budget? If yes, in which programs, and what is the match requirement for each program?**
    b. **Does the Department have a contingency plan if federal funds are eliminated?**
    c. **Please provide a detailed description of any federal sanctions or potential sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2019-20 or 2020-21.**
    d. **Compared to other states, Colorado ranks low in receipt of federal dollars. How can the Department increase the amount of federal money received?**
    e. **What state funds are currently utilized to draw down (or match) federal dollars? What state funding would be required to increase the amount of federal funding received?**

Changes in Federal Funding

The Department does not expect any changes in federal funding that are connected to the FFY 2019-20 or 2020-21 federal budget. However, current federal law does provide for a change in the federal match rate for the Children's Health Insurance Program (CHIP), referred to as the Child Health Plan *Plus* (CHP+) in Colorado. On October 1, 2019, the federal match rate for CHP+ dropped from 88 percent to 76.5 percent, and on October 1, 2020, the federal match rate will drop to 65 percent and remain at that level in future years. Because CHP+ requires a state match, the Department has accounted for the required increase in state funding as part of the November 1, 2019 budget request.

In addition, current federal law provides for a change in the federal match rate for parents and adults newly eligible under the Affordable Care Act (ACA). The federal match rate will drop from 93 percent to 90 percent effective January 1, 2020 and remain at 90 percent for future years. The Department has accounted for the required increase in state funding from the Healthcare Affordability and Sustainability Fee cash fund as part of the November 1, 2019 budget request.

Contingency Plan

The Department does not have a contingency plan if federal funds for Medicaid or CHP+ were eliminated, as the elimination of federal funding for these programs would require a comprehensive reevaluation of the state's health care programs. Almost 56 percent of the Department's FY 2019-20 budget request is federal funds. In addition, most of the Department's appropriations have an (M) headnote, which restricts the Department from spending state funds if there is no longer a federal match. The Department would be unable to continue to pay for any services without a federal match, and the Department, Governor's Office, and General Assembly would need to decide which coverage options to extend with state funding, if any, and make the corresponding statutory and budgetary changes.

Federal Sanctions

When discussing Medicaid, the term "sanction" is understood to mean a penalty for an activity that falls outside of the activities allowed by the Social Security Act (SSA). The federal Centers for Medicare and Medicaid Services (CMS) has the power to reduce the state's Federal Financial Participation or to fine the state as a sanction for these violations. CMS has not penalized or sanctioned the Department in its operation of the Medicaid program in at least the past 10 years.

Federal disallowances can be issued by CMS when they determine that a claim or a portion of a claim is not allowable under the SSA or a program violates CMS rules or regulations. In these situations, the Department may be required to pay back the federal share of the claim(s). The federal disallowances the Department typically encounters are due to disagreements over the administration of various activities. The Department actively challenges and engages with CMS regarding any disallowances by appealing disallowances to the Health and Human Services Departmental Appeals Board (DAB). However, it is unusual for the DAB to rule against CMS' disallowances, even when CMS applies current guidance retroactively or disallows funding for legitimate services provided to eligible members.

There are no disallowances during FY 2019-20. Deferral is a delay in payment by CMS while CMS requests documentation from the Department in order to determine allowability of the claim. Below are eight active deferrals:

- On March 6, 2019, CMS deferred $4,779,862 federal financial participation funds related to five items on the Department's Medical Assistance Program CMS-64 for the quarter ended June 30, 2018. CMS refunded $245,837 of this deferral. The Department submitted support documentation on July 2, 2019 for $4,534,025. The Department is waiting for CMS to respond.
- On March 6, 2019, CMS deferred $6,343,726 federal financial participation funds related to seven items on the Department's Administration for the Medical Assistance Program (CMS-64) for the quarter ended June 30, 2018. CMS refunded $1,841,370 of

this deferral. The Department submitted support documentation on July 2, 2019 for $4,278,179. The Department is waiting for CMS to respond. The Department expects to return the remaining $224,177 to CMS.

- On March 6, 2019, CMS deferred $3,123 federal financial participation funds related to time barred claims on the Department's Administration for the Medical Assistance Program (CMS-64) for the quarter ended September 30, 2018. The Department submitted support documentation on July 2, 2019 for $3,123. The Department is waiting for CMS to respond.
- On March 7, 2019, CMS deferred $116,759,749 federal financial participation funds related to four items on the Department's Medical Assistance Report CMS-64 for the quarter ended September 30, 2018. CMS refunded $114,890,756 of this deferral. The Department submitted support documentation on July 3, 2019 for $1,790,654. The Department is waiting for CMS to respond. The Department expects to return the remaining $78,339.
- On June 28, 2019, CMS deferred $6,600,362 federal financial participation funds related to the Department's Administration for the Medical Assistance Program (CMS-64) for the quarter ended March 31, 2019. The Department submitted support documentation on October 25, 2019. On December 12, 2019, CMS responded and stated they accepted the support documentation and will release the federal funds to the Department upon completion of their federal fiscal year 2019 grant finalization process.
- On June 28, 2019, CMS deferred $766,913 federal financial participation funds related to the Department's Medical Assistance Program (CMS-64) for the quarter ended March 31, 2019. The Department submitted support documentation on October 25, 2019. On December 12, 2019, CMS responded and stated they accepted the support documentation and will release the federal funds to the Department upon completion of their federal fiscal year 2019 grant finalization process.
- On June 28, 2019, CMS deferred $8,819 federal financial participation funds related to the Department's Medical Assistance Program (CMS-64) for the quarter ended March 31, 2019. The Department submitted support documentation on October 25, 2019. On December 12, 2019, CMS responded and stated they accepted the support documentation and will release the federal funds to the Department upon completion of their federal fiscal year 2019 grant finalization process.
- On September 26, 2019, CMS notified the Department of a potential disallowance for $97,331 federal financial participation funds related to the Department's CMS-64 Line 1B – Inpatient Hospital Service - DSH Adjustment Payments. The Department submitted support documentation on October 15, 2019. The Department is waiting for CMS to respond.

In summary, CMS deferred $135,359,885 and the Department proved the validity of its claims for $124,354,057 in federal financial participation funds. The Department is waiting for response from CMS regarding $10,703,312 and the Department expects to owe $302,516 in federal financial participation funds to CMS.

Receipt of Federal Dollars in Comparison to Other States

The Department's receipt of federal dollars is primarily set by the state's Federal Medical Assistance Percentage (FMAP) and funds appropriated by the General Assembly. The FMAP is calculated by CMS using a formula[15] based on a rolling three-year average of the state's per capita income and a rolling three-year average of the United States' per capita income. The only mechanism by which FMAP would increase is if Colorado's per capita income declined in such a way that it was closer to or lower than the U.S. per capita income. This scenario did occur during FFY 2014-15 through FFY 2016-17 as the U.S. economy was recovering from the Great Recession; Colorado received slightly higher FMAPs during these years.

The Department is always proactively seeking new sources of federal funds through grants and other funding mechanisms. Most recently, the Department submitted R-18 "Public School Health Services Expansion" as part of its November 1, 2019, budget request to increase federal funds reimbursement to public school districts participating in the Public School Health Services Program. This request uses certified public expenditures (CPE) which is a statutorily recognized Medicaid financing approach by which a governmental entity, such as a public school district, incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid State Plan. If this request is approved by the General Assembly, the Department expects to receive $13,431,193 in additional federal funds annually, which it would pass to school districts.

State Funds Used to Match Federal Dollars and Increasing Federal Funding

The Department uses a combination of General Fund, reappropriated funds from other agencies, and various cash funds such as the Healthcare Affordability and Sustainability fee cash fund to draw down federal dollars. Please refer to the Department's Schedule 9 Cash Funds Report for a full list of cash funds that are used.

Using the FMAP funding mechanism, the Department could increase the amount of federal funds received if the General Assembly increased state fund appropriations for measures such as increasing provider rates or approving additional benefits for members.

4. **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?**

[15] $FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$

RESPONSE

No. The Department is not spending any money on public awareness campaigns.

5. **Based on the Department's most recent available record, what is the FTE vacancy and turnover rate: (1) by department; (2) by division; (3) by program for programs with at least 20 FTE; and (4) by occupational class for classes that are located within a larger occupational group containing at least 20 FTE. To what does the Department attribute this turnover/vacancy experience? Do the statewide compensation policies or practices administered by the Department of Personnel help or hinder the Department in addressing vacancy or turnover issues?**

RESPONSE

Below is the Department's FTE turnover and vacancy rate by office. The Department tracks this data by office rather than division, so information on the turnover and vacancy rate by division is not available.

Table 1 - Turnover and Vacancy Rate by Department and Office for FY 2018-19

Office	Number of Unique Positions	Turnover Rate[1]	Vacancy Rate[2]
Executive Director's Office	5	40%	30%
Cost Control and Quality Improvement	45	20%	10%
Finance Office	152	12%	6%
Health Information Office	118	17%	11%
Health Programs Office	75	21%	15%
Office of Community Living	91	5%	8%
Pharmacy Office	12	33%	18%
Policy, Communications and Administration Office	126	25%	18%
Total by Department	**624**	**17%**	**11%**

[1] Turnover rate is calculated as the number of times an employee separated from the Department in FY 2018-19, either voluntarily or involuntarily, divided by the total number of unique positions.

[2] Vacancy rate is the percentage of time in FY 2018-19 that positions have been vacant. This includes positions that separated prior to July 1, 2018 but remained vacant for a period of time in FY 2018-19.

Below is the turnover and vacancy rate by program for programs with at least 20 FTE.

Table 2 - Turnover and Vacancy Rate by Program for FY 2018-19			
Program	**Number of Unique Positions**	**Turnover Rate[1]**	**Vacancy Rate[2]**
Customer Contact Center	37	30%	15%
Total	**37**	**30%**	**15%**
[1] Turnover rate is calculated as the number of times an employee separated from the Department, either voluntarily or involuntarily, divided by the total number of unique positions. [2] Vacancy rate is the percentage of time in FY 2018-19 that positions have been vacant.			

Below is the turnover and vacancy rate by occupational class within the larger occupational group of at least 20 or more FTE.

Table 3 - Turnover and Vacancy Rate by Occupational Group for FY 2018-19			
Occupational Group	**Number of Unique Positions**	**Turnover Rate[1]**	**Vacancy Rate[2]**
H – Professional and Supervisory	**567**	**17%**	**11%**
Accountant	22	14%	12%
Admin Law Judge	1	0%	0%
Administrator	168	12%	11%
Analyst	70	13%	8%
Auditor	7	14%	7%
Budget Analyst	17	6%	3%
Compliance Investigator	2	50%	13%
Compliance Specialist	16	6%	7%
Contract Administrator	16	31%	16%
Controller	3	0%	0%
Grants Specialist	2	0%	44%
Human Resources Specialist	6	67%	31%
Liaison	7	14%	12%
Legal Assistant	1	0%	0%
Management	12	0%	4%
Marketing & Communications Specialist	6	67%	16%
Policy Advisor	28	14%	5%
Program Assistant	19	0%	15%
Program Coordinator	4	25%	8%

Program Management	68	12%	5%
Project Coordinator	8	25%	6%
Project Manager	10	20%	1%
Purchasing Agent	9	56%	31%
Rate/Financial Analyst	35	9%	4%
Social Services Specialist	1	0%	0%
Technician	13	92%	57%
Training Specialist	16	38%	24%
I – Information Technology Services	**29**	**14%**	**7%**
Statistical Analyst	29	14%	7%
Total	**596**	**16%**	**10%**

[1] Turnover rate is calculated as the number of times an employee separated from the Department, either voluntarily or involuntarily, divided by the total number of unique positions. The separations occurred in FY2018-19.

[2] Vacancy rate is the percentage of time in FY 2018-19 that positions have been vacant. This includes positions that separated prior to the review period but remained vacant for a period of time in FY 2018-19.

Based on existing historical survey data, the most frequently cited reasons for leaving employment are: 1) the opportunity for promotions that include additional pay; 2) better pay; and 3) dissatisfaction with a supervisor.

To attract and retain employees, the Department is continuing to enhance employee engagement through developing a leadership development program; expanding employee coaching; revising and streamlining the new employee orientation and first-year onboarding process; and providing training to managers to more effectively use competency-based, in-range salary adjustments. The Department has also started to implement a more comprehensive learning and development model designed to provide staff both personal and professional development opportunities.

The statewide compensation policies, compensation ranges, and implementation rules continue to make competing with the private sector to attract and retain top talent a challenge. As the Department of Personnel and Administration noted in its FY 2020-21 Annual Compensation Report, "The State is 11.5 percent below prevailing market levels for total compensation." This disparity, particularly in wages, is a constant source of concern when hiring staff. This is exacerbated by the state's general policies to fund new positions and hire new staff at the minimum of the salary range. Most Department job postings include disclaimers that new hires are generally paid at the bottom of the range, which can have the effect of discouraging qualified candidates, and particularly those candidates with industry experience.

The Department supports the idea around a merit pay program tied to performance that DPA is working on, which would be a great step in the direction of bridging the pay gap that exists between the state and the prevailing market.

6. **Please identify how many rules you have promulgated in the past two years (FYs 2017-18 and 2018-19). 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 2017 to October 2019, the Department promulgated 86 rules. The Department does cost-benefit and regulatory analyses for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analyses are included in the rule-making document packet that accompanies each rule proposed by the Department. The cost-benefit analysis includes the following components:

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

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

With respect to these rules, no person requested a separate cost-benefit analysis for any 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 Department performed a regulatory analysis of all 84 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.

7. 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

The primary cost driver impacting the Department's FY 2020-21 General Fund 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 that this General Fund growth will be driven in large part by the aging of Colorado's population. Services incurred by people 65 years old and over and people with disabilities who qualify for Medicaid are paid for using General Fund and receive a 50 percent federal match rate.

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. Among these issues, the Department is particularly concerned about the effect of the rising minimum wage on providers who deliver personal care and homemaker services to people with disabilities; without annual rate growth to keep pace with the Constitutionally-required minimum wage increases, the Department fears that the people who deliver these services will seek other occupations that pay similarly. For this reason, the Department is requesting a 2.75 percent increase in personal care and homemaker rates as part of the November 1, 2019 budget.

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.

8. 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

Medicaid caseload grew significantly from FY 2008-09 through FY 2015-16, primarily for children and adult populations. Since then, overall caseload growth has been low or decreasing due to improving economic conditions. The Department is projecting a decline in FY 2019-20 caseload, and small growth of 2.11 percent in FY 2020-21. For populations in which eligibility is not driven by economic conditions, such as older adults and people with disabilities, the Department is projecting growth of 2.94 percent in FY 2020-21. The projected growth is informed by projections of the aging population and historical growth of people with disabilities. The State Demographer indicated that the aging and older adult population in Colorado (ages 65 and over) increased by 43 percent from 2010-2017, compared to 14 percent for the rest of the state's population, and is projected to increase by nearly 70 percent by 2030.

As caseload grows more rapidly for older adults and people with disabilities, the Department is projecting that it will spend more on long-term services and supports. For example, the Department is projecting that it will need an increase of $90.5 million General Fund in FY 2020-21 compared to FY 2019-20 to fund its Medical Services Premiums line item. Of that amount, approximately $68.9 million is attributable to services for older adults and people with disabilities, primarily for long-term services such as community-based waiver services, nursing facilities, long-term home health, and private duty nursing.

9. Please provide an overview of the Department's current and future strategies for the use of outward facing technology (e.g. websites, apps), the role of these technologies in the Department's interactions with the public and other state agencies, the Department's total spending on these efforts in FY 2018-19, and expected spending in FYs 2019-20 and 2020-21.

RESPONSE

The Department's strategy continues to focus on providing the right tools and resources to enable its member contact center to handle calls more effectively and efficiently. As part of this strategy, the Department's FY 2020-21 R-6 "Improve Customer Service" request is the next phase of incremental improvements to provide members with adequate levels of service needed to obtain important information about their health care coverage and access their benefits. The request includes funding for increasing staffing and technology improvements in the Department's Member Contact Center (MCC) to reduce average speed to answer and decrease call abandonment rates and to contract with a vendor to make recommendations on consolidating the Department's contact points into a single phone number for all customer needs. The request also includes one-time funding to implement member surveys. The Department continues to collaborate with its partners to improve the customer experience that expands beyond the contact center and includes: a detailed online member handbook, a provider directory, online application and benefit management through the Colorado Program Eligibility and Application Kit (PEAK), a mobile app

(PEAK), partner and county contact centers, the Department's websites, and in-person experiences.

Moving forward, the Department envisions a coordinated customer support system that aligns and consolidates websites where it makes the most sense for the members and creates interconnected and self-service support models to enable an improved customer experience.

Expenditure for the Member Contract Center for salary and benefits for FY 2018-19 was $2,218,430 and is projected to be $2,325,556 in FY 2019-20 and FY 2020-21.

The PEAK Health Mobile App is an access point for Medicaid and Child Health Plan *Plus* (CHP+) members to access benefits on the go. The app allows members to find a doctor, see their Medicaid Card, see account balances, and update contact information. This is a member facing technology. The expenditure estimates are for the HCPF share of pool hours are $685,000 for FY 2018-19, $975,000 for FY 2019-20 and $1,005,000 for FY 2020-21. This funding is reappropriated to OIT.

The Department received funding to improve the technology used by members and agents beginning in FY 2019-20 in the FY 2019-20 budget request R-10 "Transform Customer Experience." Expenditure is estimated to be $394,304 in FY 2019-20 and $194,000 in FY 2020-21. This request also included automation of the chat function totaling $920,000 in FY 2019-20 and $184,000 in FY 2020-21. The Department also has funding to merge customer contact systems for $200,000 in FY 2019-20 and $40,000 in FY 2020-21. This funding is reappropriated to OIT.

"PEAK Usability" funding is to enhance the user experience and primary upgrades are related to technical changes. After feedback from stakeholders, changes were necessary to enhance the user experience. The expenditure estimates for the HCPF share of pool hours expenses for FY 2019-20 are $650,000 and for FY 2020-21 are $670,000.

The Department received funding from the FY 2019-20 budget request R-12 "Medicaid Enterprise Operations" for the provider services call center, which is included in the claims system vendor contract. Contract staff interact with the provider community fielding calls when providers have billing or claim submission issues. The call center assists the providers and troubleshoots their problems. The FY 2018-19 expenditure was $796,910, the FY 2019-20 estimate is $1,628,640, and FY 2020-21 is $1,664,520. Additionally, the provider services helpdesk staff provide user access services, password reset services, and technical assistance related to other application support. The helpdesk aids the systems team during outages and events that require testing after failure and restoration of services and interacts with the Department staff and the provider community. The FY 2018-19 expenditure was $152,570, and the FY 2019-20 estimate is $250,120, and FY 2020-21 is $255,590.

10. **There are many ways in which the Department may interact with internal or external customers, including the public and other departments. How is the Department gathering feedback and evaluating customer experience? Please address all interactions, e.g. technology, in-person, call centers, as well as total spending on these efforts in FY 2018-19 and expected spending in FYs 2019-20 and 2020-21.**

RESPONSE

The Department gathers feedback and evaluates customer experience through coordination and integration across multiple channels. Feedback is gathered from the Member Contact Center, the Program Eligibility and Application Kit (PEAK) Help Desk, websites, in-person and virtual Member Experience Advisory Councils, local partners' member advisory councils, and specific, targeted user testing and surveys. The Department's FY 2020-21 budget request R-6 "Improve Customer Service" includes one-time funding to add member survey functionality to PEAK in order to better understand and improve the experience with online tools.

The Department also seeks feedback through the Member Experience Advisory Councils (MEAC). Expected spending for the MEACs in FY 2019-20 and ongoing is $35,000. This funding was appropriated in response to the Department's FY 2019-20 R-10 budget request "Transform Customer Experience." The Department absorbed costs related to the MEACs in FY 2018-19.

11. **Please highlight the long-term financial challenges of fulfilling the mission of the Department with particular attention to any scenarios identified in the Department's Long Range Financial Plan involving an economic downturn, Department-specific contingencies, emerging trends, or major anticipated expenses (Subsections 3-6 of Section 4 of the Long Range Financial Plan submitted pursuant to H.B. 18-1430).**

RESPONSE

As outlined in the Department's Long Range Financial Plan, the Department's primary budget drivers can be classified into four major categories as outlined below. The primary drivers of expected budget growth include population growth, a rapidly aging population, inflationary health care costs, and federal policy changes. Additionally, there are several key trends that will continue to drive expenditure growth in the Department's programs. In all circumstances, the Department is exploring ways to control growing costs.

Key examples of emerging trends include the rapid rise of high cost drugs that treat rare conditions, which will increase costs in the short term and costs avoided will be measured over an individual's lifetime. Other key trends that impact the Department's budget include rising minimum wages, which require rate increases for certain services to keep up with wages. Additionally, as of June 2019, over 2,895 people were on the waiting list for people with intellectual and developmental disabilities with a high unmet need for residential services. Additional trends include higher costs

in community based long-term services and supports, including participant directed programs and the Program for All-Inclusive Care for the Elderly (PACE).

Changes in Economic Conditions

Because a large majority of people enrolled qualify for Medicaid and Children's Health Insurance Program (CHIP) because their income is below specific thresholds, during times of recession or other economic contraction, caseload increases rapidly which increases General Fund costs. For example, during the last recession and the years immediately following when unemployment remained above historical averages, Medicaid caseload increased from 391,962 in FY 2007-08 to 682,994 by FY 2012-13. Significant increases in caseload also put a strain on entities providing direct service to members, such as the Member Contact Center and county departments of human/social services. The Department's Long Range Financial Plan provides a scenario of economic shock, which could increase caseload by 19.75 percent and increase expenditure in FY 2020-21 by $678,649,591 total funds. Medicaid is an entitlement program which prevents the State from capping enrollment or reducing the amount, scope, or duration of services due to a lack of state funding. Because of this, there are limited opportunities to reduce Medicaid growth during an economic downturn. When downturns occur, one of the principle ways to reduce Medicaid expenditure is through provider rate reductions, which can reduce the number of providers willing to accept Medicaid which can create access issues for Medicaid members. Economic downturns can also spur innovation, for example in FY 2009-10, the Department collaborated with providers around the State to develop plans to reduce unnecessary and duplicative utilization across a wide variety of services which may not have been considered without the pressure of restricted funding.

Additionally, because the Department administers a network of public and private providers who render services to members, changes in the provider landscape such as closure of a rural hospital, closure of a Regional Accountable Entity (RAE), or provider shortages can create access to care issues for members, which may cause them to go without needed care or utilize higher cost care.

Changes in Colorado's Demographics

The combination of Colorado's increasing population and a greater proportion of adults over 65 will continue to drive costs in the Department's programs. As people age and spend down their resources, they become eligible for Medicaid. Older adults have higher per capita costs than adults and children and receive the least amount of federal funding available, which creates budgetary pressure as more older adults are enrolled.

Increasing Health Care Costs

Key trends in rising health care costs involve rapid increases in prescription drug spending, hospital spending and physician and clinical services. Health care providers will continue to fact cost pressures due to the rising cost of wages, capital costs, health insurance, and other factors common to most businesses, which will require provider rates to be sufficient to ensure provider

participation to meet the needs of the program. While the Department continues to implement new payment methodologies, condition a portion of reimbursements on outcomes and performance metrics, and implement regulatory structures that prioritize member health, inflationary pressures will continue. In some cases, federal or state law requires the Department to increase rates to keep pace with provider costs.

Federal Policy Changes

Medicaid and CHIP are programs funded jointly by the federal government and Colorado. As such, any change in federal policy for these programs can have a budgetary impact for the state. Most major policy changes require an act of Congress which creates uncertainty for the future.

For example, repealing the Affordable Care Act could jeopardize at least $1.75 billion in federal funds for Colorado. Enacting a public health care program such as Medicare-for-All may shift costs from the State to the federal government, although there is uncertainty on the details, and the federal law could still require the state to cover costs for people who were previously eligible for Medicaid similar to how Medicare Part D was implemented by Congress. There have also been conversations around converting Medicaid to a block grant program which could reduce Colorado's available federal funds by $2.9 billion between 2020 and 2026. Additionally, Executive Action, through waivers or rulemaking could have significant effects on the operation and financing of the Medicaid program. For example, regulator action could reduce or eliminate Colorado's ability to finance portions of the Medicaid program using provider fees, which could increase the need for General Fund or drive other effects that may require additional appropriations from the General Assembly.

There are also three upcoming notable changes in federal financing for the Department's programs which include reduction in the federal medical assistance percentage (FMAP) for Medicaid expansion adults declines from 93 percent to 90 percent on January 1, 2020 which causes an increase in cash fund appropriations from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). Additionally, the CHIP FMAP reduction required additional State funding to cover the costs because Tobacco Master Settlement funds are insufficient to meet the need. Both of these items have been included in the Department's November 1 request.

Additionally, the dedicated enhanced funding for health information technology, which has been funded at 90 percent, only requiring the State to cover 10 percent expires on September 30, 2021. To date, this funding has been used to further the design and implementation of important Health IT statewide infrastructure, including connecting health records and to establish the Governor's Office of eHealth innovation, eHealth commission, and support the design and implementation of projects generated through Colorado's Health IT roadmap. The Department will work with CMS to determine the exact projects that can be maintained through alternate enhanced funding streams.

12. In some cases, the roles and duties of existing FTE may have changed over time. For all FY 2020-21 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

R-6 Improve Customer Service

a. The request is for 4.5 two-year term limited call center agents and lead staff because more staff are needed to answer calls to improve the average speed to answer and reduce the call abandonment rate. Existing staff would not be trained to absorb these roles or duties because there are already staff performing these functions, and existing staffing levels are not sufficient to meet the call demand. Absorbing this work with existing staff would not achieve the desired goal of increasing the number of agents and lead staff answering incoming calls and chats.

b. Additional staff are necessary to improve the average speed to answer and call abandonment rate so that members can get through when they contact the Department about their health coverage. A full description of the FTE is outlined in the Department's request.[16]

c. To determine the number of FTE to request, the Department reviewed the call volume and, based on other competing priorities, requested 4.5 two-year term limited FTE to help improve hold times.

R-7 Pharmacy Pricing and Technology

a. The request is for five new staff to implement the initiatives requested and to continue to respond to appeals and manage staff. Current staff cannot absorb these duties without impacting other work that is required.

b. New FTE are needed to help control the Department's spending on pharmaceuticals. The work for these staff includes: overseeing the increased number of pharmacy appeals; providing clinical subject matter expertise for various Department cost containment initiatives; monitoring federal and state compliance; and, contract management, including to overseeing system changes necessary to implement the request. A full description of each FTE is outlined in the Department's request.[17]

[16] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-6%20Improve%20Customer%20Service.pdf
[17] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-7%20Pharmacy%20Pricing%20and%20Technology.pdf

c. The Department evaluated the number of FTE needed for this request based on the workload of each task outlined, and prior experience with staffing required to handle similar tasks.

R-8 Accountability and Compliance Improvement Resources

a. The request is for 12 FTE to provide operational compliance and program oversight for existing programs. The Department cannot expand and strengthen operational compliance, program oversight and accountability within existing resources.
b. Additional staff are necessary to ensure proper functionality and oversight of Department programs. A full description of the FTE is outlined in the Department's request.[18]
c. The Department evaluated the number of FTE needed for this request based on the workload of each task outlined in the request, and prior experience with the staffing required to handle similar tasks.

R-9 Bundled Payments

a. The request is for two FTE to manage a contract and implement new rate methodology. Existing staff are currently focused on other alternative payment methodologies and standard rate setting processes and do not have the capacity to perform all the tasks necessary to manage the maternity bundled payment and to implement other bundles of high value.
b. Additional FTE are necessary for reconciling and performing ongoing operations, including data and financial analysis, of the maternity bundled payment. A full description of the FTE is outlined in the Department's request.[19]
c. The evaluation process involved the examination of current workloads across multiple FTE and position descriptions and determined the need based on existing work for payment reform projects such as alternative payment models.

R-14 Enhanced Care and Condition Management

a. The request is for one Program Manager for the Department's efforts to coordinate enhanced care and condition management with the Regional Accountable Entities (RAEs). Existing staff cannot be repurposed or retrained to assume this role because this role is strategically designed to coordinate the work of multiple, existing Department programs and staff whose individual work is critical to continue in order to better manage care for high cost, high risk members.
b. The additional FTE is necessary because the Department lacks the dedicated resources needed to transform analytic and clinical insights into real-world improvements in care

[18] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-8%20Accountability%20and%20Compliance%20Improvement%20Resources.pdf.
[19] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-9%20Bundled%20Payments.pdf

coordination and cost-reduction for the Department's highest-cost, highest-risk members. A full description of the FTE is outlined in the Department's request.[20]

c. Based on the workload required for similar types of program management, the Department determined that one FTE would be needed to coordinate and evaluate current Department clinical and cost analyses; coordinating RAEs, the Department of Human Services, regional hospitals, and other providers; serving as a central point of contact for RAEs, and assisting with the production of regional-specific plans for highly complex populations.

R-15 Medicaid Recovery and Third-Party Liability Modernization

a. The request includes six staff to improve recovery and cost avoidance operations. Existing staff are already performing these or similar duties and would not be trained to assume these roles or duties because the purpose of the request is to increase the number of staff which would increase recoveries.

b. The number of staff working on these efforts is directly correlated to the amount the Department recovers and so more staff are necessary to increase recoveries due to the complicated legal process required for recoveries and overpayments. Without more staff, the Department would not be able to increase the number of referrals and identified overpayments that it works on. A full description of the FTE is outlined in the Department' request.[21]

c. The Department considered the resources that would be needed for achieving the stated goals of recoveries and savings, based on current staff job duties.

R-16 Case Management and State-only Programs Modernization

a. The request includes four staff to perform job duties that current staff are already absorbing, and they cannot keep up with the workload. This includes addressing audit findings from the Office of State Auditor (OSA), overseeing the State Supported Living Services (SLS) program, and implementing Case Management redesign.

b. Additional staff are necessary to maintain legal compliance for important programs that serve individuals with intellectual and developmental disabilities. A full description of the FTE is outlined in the Department's request.[22]

c. The Department evaluated the number of FTE needed by determining the amount of work that must be done, identifying potential existing resources to do this work, and determining that there is a shortfall in existing resources equaling the number of requested FTE.

R-17 Program Capacity for Older Adults

[20] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-14%20Enhanced%20Care%20and%20Condition%20Management.pdf

[21] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-15%20Medicaid%20Recovery%20and%20Third-Party%20Liability%20Modernization.pdf

[22] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-16%20Case%20Management%20and%20State-Only%20Programs%20Modernization.pdf

a. The request includes one staff to perform PACE audits, which was previously audited by Centers for Medicare and Medicaid Services (CMS). Since the passage of the PACE final rule in August 2019, CMS is no longer performing regularly scheduled audits, which created a need for Department FTE.
b. This position would provide some of the resources needed to effectively administer a yearly audit of a program costing approximately $225 million in FY 2019-20. As of now PACE has many types of services within its capitation, without the current oversight needed. A full description of the FTE is outlined in the Department's request.[23]
c. The Department conducted a national environmental scan of other states' PACE programs to better understand the resources required to administer a PACE program of our size. In addition, the Department performed and analysis of Colorado's PACE staffing to determine the level of resources to successfully and proactively manage this program. The Department concluded that it was understaffed regarding PACE oversight. The Department accounted for the hours required to perform this comprehensive audit by looking at the resources required by previous audits.

13. Please describe the impact of Colorado's low unemployment rate on the Department's efforts to recruit and retain employees.

RESPONSE

The Department is experiencing difficulty in hiring positions because of Colorado's low unemployment rate. As there are more jobs than there are qualified candidates, people now have the freedom to be more selective about accepting jobs than they had in the past. Therefore, there is much competition for qualified candidates. The most likely cause is not being an employer of choice. There are many factors that contribute to employer of choice status, but some of the primary drivers include pay and benefits, leadership, culture, communication, and company perks.

In addition to struggling to find talent to fill our available roles, it's also likely that the Department is losing employees to other organizations who rate more positively on some of these aspects. Therefore, organizations who find themselves lacking employer of choice status are likely feeling the impact of the current unemployment rate, and not in a positive way. One of the most obvious ways to combat this struggle is to try to change our employer of choice status. However, the Department continues to be challenged with this as, according to the Department of Personnel and Administration noted in its FY 2020-21 Annual Compensation Report, "[when] the State's total compensation package is valued, there is a variance of 11.5 percent below the prevailing market, which is just outside of a competitive range."

[23] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-17%20Program%20Capacity%20for%20Older%20Adults.pdf

The Department is attempting to be more creative in its outreach by tapping into different niches of applicants, such as: the youth apprenticeship program through CareerWise Colorado; and the disability community through the Department of Vocational Rehabilitation.

14. State revenues are projected to exceed the TABOR limit in each of the next two fiscal years. Thus, increases in cash fund revenues that are subject to TABOR will require an equivalent amount of General Fund for taxpayer refunds. Please:

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

b. For each source, list actual revenues collected in FY 2018-19, and projected revenue collections for FY 2019-20 and FY 2020-21.

c. List each decision item that your department has submitted that, if approved, would increase revenues subject to TABOR collected in FY 2020-21.

RESPONSE

General Fund (Fund 1000)

There is an annual transfer from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Cash Fund to the Department to offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums. The expected annual transfer amount is $15,700,000 in subsequent years.

Secondly, the Department receives an annual intergovernmental transfer from Denver Health in the amount of $700,000 to assist with payments to eligible nursing facilities to expand access for patients who require special long-term care services and supports because of physical, behavioral, and/or social complexities. The intergovernmental agreement of the transfer is expected to continue at $700,000.

Lastly, the Department receives non-exempt interest income from drug rebates. Pharmaceutical manufacturers pay the Department rebates on certain drugs prescribed to Medicaid members. The manufacturers are billed for the drug rebates related to pharmacy claims and have 38 days to pay. They are charged interest on outstanding balances if they do not pay timely. The amount of interest income collected is dependent on how many pharmaceutical manufacturers are delinquent in their drug rebates and the amount they owe.

Children's Basic Health Plan Trust (Fund 11G0)

Premiums are collected from families of Child Health Plan *Plus* enrollees who enter the program. Premiums are $25 for families with one child enrolled and $35 for families with two or more children enrolled. Any families that are below 150 percent the federal poverty level (FPL) do not pay a premium. Revenue is driven by the number of families enrolled in the program and the household size and federal poverty level of each family.

Medicaid Buy-In Cash Fund (Fund 15B0)
Premiums are paid by members eligible for and participating in the Medicaid Buy-In Program based on a sliding-fee scale. Revenue is driven by the number of members that participate in the program.

Breast and Cervical Cancer Prevention and Treatment Program (Fund 15D0)
A $25 surcharge is placed on breast cancer awareness special license plates. This revenue is driven by the amount of Colorado residents purchasing the special license plate. In addition, non-exempt interest income is received from the cash fund balance. The amount of interest income is based on the balance of the cash fund.

Service Fee Fund (Fund 16Y0)
Service fees are collected from private and public intermediate care facilities who provide care for individuals with intellectual disabilities. The fee level is set by the Medical Services Board, not to exceed five percent of the total costs incurred by all intermediate care facilities. Revenue is driven by the number of private and state operated intermediate care facilities that the Department collects fees from.

Medicaid Nursing Facility Cash Fund (Fund 22X0)
The Department is required to collect a Quality Assurance Fee from nursing facilities, including facilities that do not serve Medicaid members. Each year the fee is increased by inflation based on the national skilled nursing facility market basket index determined by the Secretary of Health and Human Services. In FY 2018-19 the fee could not exceed $14.80 and in FY 2019-20 the fee cannot exceed $15.26. Revenue is driven by the number of licensed nursing facilities and the fee amount collected.

Health Care Policy & Financing Cash Fund (Fund 23G0)
Fee revenue currently consists of provider screening, enrollment and recertification fees which, pursuant to federal regulations under 42 CFR § 455.460, must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government. Revenue is driven by the number of Medicaid providers that need recertification and number of new providers undergoing background checks to become a Medicaid provider.

Intellectual and Developmental Disabilities Services Cash Fund (Fund 27U0)

Non-exempt interest income is received from the cash fund balance. The amount of interest income is based on the balance of the cash fund.

Nursing Home Penalty Cash Fund (Fund 2840)
Revenue is derived from civil penalties imposed upon and collected from nursing facilities for violations of federal regulations based on surveys by the Department of Public Health and Environment. Penalty amounts are based on facility survey history and the severity of the deficiencies and are determined by either the Centers for Medicare and Medicaid Services or the Department. Revenue is driven by the number of nursing facilities that receive violations of federal regulations and the severity of the violations. In addition, non-exempt interest income is received from the cash fund balance. The amount of interest income is based on the balance of the cash fund.

Adult Dental Fund (Fund 28C0)
Non-exempt interest income is received from the cash fund balance. The amount of interest income is based on the balance of the cash fund.

b. For each source, list actual revenues collected in FY 2018-19, and projected revenue collections for FY 2019-20 and FY 2020-21.

RESPONSE

Non-Tax Revenues Collected by the Department of Health Care Policy & Financing That Are Subject to TABOR (excluding sources that amount to less than $100,000/year)				
		Revenues Collected Annually		
Revenue Source	Associated Cash Fund	FY 2018-19 Actual	FY 2019-20 Projection	FY 2020-21 Projection
Transfer from TABOR Enterprise	General Fund (Fund 1000)	$15,888,496	$15,700,000	$15,700,000
Other Intergovernmental Transfers	General Fund (Fund 1000)	$700,000	$700,000	$700,000
Non-Exempt Interest Income	General Fund (Fund 1000)	$332,913	$332,913	$332,913
Children's Health Plan Premiums	Children's Basic Health Plan (Fund 11G0)	$1,264,903	$1,184,893	$1,205,938

Medicaid Premiums	Medicaid Buy-In Cash Fund (Fund 15B0)	$3,939,593	$4,612,286	$5,027,305
Motor Vehicle Registrations	Breast and Cervical Cancer Prevention and Treatment Program Fund (Fund 15D0)	$823,172	$823,172	$763,821
Non-Exempt Interest Income	Breast and Cervical Cancer Prevention and Treatment Program Fund (Fund 15D0)	$131,974	$100,000	$100,000
Health Care Provider Fees	Service Fee Fund (Fund 16Y0)	$282,900	$251,097	$253,053
Health Care Provider Fees	Medicaid Nursing Facility Cash Fund (Fund 22X0)	$56,661,683	$58,089,557	$60,157,546
Medicaid Provider Enrollment Fees	Health Care Policy & Financing Cash Fund (Fund 23G0)	$101,497	$149,791	$149,791
Non-Exempt Interest Income	Intellectual and Developmental Disabilities Services Cash Fund (Fund 27U0)	$294,862	$141,744	$76,175
Other Fines	Nursing Penalty Cash Fund (Fund 2840)	$1,002,278	$1,002,278	$1,002,278
Non-Exempt Interest Income	Nursing Penalty Cash Fund (Fund 2840)	$172,636	$199,798	$217,060
Non-Exempt Interest Income	Adult Dental Cash Fund (Fund 28C0)	$545,758	$300,000	$200,000
TOTALS		**$82,142,665**	**$83,587,529**	**$85,885,880**

c. List each decision item that your department has submitted that, if approved, would increase revenues subject to TABOR collected in FY 2020-21.

RESPONSE

The Department does not have any FY 2020-21 decision items that would drive an increase to revenues subject to TABOR.

15. **Please describe the Department's current practice regarding employee parking and other transportation options (i.e. EcoPass). Please address the following:**
    a. **Does the Department have adequate parking for all employees at all locations?**
    b. **If parking is limited, how are available spaces allocated?**
    c. **If free parking is not available, how is parking paid for, and who pays (employee or Department)? (e.g. stipends, subsidized parking, eco passes)**
    d. **If employees pay fees for parking, where is the revenue credited and how is it spent, and is it subject to TABOR?**
    e. **Do parking and/or transportation benefits factor into Department compensation and/or retention efforts?**

RESPONSE

a. No, HCPF does not have parking for all employees.
b. Reserved parking spaces are available on a first-come, first-serve basis. The Department maintains a waiting list for employees who are seeking parking at its primary location at 1570 Grant St. For commercial leased space at 303 E. 17th St., the building contracts with a private vendor who also maintains a waiting list when spaces are unavailable.
c. Employees pay for personal parking spots. Parking is provided for some senior executives as part of a compensation package.
d. Payment is made directly to parking vendors via payroll deduction by employees, so it is not subject to TABOR.
e. No, parking and transportation isn't a factor of compensation. As the Department's offices are in downtown Denver, most employees are familiar with the lack of parking and opt for other options of transportation. It has not contributed to our retention efforts. However, with using a vendor, the rates are subject to increases each year and for the last three years they keep increasing, which is starting to cause some frustration and complaints amongst staff.

16. **Please identify all continuously appropriated funds within the Department's purview with a fund balance or annual revenue of $5.0 million or more. Please indicate if these funds are reflected in the FY 2019-20 Long Bill.**

RESPONSE

The Department does not have any continuously appropriated cash funds.