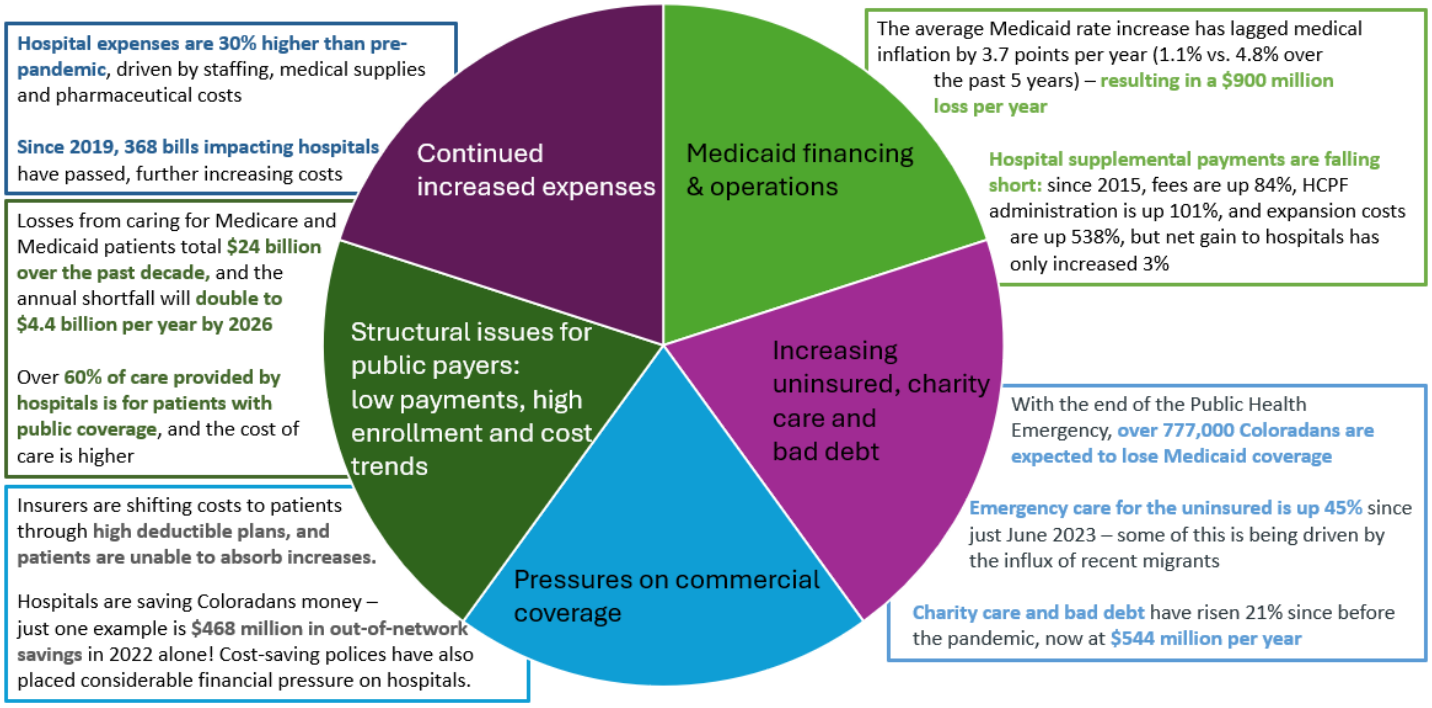
State Policy Solutions to Address Crucial Health Care Challenges
Mar. 29, 2024

Overview

Colorado hospitals are facing dramatically increasing uncompensated and undercompensated care, which has contributed to more than 59 percent of Colorado hospitals posting negative operating margins, with 70 percent of the state's hospitals below the threshold needed to ensure long-term sustainability. The vitality of Colorado's health care delivery system is under threat, and the statistics are staggering.



These structural problems in Colorado's health care delivery system demand strong dedication and comprehensive solutions in both the immediate and longer term. State policies can move the needle on these issues, representing an opportunity to collectively support patients and providers now and into the future.

Through CHA and as individual organizations, Colorado hospitals have been longstanding and stalwart champions of expanded health care coverage, sustainable reimbursement rates, and a wide range of state and federal policies that support and enhance access to care for all Coloradans. We are driven to find win-win policy solutions that improve conditions for all stakeholders – including all hospitals – and stand ready to partner with the Polis administration and the legislature to lead these efforts and achieve our shared goals.

Summary of Recommendations

Included here are additional details on these structural issues and solutions that would help ensure Colorado's health care delivery system can continue to serve all Coloradans. In summary, the state must take immediate action on the following items:

1. **Provide support to hospitals by taking full advantage of allowable federal Medicaid funds.**
   Immediate priority: Set the Upper Payment Limit to 100 percent in perpetuity to draw down additional federal dollars and recoup funds for the two most recent fiscal years, as allowed under federal law. New funding should directly support Colorado hospitals through the state's existing CHASE program.

2. **Improve performance on Medicaid redetermination to maintain coverage for Coloradans.**
   Immediate priority: Adopt practices from high-performing states, such as dramatically expanding ex parte renewals, and increase assistance for patients ineligible for Medicaid to get commercial coverage.

3. **Immediately address RAC issues and refocus HCPF budget to prioritize patients.**
   Immediate priorities:
   - Immediately cease Medicaid RAC audits regarding suspected COVID admissions and immediately adopt significant and meaningful reforms to the RAC program, as proposed by CHA more than a year ago.
   - HCPF's budget should be "right sized" and refocused in the wake of the PHE to prioritize patients and improve efficiency.

4. **Actively oppose devastating ballot initiatives (Peer Review and Liability Caps) that threaten health care affordability, patient safety, and access.**
   Immediate priority: The administration should oppose ballot initiatives to eliminate peer review and increase health care costs for Coloradans by eliminating liability caps. The administration should push for reasonable adjustments to liability caps for non-economic damages in the legislature by supporting Senate Bill 24-130.

Challenge #1: Hospitals bear a heavy burden of uncompensated and undercompensated care.

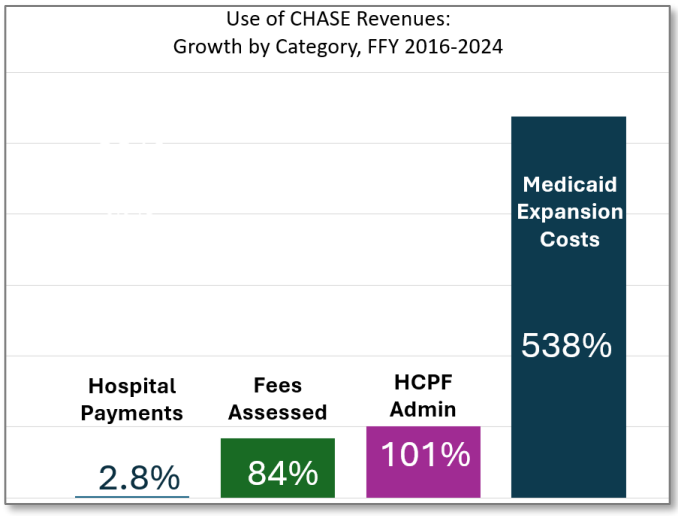
Payment rates for Medicare and Medicaid chronically fall short of the cost of providing care. These payment rates are falling further behind by not keeping pace with inflation, yielding the following results:

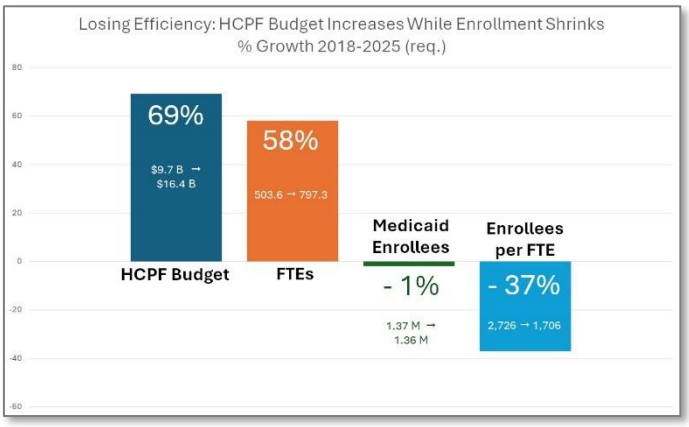
- Over the last 5 years, the average annual rate increase for Medicaid has fallen short of health care inflation by 3.7 points per year: 1.1 percent versus 4.8 percent– resulting in $900 million in annual payment shortfall for Medicaid alone
- Medicare and Medicaid payment shortfalls to hospitals over the past decade total $24 billion
- Annual payment shortfalls to hospitals for Medicare and Medicaid are projected to reach $4.4 billion per year by 2026

These trends are unsustainable, particularly for hospitals that already have nonexistent or narrow margins.

Colorado's landmark Hospital Affordability & Sustainability Enterprise (CHASE) supplemental payment program is intended to reduce Medicaid payment shortfalls to hospitals and increase coverage for Medicaid enrollees. However, the program has failed to keep pace with funding demands and has thrust the burden of enormous increases in payment shortfalls and uncompensated care onto hospitals. While hospital payments have increased just 2.8% since FFY 2016, costs for HCPF administration of the program are up 101% and costs for Medicaid expansion up a staggering 538%.

This is particularly problematic for hospitals, many of which are rural, without enough commercially insured patients to balance payer trends.





Beyond the CHASE fee, HCPF's budget has increased dramatically and demonstrated an inability to flex staff to expected enrollees. Although Medicaid enrollment is projected to have a net decreased since 2018, HCPF staffing levels and budget have increased dramatically.[1]

We are grateful to the Joint Budget Committee (JBC) for acknowledging Medicaid underfunding and working to increase the across-the-board Medicaid rate increase for SFY 2024-25 from the Governor's proposal of 0.5 percent to 2.5 percent, although significant underpayment will persist.

[1] Analysis of HCPF Budget documents SFY 2017-18 through SFY 2024-25.

Solutions: Improve coverage rates and draw down additional allowable federal funds to increase Medicaid payments to providers.

1. **Immediate Priorities:**
    a. **Upper Payment Limit:** HCPF should enhance hospital reimbursement within the current CHASE supplemental payment program and draw down the allowable federal share by increasing the Upper Payment Limit (UPL) from 97 percent to 100 percent. This should be done prospectively on an annual basis ***and*** is permitted to be applied retrospectively for two years. Funds should be solely directed to hospitals consistent with the statutory structure and intent of the current CHASE program. CHA has provided additional detail to support operationalizing this recommendation in Appendix A.

    If full funding were achieved immediately, over $113.5 million could be provided to hospitals – supporting continued access to care, particularly for Medicaid and uninsured patients, and improved viability for at-risk hospitals.

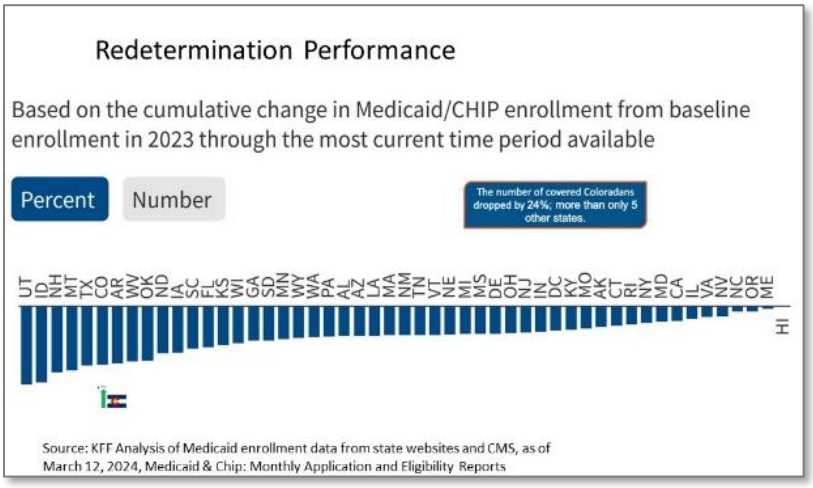
2. **State Directed Payment Program:** Colorado should follow the lead of 42 other states by partnering with CHA to develop a state directed payment program in the next several months.[2] These federal programs provide enhanced funding to offset losses related to Medicaid managed care. Managed care is currently not part of the CHASE program, and accounts for 10-15% of hospital costs for Medicaid patients. Initial estimates suggest over $100 million of net new funding per year could be brought into Colorado.

3. **CHASE Program Improvements:** Work within the existing CHASE program to improve program transparency and improve the integrity of payments funding state administrative costs, Medicaid expansion costs, and distribution of payments to hospitals. The Department should also avoid redirecting CHASE funds to state administrative costs in favor of maximizing support to hospitals that serve the state's Medicaid and uninsured populations.

[2] Centers for Medicare and Medicaid Services, Approved State Directed Payment Preprints, https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints

Challenge #2: Colorado faces a rapid rise in uninsured – and associated increases in uncompensated care – due to the end of the Public Health Emergency.

With the end of the Public Health Emergency, over 777,000 Coradans are expected to lose Medicaid coverage this year, making **Colorado the worst-performing Democratically controlled state in the nation.**



- The number of Coloradans with health care coverage has dropped by 24 percent – more than only five other states[3]
- Colorado has disenrolled 48 percent of Medicaid members – more than only seven other states[4]
- Only six percent of those pre-screened by HCPF as eligible for commercial coverage are actually converting into coverage[5]

HCPF has urged caution in using multi-state comparisons that fail to account for differences among states, but comparing performance solely to Colorado's pre-PHE disenrollment experience assumes re-enrollment performance was optimal before COVID.

Of 30 options provided by CMS to support state efforts to keep Medicaid enrollees covered, CO has implemented only seven. States that use ten or more waivers have a lower disenrollment rate than Colorado. Colorado hospitals have been actively leading efforts to improve Colorado's performance, alongside provider and patient advocacy organizations, with opportunities outlined in Appendix B. However, hospitals are already experiencing early impacts from losses in coverage:

- Emergency care for the uninsured is up 45 percent since just June 2023[6]
- Hospitals currently provide $544 million in charity care and bad debt, up 21 percent since before the pandemic[7]

Further, Colorado's current Hospital Discounted Care program disincentivizes Medicaid enrollment, shifting costs from the state directly onto hospitals – CHA appreciates HCPF's support for SB 24-116 to help address this concern. We also appreciate that Cover All Coloradans will expand coverage for children and pregnant persons regardless of their immigrant status beginning on Jan. 1, 2025 and that OmniSalud currently covers 11,000 undocumented individuals. Unfortunately, with Colorado's uninsured rate already growing, these efforts barely scrape the surface of uncompensated care hospitals are providing.

[3] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Mar 4, 2024. Five states with a higher percentage of lost coverage include ID, UT, NH, MT, TX.
[4] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Mar 4, 2024. Seven states with higher disenrollment figures include UT, MT, SD, OK, ID, TX, GA.
[5] HCPF Statement, Feb. 27, 2024
[6] CHA DATABANK, Feb. 2024
[7] Uninsured care data from CHA Claims. Charity care and bad debt from 2024 Hospital Financial Transparency Report, https://hcpf.colorado.gov/hospital-financial-transparency

Solutions: Improve performance on Medicaid redetermination to maintain coverage for Coloradans through Medicaid or commercial coverage.

1. **Immediate Priority: Medicaid Retention and Conversion to Commercial Coverage:** The state should adopt practices from high-performing states and increase assistance for patients ineligible for Medicaid to get commercial coverage. This includes action to implement a short-form application, expedite application processing, further expanding ex parte renewals, and increase strategic marketing about available subsidies.
    a. Pursue additional federal waivers to streamline the reenrollment process and reduce the procedural denial rate
    b. Work with the federal government to ensure that emergency Medicaid coverage is as inclusive as possible
    c. Further streamline the lengthy and arduous Medicaid application process
    d. Ensure effective and efficient use of previously allocated state resources by improving coordinated marketing between HCPF, the RAEs, and Connect for Health Colorado
    e. Increase training and targeted education messaging for counties with low commercial conversion rates
    f. Expedite passage and implementation of presumptive eligibility options created under SB 24-116
    g. Collaborate with other states to leverage their best practices

Challenge #3: Hospitals face extreme administrative burdens attempting to provide care to the 1 in 4 Coloradans covered by Medicaid.

As described above, hospitals continue to experience significant financial challenges as a result of their commitment to care for patients covered by Medicare and Medicaid, while also facing high levels of administrative burden.

Colorado's RAC program requires immediate action. Hospitals are committed to Medicaid integrity, evidenced in part by our support of HCPF's HB 24-1146. However, Colorado's RAC program is among the most aggressive in the nation, unjustly clawing back money from providers. Currently, the program is recouping funds related to suspected COVID patients admitted to inpatient care for sepsis and respiratory conditions during the (PHE). Two examples include:

- Colorado comprises 67% of HCA Healthcare's nationwide RAC account activity, despite being home to just 7 of their 180+ hospitals.
- Banner Health reports that CO Medicaid patients are 40 times more likely than other patients to receive a retroactive payment denial.

In contrast, models from other states – including the 34 states and DC that have received federal approval not to conduct Medicaid RAC audits – demonstrate other pathways to maintaining high program integrity standards without the aggressive, burdensome, and litigious nature of Colorado's program.[8]

Additionally, HCPF's hospital reporting requirements have expanded significantly in recent years, creating considerable administrative work, redundancy and lack of clarity, and an overwhelming amount of information without meaningful value to stakeholders. Over 500 pages were published by HCPF in Feb. 2024 for multiple different reports and, at the same time, hospitals are also reporting considerable new information on pricing and costs publicly due to new federal requirements.[9]

Issue	Status- 3/18/2024
Improve Hospital Discounted Care (HDC)	**In Progress:** Partnership on SB 24-116
Improve RAC processes (HB 23-1295)	**In Progress:** Monthly SME meetings, commitments on specialty audit, volume, communications, rebilling, and provider advisory group.
Streamline duplicative reporting	**In Progress:** HCPF willingness to streamline, details TBD
Streamline Inpatient Hospital Review Program	**In Progress:** Step 1 indefinitely on hold, Steps 2 and 3 pending further work.
Reduce HTP engagement burden	**Pending**
Simplify Medicaid applications	**Pending**
Ensure access to specialty drugs	**HCPF Solution Proposed:** OP/IP at 97% invoice cost
Enhance rural payments/ sustainability	**Pending**
Monitor and improve redetermination issues	**In Progress:** ex parte renewals, procedural denials
Approve COPA (SB 23-298) proposals	**First application approved**

HCPF has made progress on a number of areas in partnership with CHA over the past several months, including improvements in the RAC program, Inpatient Hospital Review Program (IHRP), and high-cost drugs pursuant to a joint CHA-HCPF priorities workstream begun in Aug. 2023. However, additional immediate action is essential.

[8] Government Accountability Office. CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program. Jun. 28, 2023.

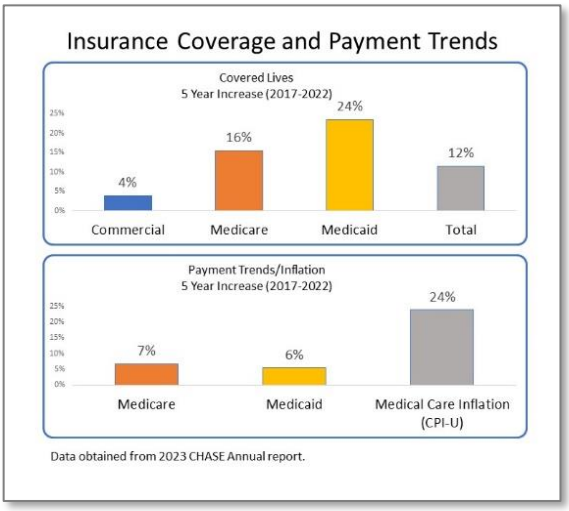
[9] These included the CHASE Annual Report (including reporting on the Hospital Transformation Program and the Hospital Quality Incentive Program), the Hospital Expenditure Report, Community Benefit Report, Price Transparency Reporting, and the Hospital Payment Variation Tool.

Solutions: Immediately address RAC issues and aggressively "right size" and refocus HCPF budget to prioritize patients.

1. **Immediate Priority: Recovery Audit Contractor Program:** Immediately cease Medicaid RAC audits related to suspected COVID patients admitted to inpatient care during the COVID Public Health Emergency for sepsis and respiratory conditions. Further, immediately adopt significant and meaningful reforms to the RAC program to align it with national best practices, as proposed by CHA more than a year ago. Additional detail is provided in Appendix C, but urgent reforms must include:
   a. Reducing the lookback period from seven to three years
   b. Reducing the number of record requests
   c. Limiting the contingency payment to the Medicare standard
   d. Prohibiting nonpayment for legitimate care provided
   e. Ensuring sufficient expertise for medical necessity reviews

2. **Immediate Priority: Refocus and "Right Size" the HCPF Budget:** As the state struggles to fully fund many priorities and hospitals strive for affordability, administrative efficiency is paramount. While CHA supports HCPF having resources sufficient to do its core work, we are concerned that administrative efficiency has dropped 37 percent since 2018 and request a high degree of scrutiny for administrative costs, particularly as we transition out of the Public Health Emergency. Several opportunities to refocus HCPF and/or hospital efforts on patients include:
   a. **HCPF Reporting:** Colorado should overhaul and streamline HCPF hospital reports to improve value and reduce unnecessary administrative burden on both HCPF and hospitals.
   b. **Inpatient Hospital Review Program:** Colorado should take action to streamline the post-admission review process in the Inpatient Hospital Review Program (IHRP) 2.0 (Steps 2 and 3) and focus on meaningful opportunities for discharge assistance.
   c. **Hospital Transformation Program (HTP):** The HTP program requires extensive reporting on multiple measures that differ from industry standards. While measures should be evaluated and refocused to improve value in the current iteration of HTP, considerable strategic planning in partnership with hospitals is essential to begin soon to jointly develop what will follow when HTP sunsets in 2026.
   d. **Accountable Care Collaborative:** In the next iteration of the Accountable Care Collaborative, the Department should avoid proposals that would add additional care coordination burdens to hospitals without appropriate reimbursement or meaningful clinical impact.

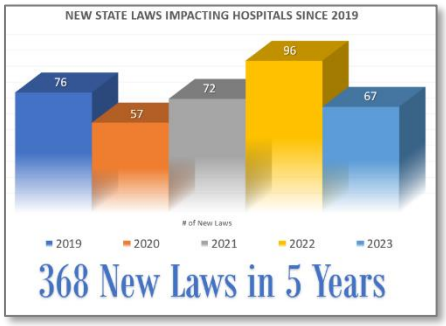
Challenge #4: Hospitals are experiencing financial strain after years of making considerable contributions to affordability, access, and quality.



Hospitals continue to manage a challenging post-COVID environment. While the Public Health Emergency has ended, recovery is still underway in the health care community. To highlight just three converging factors:

- Incidents of workplace violence are up dramatically
- Expenses are up 30 percent over pre-pandemic levels,
- Colorado has passed 386 laws impacting hospitals since 2019

Together, these create untenable pressures on frontline health care workers and administrators alike, further contributing to burnout, exacerbating a pre-existing workforce shortage, and resulting in high turnover at all levels.



Despite these challenges, Colorado hospitals are committed to improving affordability and saving Coloradans money on health care. Based on data provided by the Division of Insurance, hospitals are contributing more than **$1.2 billion** toward greater affordability in the form of increased fees (to support reinsurance) and lower payments from commercial insurers (in support of Colorado Option and elimination of surprise billing).

Finally, we appreciate the Governor's partnership on health care workforce development and supports and are grateful for the historic state investment of $63 million in SB 22-226, which was matched by private workforce investments of over $1 billion in 2020-2021 alone. These partnerships demonstrate our ability to find win-win solutions together that result in positive outcomes for our employees and the patients and communities we serve.

Solutions: Actively oppose devastating ballot initiatives that threaten health care affordability, patient safety, and access.

The Governor should actively oppose ballot initiatives to eliminate peer review and increase health care costs for Coloradans by eliminating liability caps. The administration should actively support reasonable adjustments to liability caps for non-economic damages in the legislature by supporting Senate Bill 24-130.

- For nearly 40 years, Colorado has supported lower health care costs through statutory caps on medical liability claims and ensured doctors and other health care providers can improve patient safety and care quality by confidentially sharing their experiences.
- Ballot Initiatives #149 and #150 would eviscerate these protections and cause additional downstream challenges that will have a detrimental effect on quality, interfere with the provider-patient relationship, and increase health care costs.
- The health care community has partnered to address key concerns of these initiatives' proponents by offering a series of reasonable compromises on Colorado's statutory cap for medical liability claims.
- Colorado hospitals support fair compensation for individuals harmed by medical errors; however, we will not sacrifice our commitment to patient safety in order to line attorneys' pocketbooks.
- We need the Governor's support to ensure a reasonable solution is reached.

APPENDIX

Appendix A: UPL Recommendation Detail

Introduction

Upper payment limit (UPL) demonstrations for Colorado are a determinative factor in federal matching funds Colorado receives through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). Significantly, the partnership inherent in the CHASE – and part of its constitutionally-required business purpose – is to leverage fees paid by hospitals to generate additional federal funds to offset the need for state general funding ***for hospital reimbursement***.

While state statute requires HCPF to maximize the UPL calculation to fulfill this partnership, the UPL has been unnecessarily restricted to amounts below what is allowed under federal rules, leaving significant federal funds "on the table" that would otherwise go to support payments to hospitals, Medicaid coverage, and HCPF administrative costs, as required by state law. The current calculations fall short in two distinct ways:

1. The current calculations establish a "false ceiling" below 100% of allowable costs
2. The current calculations do not include the totality of Medicaid costs by excluding some hospitals and failing to account for Colorado Medicaid enrollees that receive care outside of Colorado

Analysis

1. The current calculations establish a "false ceiling" below 100% of allowable costs.

The current UPL calculations are currently set at 97.2% of allowable costs for hospitals that receive supplemental payments in the CHASE model. Furthermore, in the four most recent model years where UPL was the limiting factor for the CHASE fee model, the UPL has ranged from 96.5% to 97.2%. If adjusted to 100% of allowable costs immediately, over $113.5 million could be provided to hospitals – supporting continued access to care, particularly for Medicaid and uninsured patients, and improved viability for at-risk hospitals.

We appreciate that HCPF has previously expressed concern over audit risk if the UPL is set at 100%. However, based on a review of experience from other states and federal statements, their concern is misplaced. UPL is described as a "reasonable estimate" of what Medicare would pay and is based on prospective estimates.[10] By definition, the UPL calculations are not intended to be retrospectively evaluated or audited since CMS has prospectively determined the estimates are reasonable. As evidence, CMS has not required Colorado, or any other state, to perform a retrospective reconciliation of its UPL. The Medicaid and CHIP Payment and Access Commission (MACPAC) has confirmed that UPL demonstrations are not audited or reconciled with other sources.[11] CMS comments on the practice used by many states to make additional supplemental payments - "Where Medicaid base payments are below the aggregate UPL calculation, states have the ability to make supplement payments to providers, by ownership group, up to the calculated limit."[12]

2. The current calculations do not include the totality of Medicaid costs by excluding some hospitals and failing to account for Colorado Medicaid enrollees that receive care outside of Colorado.

UPL calculations refer to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.[13] Currently, only hospitals receiving supplemental payments through the CHASE program are included in the UPL calculation, which excludes psychiatric hospitals. In evaluating hospital UPL limits, all hospitals providing care within Colorado should be included. Additionally, to the extent that Medicaid patients receive care outside of Colorado, the UPL should include relevant hospital payment and cost estimates for those services.

[10] See 42 C.F.R Section 447.282; 447.321
[11] "Oversight of Upper Payment Limit Supplemental Payments to Hospitals," MACPAC, 37-38 (March 2019)
[12] See Medicaid Program; Medicaid Fiscal Accountability Regulation, 82 Fed Reg 63,722 (Nov 18, 2019)
[13] See 42 C.F.R Section 447.282; 447.321

Existing Colorado law requires Medicaid to maximize both inpatient and outpatient payments to hospitals up to UPL limits as defined in CMS regulations. Colorado's State Plan contains language identical to CMS regulations and permits Colorado to make supplemental Medicaid inpatient and outpatient payments up to, or "not to exceed", the UPL. Additionally, federal law allows states to adjust prior UPL filings and retrospectively apply new calculations to prior model years that fall within the CMS two-year filing deadline.

Recommendations

- HCPF should immediately implement the following modifications to the hospital provider fee (HPF) model prospectively beginning with the FFY 2023-24 model, and retrospectively update federal filings for the FFY 2021-22 and 22-23 model years:
    - Set the UPL to 100% of reasonable estimates
    - Develop UPL estimates based on all hospitals in Colorado
    - Include estimates of care provided to Colorado Medicaid patients in UPL estimates using best practices from other states to establish methodology

- Retrospective payments resulting from retroactive corrected filings for FFY 2021-22 and 22-23 and 100% of additional federal funds received on a go-forward basis should be allocated to hospitals as supplemental payments, consistent with the CHASE statute.

Appendix B: Redetermination Improvement Detail

Colorado's Medicaid application and enrollment processes have major and long-standing systemic challenges that were exacerbated by the COVID-19 public health emergency (PHE) "unwind." While HCPF initially projected a net Medicaid enrollment decrease of 16% in December 2023, it now stands at a net 22% decrease - 519,000 Coloradans losing coverage. **The state should adopt practices from high-performing states to address short-term needs and long-term reforms and build upon the seven federally-approved 1902(e)(14)(A) waivers currently being implemented to address unwinding challenges by implementing 14 additional waivers.**

Immediate Solutions

- **Publish disaggregated data by county on a monthly basis**
  - Transparent and clear data regarding the areas in Colorado where residents are experiencing coverage losses is essential to more effectively direct resources.
- **Leverage available federal flexibilities.**
  - Colorado has implemented seven federally approved 1902(e)(14)(A) waivers to address unwinding challenges but should explore 14 additional waivers (as described in the chart below). There is an appetite in D.C. to extend some or all of these flexibilities beyond their current expiration at the end of this year. Colorado should immediately implement these waivers and advocate for federal extensions.
  - We appreciate the Department's work on House Bill (HB) 24-1400, Medicaid Eligibility Procedures, to make four authorities permanent (increasing ex parte renewal rates and decreasing procedural terminations).
- **Expand options for hospitals to become presumptive eligibility sites for all Medicaid eligible patients who visit our facilities.**
  - We appreciate the Department's partnership on Senate Bill (SB) 24-116, Discounted Care for Indigent Patients to increase coverage for Medicaid eligible Coloradans.
- **Leverage the Regional Accountable Entities (RAEs):**
  - The Department should require RAEs to examine and report to HCPF how they can increase counties' capacity to process eligibility and renewal applications.
  - The RAEs should also provide or fund enrollment assistance staff at local public health agencies, local community-based organizations or clinics that offer enrollment and renewal assistance for RAE members.

Long-Term Reforms

- **Convene a task force to improve the Medicaid application and renewal process**
  - The Department should convene a task force to streamline Colorado's application and renewal process.
- **Replace or update the Colorado Benefits Management System (CBMS)**
  - CBMS is antiquated and bogged down by numerous makeshift solutions that discourage prompt benefits approval and renewal.

- **Explore a solution to Colorado's county-based eligibility and enrollment system**
    - Colorado is one of only ten states with a state-supervised, county administered enrollment system. Certain counties continue to experience documented processing backlogs. Colorado should evaluate other states' models.

Federal Waiver Opportunities

In Place in Colorado	Additional Waivers to Pursue
• 4 to increase ex parte renewal rates • 1 to update contact info • 1 extending the timeline on fair hearing requests • 1 to support enrollees with renewal form submission or completion to reduce procedural terminations	• 7 to increase ex parte renewal rates, including strategies to verify assets, income, other benefits, and implement additional ex parte processes • 3 to update contact information • 1 to support enrollees with renewal form submission or completion to reduce procedural terminations • 1 to facilitate reinstatement of eligible individuals for procedural reasons • 1 strategy related to fair hearings • 1 strategy to delay resumption of Medicaid premiums

Scoring System: *This system is based on success in other states and potential alignment with Colorado's existing systems.*			
In use in CO	**High Priority**	**NA or Undetermined/Low Priority**	
Ex Parte Renewal Waivers			
Topic	**Waiver Authority**	**Details and Additional Information Provided by CMS**	**Colorado Viability**
1. SNAP Strategy (MAGI) *In use in 27 states/ territories (including CO).*	Enroll and/or Renew Individuals Based on SNAP Eligibility (MAGI)	Redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income program and assets, as applicable, are below applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs. This strategy is also available for states to use at application. Additional considerations may apply to states seeking to implement this authority for individuals enrolled in Medicaid on a non-MAGI basis	In use in CO
2. SNAP Strategy (Non-MAGI) *In use in 10 states/ territories (AK, AR, DC, IN, MD, MI, MN, NY, OK, TN).*	Enroll and/or Renew Individuals Based on SNAP Eligibility (Non-MAGI)	Redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income program and assets, as applicable, are below applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs. This strategy is also available for states to use at application. Additional considerations may apply to states seeking to implement this authority for individuals enrolled in Medicaid on a non-MAGI basis	NA for CO
3. TANF Strategy (MAGI) *In use in 9 states/ territories (including CO).*	Enroll and/or Renew Individuals Based on TANF Eligibility (MAGI)	Redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income program and assets, as applicable, are below applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs. This strategy is also available for states to use at application. Additional considerations may apply to states seeking to implement this authority for individuals enrolled in Medicaid on a non-MAGI basis	In use in CO
4. TANF Strategy (Non-MAGI) *In use in 4 states/ territories (IN, MI, MN, TN).*	Enroll and/or Renew Individuals Based on TANF Eligibility (Non-MAGI)	Redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income program and assets, as applicable, are below applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs. This strategy is also available for states to use at application. Additional considerations may apply to states seeking to implement this authority for individuals enrolled in Medicaid on a non-MAGI basis	NA for CO

5. 0% Income Strategy *In use in 37 states/ territories (including CO).*	Renew Medicaid Eligibility for Individuals with No Income and No Data Returned on an Ex Parte Basis	Complete a Medicaid income determination at renewal without requesting additional information or documentation if: (1) the most recent income determination was no earlier than 12 months prior to the beginning of the COVID-19 PHE (i.e., March 2019) and was based on a verified attestation of zero-dollar income; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received.	In use in CO
6. 100% Income Strategy *In use in 20 states/ territories (including CO).*	Renew Medicaid Eligibility for Individuals with Income at or below 100% of Federal Poverty Level (FPL) and No Data Returned	Complete a Medicaid income determination at renewal without requesting additional information or documentation if: (1) the most recent income determination was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019) and was based on verified income at or below 100% FPL; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received. This strategy may be especially beneficial to improve ex parte rates for individuals who are selfemployed, especially in states not using tax data as part of an ex parte determination.	Top CHA priority-waiver approved-will be in use in April 2024.
7. Asset Verification System Strategy *In use in 24 states/ territories (GA, HI, ID, IL, IN, KS, KY, LA, MD, MI, MO, NV, NH, NM, NC, OR, TN, UT, VT, WA).*	Renew Medicaid Eligibility for Individuals for Whom Information from the Asset Verification System (AVS) Is Not Returned Within a Reasonable Timeframe	Assume no change in resources verified through the AVS when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe, and complete an ex parte renewal process without any further verification of assets. .	CO should explore this option.
8. Stable Income Strategy *In use in ten states/ territories (CA, HI, ME, MN, NV, NJ, NY, ND, VT, WI).*	Renew Medicaid Eligibility for Individuals with Only Title II or Other Stable Sources of Income Without Checking Required Data Sources	Complete an ex parte income determination at renewal without requesting additional information or documentation of income if: (1) the most recent income was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019); and (2) the beneficiary only had Title II Social Security or other stable income at the most recent determination.	CO should explore this option.
9. Streamlining Asset Determination Strategy *In use in 15 states/ territories (CA, DE, HI, KY, ME, MD, MA, MI, MN, NV, NY, RI, SC, VT, WY).*	Renew Medicaid Eligibility Based on a Simplified Asset Verification Process	Assume no change in resources verified through the AVS when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe, and complete an ex parte renewal process without any further verification of assets. .	Not in use in CO
10. Applying for Other Benefits Strategy *In use in 15 states/ territories (AK, AZ, CA, HI, IN, KS, KY, ME, MT, NE, NC, SC, TN, VT, WY).*	Suspend the Requirement to Apply for Other Benefits Under 42 C.F.R. 435.608	This strategy may be especially beneficial to minimize churn for individuals who meet all eligibility requirements, except for meeting the requirement to apply for other benefits to which they are entitled. This strategy would reduce the workload for eligibility staff who otherwise must follow up with beneficiaries whose coverage was continued despite not having applied for such other benefits per 42 C.F.R. 435.608 while the continuous enrollment condition described in section 6008(b)(3) of the Families First Coronavirus Response Act, as amended by the Consolidated Appropriations Act, 2023, was in effect. States may use this strategy to reduce procedural denials or terminations for failure to respond to requests for additional information regarding application for other benefits.	CO should explore this option.
11. Medical Support Cooperation Strategy	Suspend the Requirement to Cooperate with the Agency in	This strategy may be especially beneficial to minimize churn for individuals who meet all eligibility requirements, except for meeting the requirement to cooperate with medical support enforcement	CO should explore this option.

In use in 12 states/ territories (AK, AZ, CA, HI, IN, KY, MD, NV, NC, ND, SC, TN).	Establishing the Identity of a Child's Parents and in Obtaining Medical Support	or establish good cause for not doing so. This strategy would reduce the workload for eligibility staff who otherwise must follow up with beneficiaries whose coverage was continued despite not having met medical support cooperation requirements per Section 1902(a)(45), Section 1912, 42 C.F.R. 435.610, § 433.147, 433.145, and 433.148 while the continuous enrollment condition described in section 6008(b)(3) of the Families First Coronavirus Response Act, as amended by the Consolidated Appropriations Act, 2023, was in effect. States may use this strategy to reduce procedural denials or terminations for failure to respond to requests for additional information regarding medical support cooperation.	
12. Back End Ex Parte Strategy *In use in 15 states/ territories (AL, DE, ID, ME, MN, NE, NV, OH, PA, SC, SD, UT, VA, WA, WV).*	Ex Parte Attempt Prior to Termination	No information provided by CMS.	CO should explore this option.
13. Other Ex Parte Strategies *In use in five states (CA, KY, NJ, NY, NC)*	Other states utilize Title II disability income data, suspended requirements, and manual ex parte reviews.	No additional information provided.	The Department should connect with other states with "other" waivers with ex parte renewal rates above CO's rate of 49% (KFF): NC- 99%, KY- 84%, CA- 71%
Waiver flexibility to support enrollees with renewal form submission or completion to reduce procedural terminations			
Topic	**Waiver Authority**	**Details and additional information provided by CMS**	**Colorado Viability**
14. MCO Renewal Support Strategy *In use in 21 states/ territories (AZ, AK, DC, IN, KS, KY, MD, MA, MI, MS, NV, NM, ND, OH, RI, SC, TN, TX, UT, VA, WV)*	Permit Managed Care Plans to Provide Assistance to Enrollees to Complete and Submit Medicaid Renewal Forms	Permit Medicaid managed care plans to voluntarily (or contract with managed care plans to) assist their enrollees in completing the Medicaid renewal process, including completing certain parts of renewal forms. Managed care plans must limit their renewal form assistance to completing fields in the renewal forms with information provided by the enrollee, excluding any fields associated with managed care plan selection or the enrollee's signature. Managed care plans must not provide choice counseling (defined at 42 CFR § 438.2) services to their enrollees. State payment to managed care plans for work of this type conducted on behalf of the state must be separate from the actuarially sound capitation payments to plans.	Unclear viability in CO due to CO bifurcated managed care system
15. Authorized Representative Designation Strategy *In use in 12 states (including CO).*	Permit the designation of an authorized representative for the purposes of signing an application or renewal form via telephone without a signed designation	This strategy can maximize the effectiveness of assistors and other community partners who are assisting beneficiaries in completing their renewal form over the phone.	In use in Colorado
16. Telephonic Signature Recording Strategy	Waive the recording of the telephone signature from the applicant or beneficiary	This strategy can maximize the effectiveness of assistors and other community partners who are assisting beneficiaries in completing their renewal form over the phone.	CO should explore this option.

In use in 11 states/ territories (AL, CT, KY, MD, MN, NV, NM, SC, VT, WV).			
17. Simplified Renewal Form Strategy *In use in 1 state (AK).*	Use a simplified renewal form, only asking if an individual's income and assets (if applicable) remain below the eligibility standard	No additional information provided.	Low priority- untested
Strategies to Update Contact Information			
Topic	**Waiver Authority**	**Details and Additional Information Provided by CMS**	**Colorado Viability**
18. MCO Beneficiary Contact Update Strategy *In use in 32 states/ territories (AZ, AK, CA, DC, GA, HI, IL, IN, IA, KS, KY, LA, MA, MI, MN, MI, MO, NE, NV, NJ, NM, NY, ND, OH, OR, PA, SC, TN, TX, UT, VA, WA).*	Partner with Managed Care Plans to Update In-State Beneficiary Contact Information	No additional information provided.	Unclear viability due to CO's bifurcated system.
19. NCOOA and/ or USPS Contact Update Strategy *In use in 37 states/ territories (including CO).*	Partner with National Change of Address Database and/or United States Postal Service Forwarding Address to Update In-State Beneficiary Contact Information	No additional information provided.	In use in CO
20. Enrollment Broker Contact Update Strategy *In use in 6 states/ territories (DC, IN, LA, MI, NY, VA).*	Partner with Enrollment Brokers to Update In-State Beneficiary Contact Information	No additional information provided.	CO should explore this option.
21. PACE Contact Update Strategy *In use in 6 states/ territories (CA, DC, LA, ND, OR, VA).*	Partner with PACE Organizations to Update In-State Beneficiary Contact Information	No additional information provided.	CO should explore this option.
22. Other Contact Information Strategy *In use in 6 states/ territories (AR, ME, MA (2), OK, OR).*	These waivers allow states to obtain contact information from other sources, such as Qualified Health Plans.	No additional information provided.	CO should explore this option.

Strategies to Facilitate Reinstatement of Eligible Individuals for Procedural Reasons			
Topic	**Waiver Authority**	**Details and additional information provided by CMS**	**Colorado Viability**
23. State Agency Using Presumptive Eligibility (PE) Strategy *In use in zero states/ territories.*	Designate the state agency as a qualified entity (QE) to make determinations of PE on a MAGI basis for individuals disenrolled from Medicaid or CHIP	Under this strategy, the state agency completes the PE determination based on the submission of a renewal form or application, for individuals disenrolled for procedural reasons without also having to complete a PE determination for other applicants. Consistent with PE regulations at 435.1103(b), this strategy is only available for MAGI determinations. The PE period extends from the date of the PE determination by the state agency to the date a final determination of eligibility is made. This strategy is intended to provide PE only for individuals recently disenrolled for procedural terminations; it does not impact states' ability under the state plan to authorize qualified entities to make PE determinations for other individuals as well.	Low priority - untested
24. Other Qualified Entities Using Presumptive Eligibility (PE) Strategy *In use in zero states/ territories.*	Designate Pharmacies, CBOs, or Others as a Qualified Entity (QE) to Make Determinations of PE on a MAGI Basis for Individuals Disenrolled from Medicaid or CHIP	Under this strategy, the designated qualified entities would make PE determinations for individuals who were disenrolled for procedural reasons and with whom the entity comes into contact without also having to complete a PE determination for other applicants. The entity would encourage and/or assist the individual to complete their renewal form. Consistent with PE regulations at 435.1103(b), this strategy is only available for MAGI determinations. The PE period extends from the date of the PE determination by the qualified entity to the date a final determination of eligibility is made. This strategy is intended to provide PE only for individuals recently disenrolled for procedural terminations; it does not impact states' ability under the state plan to authorize qualified entities to make PE determinations for other individuals as well.	Low priority – untested
25. Reinstate Eligibility Back to Termination Date During Reconsideration Period Strategy *In use in 17 states/ territories (AK, CA, DE, DC, IN, KS, KY, ME, MA, MI, NM, NC, SC, TN, VA, WY).*	Reinstate eligibility effective on the individual's termination date for those procedurally disenrolled and subsequently redetermined eligible during the reconsideration period	This strategy reduces burden on state eligibility workers by eliminating the need to verify eligibility during the retroactive eligibility period prior to the date or month in which the renewal form was returned. It also will enable states to retain the individual's original renewal cycle	CO should explore this option. **Currently in process*** **
26. Managed Care Plan Auto-Reenrollment Strategy *In use in 10 states/ territories (DE, DC, IN, KY, MI, MO, NH, NM, NC, SC)*	Extend automatic reenrollment into a Medicaid Managed Care Plan up to 120 Days After a Loss of Medicaid coverage	Permits states to temporarily automatically reenroll individuals into a managed care plan who are reenrolled into Medicaid after a loss of Medicaid coverage for up to 120 days, instead of up to 2 months, as required under 42 CFR 438.56(g). States may elect time periods between 60 and 120 days.	Unclear viability in CO due to CO bifurcated managed care system
27. Other *In use in 0 states/ territories.*	NA	NA	Low priority- untested

Other Strategies			
Topic	**Waiver Authority**	**Details and Additional Information Provided by CMS**	**Colorado Viability**
28. Fair Hearings Timeframe Extension Strategy *In use in 25 states (including CO).*	Extend Timeframe to Take Final Administrative Action on Fair Hearing Requests		In use in CO
29. Other Strategies Related to Fair Hearings *In use in 2 states (CA, NJ).*		No additional information provided.	CO should explore this option.
30. Medicaid Premium Resumption Delay Strategy *In use in 8 states (ME, MI, MN, NC, ND, OH, WV, WY).*	Delay Resumption of Medicaid Premiums Imposed Under the State Plan Until After a Redetermination of Eligibility	No additional information provided.	CO should explore this option.

Appendix C: RAC Audit Detail

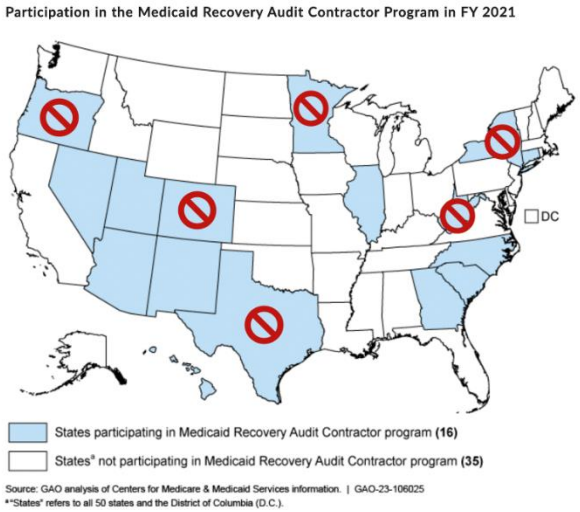
Medicaid RAC audits, under the supervision of the Department of Health Care Policy and Financing (HCPF), are a method for ensuring Medicaid payments are appropriately made to health care providers for services delivered to Medicaid enrollees. While federal law sets basic requirements for Medicaid RAC audits, states have significant leeway to alter programs at the state level.[14]

While Medicaid payment reviews and audits have value to ensure the state's resources are safeguarded from fraud, these reviews and audits should be warranted, effective, and efficient. Doctors and hospitals are steadfastly committed to compliance and stewardship of Medicaid dollars, but audits are incredibly time consuming and are often driven by "bounty hunting" financial incentives, without regard to patient needs and patient care actually provided.

Colorado's aggressive approach to Medicaid RAC audits threatens access to care and the integrity of Colorado's Medicaid program. Over the past several years, providers have identified significant transparency, accountability, and efficiency failures that have led to considerable administrative burden, unwarranted recoupments, and considerable litigation activity – all of which increases health care costs and jeopardizes provider participation in the Medicaid program.

Of the 16 states with RAC programs, only 6 states have lookback periods beyond federal law (CO, MN, NY, OR, TX, WV).[15] As of March 29, the Department indicated their intent to hold the contractor to a three-year standard.

Following over a year of collaboration, the Department recently shared a list of twelve program enhancements they plan to make to Colorado's RAC program. We appreciate the Department's partnership and willingness to work with the hospital community on improvements. Hospitals are deeply committed to compliance and stewardship of Medicaid dollars and support review processes that are warranted, effective, and efficient.



Since late 2022, CHA has engaged with HCPF and the Joint Budget Committee on a list of ten reforms to the RAC program. As of March 29, below is a list of where those reforms stand and <u>immediate actions</u> the Department should take:

1. **Immediately resolve place of service concerns**
    - HMS has been applying a standard to inpatient claims that we do not know and that does not appear to comport with HCPF billing guidance prior to Oct. 20, 2023. We are grateful for the plan to include additional Department oversight over this process in the future. We recommend that we use this situation as a test case to expeditiously resolve this confusion.
2. **Immediately cease the RAC audit clawing back payment for suspected COVID admissions involving sepsis and respiratory distress during the height of the PHE.**
    - CHA recently became aware of an unconscionable audit that flies in the face of hospitals' and clinicians' efforts to provide adequate care for patients through a global pandemic with rapidly evolving clinical recommendations and standards.

[14] 42 CFR § 455.508(f)

[15] Government Accountability Office, https://www.gao.gov/products/gao-23-106025

3. **Conduct an independent review of recent audits to ensure compliance with coding practice standards and Colorado law and increase medical oversight.**
    - CHA has been engaged in several disputes with the Department about the "right" way to code with ongoing confusion.
    - We appreciate the acknowledgement that the contractor should be held to clear billing practices that align with HCPF billing procedures and steps that are in place.
4. **Address the significant volume concerns**
    - The current volume levels are unsustainable and make it difficult, expensive, and time-consuming for hospitals and health systems to meaningfully participate in the review process.
    - CHA appreciates the Department's commitment to a fair and balanced process and would ask for adjustments to the claims and tiers limits.
    - For less than 50% of hospital capacity in the state, since the beginning of 2023, hospitals and health systems have experienced audits for over $368.8 million in services provided to Medicaid clients.
5. **Reduce the length of the lookback period to three years and limit the number of records the RAC contractor may request**
    - We greatly appreciated the update that HMS is only reviewing claims within the last three years and the recognition that audits further in the past are a burden on providers.
    - We request that the Department formalizes this change.
6. **Prohibit "nonpayment" for legitimate care provided and ensure reimbursements are sufficient to enable access to care.**
    - Currently, when RAC audits identify that a service could have been provided in a lower cost setting, they recoup the entire cost of the service, rather than the difference between high- and low-cost.
    - CHA appreciates the Department's commitment to automated rebilling and would ask for continued attention to this important issue to ensure that hospitals are fairly paid for the services they rendered.
7. **Improve engagement with providers, increase transparency, and take an education first approach.**
    - We believe the promised reforms will go a long way towards these goals, and CHA looks forward to continuing to work collaboratively on this goal.
8. **Pivot away from Inpatient Hospital Review Program (IHRP):**
    - We understand the Department's decision to focus on RAC retrospective audits instead of IHRP prospective prior authorization reviews (PARs). We would recommend communicating about the RAC enhancements and commitment to not reinstitute the IHRP PARs at the same time.
    - This would provide important clarification about the Department's utilization management goals.
9. **Place a limit on the RAC Audit contractor's "bounty-hunting" contingency payments**
    - The federal maximum contingency rate is 12.5% for all services except for durable medical equipment.
10. **Allow appeal decisions made by the Office of Administrative Courts (OAC) to have precedential value.**
    - Currently, appeals must be pursued on each incident, and decisions of OAC do not have precedential value that extends to other appeals. This increases burdens on providers and increases health care costs.

Below is a list of all promised reforms cross-walked with previous CHA recommendations to improve the RAC program (as of Mar. 29). In summary:

Sufficient Commitment Made- *HCPF acknowledged the problem and is working with CHA on solutions*	**Interim Commitment Made-** *HCPF acknowledged the problem, need for further commitment*	**No Commitment Made** *These concerns could be resolved by addressing the volume issue*
• Increase Clinical Oversight • Increase Transparency • Promote Education • Fix the Initial Hospital Care Codes Audit	• Decrease volume • Establish a Three-Year Lookback • Stop clawing back payments for COVID-19 Admissions • Permanently Stop the Inpatient Hospital Review Program (IHRP)	• Establish Precedential Value • Decrease Auditor Contingency Payments

Program Operations		
Topic	**Background/ Ask**	**Status**
Clinical Oversight	CHA has been engaged in several disputes with the Department about the "right" way to code with ongoing confusion. It is important that the contractor be held to clear billing practices that align with HCPF billing procedures. **Ask:** Conduct an independent review of recent audits to ensure compliance with coding practice standards and Colorado law and increase medical oversight.	**On Mar. 27, HCPF committed to:** • *"Add a RAC physician to the HCPF Clinical Team to participate in the hospital level of care audit reviews. This physician will report to Dr. Pete Walsh, HCPF CMO and a past executive at Centura. The physician will observe exit conferences and manage informal reconsiderations, with final decision authority in collaboration with Dr. Walsh."* **Status:** CHA will closely track implementation of this enhancement to see if it improves the process.
Transparency and Collaboration	HB 23-1295 required a new provider advisory group and mandatory quarterly reporting. HB 23-1295 required a new quarterly report with: • Current and recently completed audits and reviews, • Summaries of the findings of the audits and reviews, • The number and amounts of overpayments and underpayments found • The number and results of the appeals, • The amount collected; and, • The error rate identified. The Dept. should continue to take steps to improve collaboration. **Ask:** Improve engagement with providers, transparency, and accountability.	***The quarterly report and advisory committee are expected within the next 60 days.*** **March 26/ 27:** • *"We will establish hospital-specific RAC workgroups to foster better collaboration and streamline communication between hospitals, HMS and HCPF."* • *"The Department will continue to update reporting on both the HMS and the Department's websites, including tiers, limits, overpayments, underpayments, audit protocols, educational resources, and overturn/uphold rates."* • *"HCPF is making a host of RAC website improvements, including navigation, Q&A, new system enhancements, and a separate landing page for hospitals. We will also publish a meeting recording archive as well as audit tiers for individual providers by Medicaid ID, findings, as has been requested."* • *"HCPF is creating template cover sheets to assist providers who wish to request informal reconsideration or submit formal appeals. The templates will include fields for providers to identify the particular claims and specify the clinical or other reason for the informal reconsideration request or appeal. It will also enable providers to submit any additional supporting documentation."* • *"We will ensure the RAC Advisory Committee Meetings are compliant with open meeting laws, as requested."* • *"HCPF will release a new tool detailing all active RAC audits with references to the billing manual as well as clinical/regulatory guidance links. This tool will be available on the website, after being reviewed for input from the RAC Advisory Committee in April."* **March 28:** • *"Our External Communications Liaison on the RAC team, Meghan, reached out to all Provider Advisory Board members. They were given dates all through April to provide their availability in a 3-hour block. Meghan is finalizing*

		the dates and is sending out the invite. We will also post the agenda, link, and the dates/times prior to the meeting so everyone is aware. We will further reach out to associations and release an email blast. We are really excited to get these meetings going." • *"We are actively drafting updates to the website now to have the reporting on the website prior to the May 2024 Stakeholder engagement, though we are aiming to get this done in the next few weeks. We will update you as soon as we get those posted."* **Status:** CHA will continue to closely track transparency measures, including the Office of the State Auditor (OSA) audit (*expected June 2024).*
Education	The current RAC process is incredibly opaque, and it can be difficult for providers to understand what billing practices are inaccurate and fix them. **Ask:** Take an "education first" continuous improvement approach to engaging providers and provide clear and transparent coding guidance when errors are identified.	March 27: • *"HCPF will be adding RAC audits to the HCPF provider training team's responsibilities."* **March 28:** • External communication promised about exit conference details that encourage hospitals to leverage this effective process, prior to an initial notice being sent out. **Status:** CHA will closely track implementation of this enhancement.
Volume ***Need for further commitments***	It is incredibly time-consuming and expensive to comply with the current volume of audit requests. The current volume levels are unsustainable and make it difficult, expensive, and time-consuming for hospitals and health systems to meaningfully participate in the review process. **Ask:** Decrease the claims and tiers limits.	HCPF committed to work with hospitals on volume issues during the hospital leadership meeting on Feb. 22 and CHA'S Hospitals on the Hill meeting. **March 27:** • *"The Department will commit to continuing to evaluate claims tiers and limits and will make adjustments as needed for all providers to ensure we comply with federal requirements while ensuring a fair and balanced approach."* **CHA Ongoing Ask:** Immediately reduce the tier limits or develop a collaborative process with the new hospital working group to determine appropriate levels.
Three-Year Lookback ***Need for further commitments***	Only six states have lookback periods beyond federal law. It is incredibly difficult to comply with audits for records before that period.	March 27 • *"While CMS and OIG have the right to claw back improper payments to states going back 10 years, and HCPF currently limits our look-back audit period for providers to seven years, HCPF is currently auditing within the three-year look-back period (not including the most recent timely filing year). The Department commits to pursuing a goal of auditing within the prior three years (not including the most recent timely filing year)."*

	Ask: Reduce the length of the lookback period to three years and limit the number of records the RAC contractor may request	**March 28:** • *"As we have gotten closer to real time for auditing claims, we are generally not reviewing claims with dates of service past 2020. In certain circumstances, we may still need to audit further back than three years, but our intent is to audit within the past 3-4 years, recognizing the additional year that providers have to bill (timely filing) is not included in this 3-year look back target. We will update our reporting and communications surrounding the lookback period so there is visibility for external stakeholders." (underlined NEW commitment)* **CHA Ask:** Formalize this commitment.
Precedential Value	When the Office of Administrative Courts (OAC) finalizes decisions, other providers should be able to use those determinations in their appeals. **Ask:** Allow appeal decisions made by the OAC to have precedential value.	Not addressed by HCPF as of March 27. **Status:** this could be resolved by fixing the overall volume issue.
Contingency Payments	The federal maximum contingency rate is 12.5% for all services except for durable medical equipment. **Ask:** Place a limit on the RAC Audit contractor's "bounty-hunting" contingency payments	Not addressed by HCPF as of March 27. **Status:** this could be resolved by fixing the overall volume issue.

Coding Issues		
Initial Hospital Care Codes Audit	On Jan. 30, the Department committed to pause the audit prospectively and rescind findings in informal reconsideration and appeal. The Department sent initial clarification on Feb. 26, 2024 – this only included the fix for the audit moving forward, not for the audits in informal reconsideration and appeal. On Feb. 28, 2024, they indicated this omission was unintentional and **Ask:** Stop this audit and resolve claims.	HCPF committed to a follow up memo clarifying those pieces- we are waiting for that memo. **March 28:** • *"We will be providing the communication about the initial hospital care codes next week so that you have that information to provide to your members. We will send out an email blast and will also post this publicly on our website. The memo clarifies the rules that are applied to claims in informal reconsideration and appeals. It also better defines what this audit looks like in the future."* • External communication promised **Status:** We expect this memo during the week of April 1.
	After the initial memo, members identified concerns with the new wording that prohibits providers in the same medical/ physician group from billing the initial code (regardless of	**March 28:** • We expect updates on this during the April 1 memo

	specialty). This impacts hospitals that operate physician groups "without walls." The memo also indicated that providers could not bill for these codes where the physician group owned or billed under the same Tax ID as the hospital. Our members indicated that this would also be a concern for their "practice without walls" model. **Ask:** Work with hospitals to address these concerns.	**Status:** On March 6, HCPF committed to work with hospitals on this on a case-by-case basis and adjust the audit if necessary.

Medical Necessity		
Place of Service	When a service was overpaid as inpatient when it could have been provided at a lower level of care, the RAC contractor claws back all the hospital's reimbursement. CHA argues that hospitals should be paid for the services they provide. There is a manual pilot program to allow hospitals to rebill those claims at the outpatient level. We are not aware of any approved rebills and HCPF limited the rebilling process to only claims in informal reconsideration. HCPF is working to program the claims system with a permanent, automatic process. **Ask:** Prohibit "nonpayment" for legitimate care provided and ensure reimbursements are sufficient to enable access to care, also fix the current pilot.	**March 27:** • *"We will have automated inpatient/outpatient re-billing in place within the July 1, 2024 promised target date, but likely earlier. We have paused additional notices for the hospital level of care audit in the interim. Notice letters are being updated to reflect the rebilling option currently in pilot. Concurrently, we are working on updated guidelines to allow for rebilling both before informal reconsideration and before a formal appeal."* **March 28:** • External communication promised on MCG and InterQual at informal reconsideration • Rebilling update promised **Status:** CHA will closely track this process.
	NEW CONSIDERATION MARCH 28: The rebilling pilot will be a huge help for areas where hospitals and the Department agree that care could have been provided at a different place of service. This issue is separate from an issue we learned about March 28 from our legal counsel - HMS has been applying a standard to inpatient claims that we do not know and that does not appear to comport with HCPF billing guidance prior to Oct. 20, 2023.	It is important to clarify that rebilling will only solve instances where it is appropriate for HMS to challenge place of service instances. On March 28, we became aware of an audit that appears to apply Oct. 2023 billing standards to claims filed before then and inappropriately deny an inpatient level of care. **Ask:** use this to test-drive the new HCPF oversight model and get Dr. Walsh, our lawyers, and HMS in a room now to resolve this confusion expeditiously.
COVID-19 Admissions ***Need for further commitments***	CHA recently became aware of an unconscionable audit that flies in the face of hospitals' and clinicians' efforts to provide adequate care for patients through a global pandemic with rapidly evolving clinical recommendations and standards. **Ask:** Immediately cease the RAC audit clawing back payment for suspected COVID admissions involving sepsis and respiratory distress during the height of the PHE.	On March 22, HCPF committed to clarify how the auditor is verifying COVID-19 in the medical record. CHA will use this to troubleshoot concerns (ex. Is HMS looking for a positive COVID-19 test during the time there was a testing shortage, etc.). March 28:

		• *"We are working to connect with them so that HMS' medical director, Dr. David Johnson and the senior medical director, Dr. Gary Call, can have a meaningful conversation about the clinical findings HealthOne is receiving. Based on the PHE-induced challenges and the outcome of the clinician-to-clinician conversations, we will update clinical findings, if needed. Again, clinician-to-clinician engagement is very productive."* **Status:** CHA will continue to seek clarification and make connections.
IHRP ***Need for further commitments***	SB 18-266 required HCPF to implement a hospital review program (IHRP) and that the program was suspended during COVID-19. IHRP 1.0 applied to all claims pre-admission (minus maternity and LTAC) and had significant technical difficulties. HCPF tested IHRP 2.0 in Spring of 2023 and never re-launched the PARs due to significant technical difficulties. HCPF still has authority to reinstitute pre-admission reviews (PARs) on all claims. The Department indicated that they need a robust RAC program because they have made a choice to stop all IHRP PARs. **Ask:** Formally commit to never resume IHRP PARs.	The Dept. committed to this verbally on March 22. **CHA Ask:** Formally commit to never resume IHRP PARs.

Updates not requested:

The Department will continue to ensure providers can adjust medical claims and correct information on those claims within the timely filing period and to self-identify those outside of it. The RAC program will wait until after the timely filing period (365 days) has expired before auditing claims.