COLORADO
Department of Health Care Policy & Financing

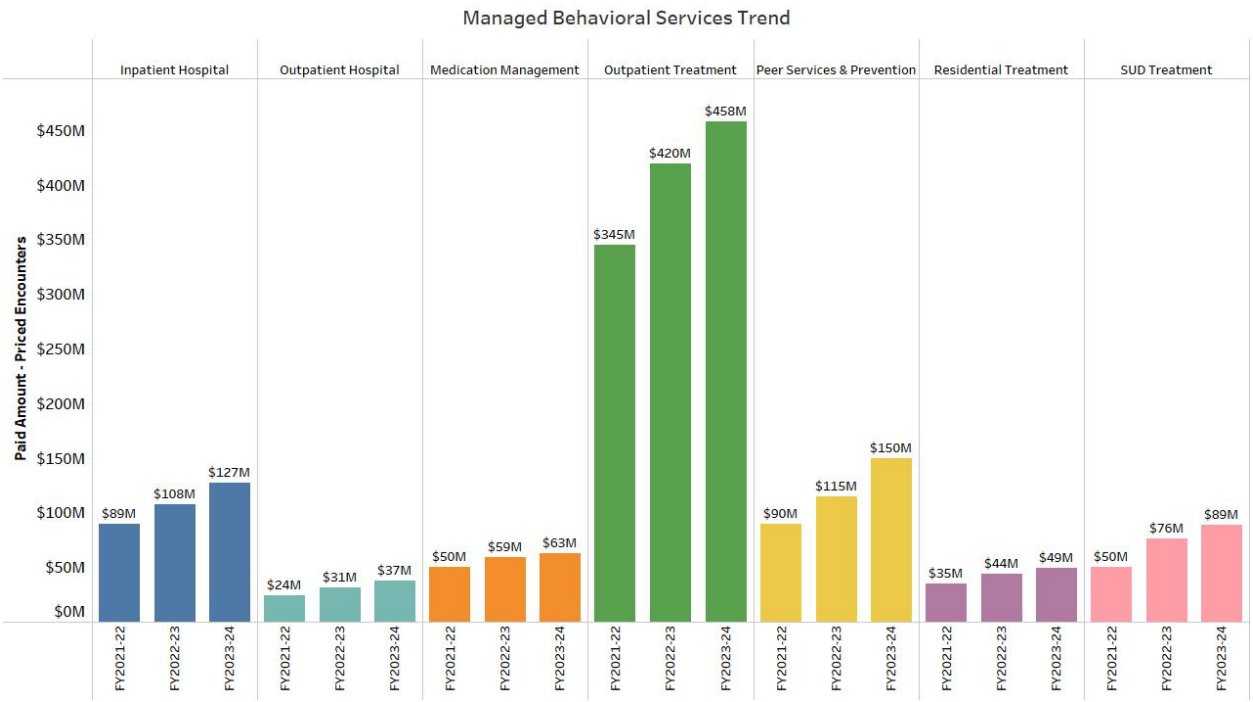
Department Discussion Questions Follow-Up

Service Trends & Match Rates

1. **Sen. Amabile - The Department provided information on major drivers of expenditures in slide 7. Do the behavioral health figures include pharmacy and inpatient services?**

RESPONSE

The figure below shows the breakdown of the priced behavioral health utilization within the behavioral health capitation payments. That includes most inpatient hospital and outpatient services for behavioral health; those behavioral health services that would be covered under the medical benefit include such care as a hospital admission for detox or overdose emergency care. Pharmacy is not a part of the capitated behavioral health program and is not included in the behavioral health figures shown. Most pharmacy expenditures for behavioral health are included in the fee for service pharmacy figures in the graphic with the exception of medication assisted therapy (MAT) such as methadone provided within an OTP (opioid treatment program).



2. **Sen. Bridges - The match rate for members receiving long-term services and supports is 50 percent, but what are the match rates for members not receiving long-term services and supports? Approximately how many clients are in each major match rate category? What is the weighted average match rate for non-LTSS clients?**

RESPONSE

The weighted average FMAP based on the November 2024 forecasted expenditure for Acute Care, Behavioral Health, Accountable Care Collaborative (ACC), and CHP+ services is 63.20%. The chart below highlights the estimated number of members associated with each federal match rate based on FY 2023-24 actuals.

50% Non-Expansion, LTSS Members	50% Non-Expansion Members, Excluding LTSS members	65% Medicaid CHP+ Expansion and BCCP*	65% CHP+ Members	90% ACA Expansion
65,823	788,098	64,283	68,564	471,984

*Breast and Cervical Cancer Program

Provider Rates/Worker Wages

3. **Sen. Kirkmeyer - With no proposed provider rate increase, how does the Department expect providers to keep pace with inflationary pressures? In particular, discuss the impact of minimum wage increases on providers of long-term services and supports.**

RESPONSE

Overall provider rates have increased uniquely over the last few years, through both across-the-board and targeted increases, largely concurrent with COVID-related federal stimulus dollars and the COVID-related wage and inflationary challenges experienced by our providers. A return to pre-pandemic, pre-federal stimulus provider rate increase norms should be considered to manage Medicaid trends. The average annual across-the-board increase for FY 2010-11 through FY 2019-20 was 0.62%, while increases from FY 2021-22 to FY 2024-25 compound to 10%, or an average of 2.4% annually, which is almost four times higher. In parallel, the targeted rate increases implemented over the last few years were also about four times higher than historic norms. These recent significant increases should help alleviate the inflationary pressures experienced by providers.

There is also an opportunity to provide targeted increases to safety net providers while using financing offsets, such as from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), to help balance the impact on the State's budget. This year, the Department agreed to - and the CHASE Board approved – an increase in the Upper Payment Limit to 99.25% for eight quarters retroactively and ongoing as well. This increased net payments to hospitals by $54 million for the previous two federal fiscal years: FFY 22-23 increase is $32.7 million and FFY 23-24 increase is $19.3 million. The General Assembly could choose to pass legislation to use some portion of that amount to offset General Fund to enable a targeted rate increase in provider payments, such as safety net providers based on the listening session held by JBC members, related press, and other provider feedback or a small across the board increase more in line with pre-pandemic levels. Similar actions to leverage available CHASE dollars were taken by the JBC in FY2010-11 ($150 million) as well as in FY2020-21 with HB20-1386, which authorized $161 million of CHASE cash fund as Medical Services Premiums General Fund offset. For context, the impact of a 1% across-the-board provider rate increase is $32 million General Fund.

The table below provides a breakout of the additional CHASE fee $54 million distribution referenced above, which occurred in December 2024. The Hospital Transparency Reports, which will be released on January 15, illuminate the financials associated with the recipients below to further inform how the JBC might wish to leverage this additional $54 million in federal match dollars, given the concerns with the safety net providers and other stakeholder feedback.

FFYs 2022-23 and 2023-24 CHASE Reimbursement Change to 99.25% UPL			
System/Hospital	Fee $ Change	Payment $ Change	Net $ Change (Payment less Fee)
Banner Health	$823,735	$3,147,650	$2,323,915
AdventHealth	$2,167,107	$5,414,951	$3,247,844
CommonSpirit Health	$4,182,509	$11,559,403	$7,376,894
Children's	$1,365,716	$4,234,714	$2,868,998
Denver Health Medical Center	$1,105,438	$1,753,972	$648,534
HealthONE	$6,935,097	$19,339,625	$12,404,528
San Luis Valley	$154,596	$877,450	$722,854
Intermountain Health	$3,313,826	$8,917,947	$5,604,121
UCHealth	$8,768,486	$17,259,731	$8,491,245
Encompass	$ -	$11,909	$11,909
Kindred	$ -	$19,174	$19,174
All Others	$2,306,354	$12,620,334	$10,313,980
Total	$31,122,864	$85,156,860	$54,033,996

We have leveraged American Rescue Plan Act (ARPA) funds to kickstart base wage increases to HCBS providers, including an increase to $15.00 per hour in FY 2021-22, $15.75 per hour in FY 2023-24, and $17.00 per hour in FY 2024-25. In addition, we used these funds to support recruitment and training for over 1,500 Home and Community-Based Services (HCBS) providers. Through these funds, we've created resources to help providers manage staffing challenges. This includes 30 training modules to prepare Direct Care Workers (DCWs) for the workforce, along with 20 soft skill modules to improve job readiness and work-life balance. These resources are available for free on the Direct Care Careers website.

The site also allows providers to post job openings at no cost, helping them connect with a wider pool of candidates. By using these free resources, it eases some of the financial pressures on providers related to recruitment and training, helping to offset the impact of inflation, including minimum wage increases.

HCPF also intends to leverage ARPA funds one last time by providing a final HCBS provider payment for select services, pending JBC approval (see supplemental S-11/BA-11, which serves to true-up unspent HCBS ARPA appropriations to the final ARPA Spending Plan). Providers have been, and continue to be, extremely valued partners in Colorado's efforts to serve people with disabilities receiving services in their community through HCBS. This final payment further addresses financial pressures for LTSS providers by leveraging available resources.

Recovery Audit Program

4. **Rep. Taggart - Why are providers abandoning less formal procedures for resolving RAC findings in favor of submitting formal appeals? Is this trend problematic? If so, what is the solution? If not, why not?**

RESPONSE

- Under our traditional RAC program, some care providers have taken part in pre-appeal, informal RAC processes including exit interviews and informal reconsiderations and have zero or very low appeals. Some providers do not leverage RAC program pre-appeal, informal processes and appeal a significantly high number of RAC findings. Some providers that are not leveraging pre-appeal exit interviews and informal reconsideration have voiced that those informal procedures are unproductive for them and a poor use of their resources.
    - Learning from this feedback, HCPF has recently changed how RAC exit conferences and informal reconsiderations are conducted to make them more productive for providers; HCPF has received very positive feedback from the providers who have engaged in the revamped processes thus far, with providers also learning from the engagement and advancing their

billing practices as a result to improve their compliance with Medicaid billing standards, which is an important goal of the RAC program.

- Additionally, to preserve their right to agree with the finding but get paid on a revised, correctly billed claim, some providers felt they had to exercise their formal appeal rights. (i.e.: provider agrees with the audit finding that the care should not have been billed at the higher cost inpatient hospital setting but at the lower cost outpatient hospital setting and rebills the claims accordingly).
    - To address this, HCPF has since improved its audit finding notices to providers, clarified the rebilling opportunity to ensure they are paid on the proper billings, created a rebilling system to assist providers in retaining the appropriate payment while enabling the state to recoup the overpayment.
- Those providers that are appealing all or the majority of Medicaid RAC findings are driving an unsustainably high volume of appeals for the Medicaid RAC program to properly function as intended. Litigation is costly to the state, is resource-intensive, and takes a very long time for all parties involved, including HCPF, the providers, the Office of the Attorney General and the Office of Administrative Courts (OAC) that administers all of these appeals. As an illustrative example, to resolve the RAC appeals currently pending before OAC, we estimate that OAC would have to hold hearings seven days a week for a year and a half and would require both state and provider personnel to spend all of their time testifying at these hearings. As a second example, at the current staffing, it would take ten years to work through just one major hospital system's appeals through the legal system. The state simply doesn't have the resources to litigate hundreds of claims per RAC audit finding dispute, given that each individual claim dispute is like a mini trial.
- Because of this reality, the volume of provider appeals has driven the need for the state to settle RAC finding disputes that result in the provider paying back a fraction of the total identified overpayments. This is at significant cost to the state General Fund. Note that the high volume of appeals is largely driven by hospital systems, with the majority of appeals responding to the RAC hospital inpatient audit, which reflects 62% of the appeals (167 out of 270 appeals). Each of these appeals can reference hundreds of individual claims, which would require administrative law judge review and finding on each individual claim. The Inpatient Hospital RAC has two types of findings in it: place of service (inpatient vs. outpatient) and DRG coding validation. A DRG or "Diagnosis Related Group," is a system used to categorize hospitalized patients based on their diagnosis, procedures performed, and other factors, enabling a standardized way to calculate the cost of a hospital stay and therefore reimbursement.

- Because there are no RAC requirements to drive the provider through the pre-appeal, informal reconsideration process, some providers follow the path that enables them to settle with the state for a lower financial cost. Further, no overpayment recoupments are collected while the appeal is pending, which may take years, and that means the provider retains the overpayment (and the interest on the monies held) until the appeal is resolved. This is clearly not in the best interest of the state's budget or state general fund.
- The current lack of RAC provider requirements to engage in good faith in the modernized informal reconsideration process inappropriately incentivizes the providers to appeal all or the majority of findings to draw out the legal process as long as possible; the state, however, is required to pay the federal share of the identified overpayment back to CMS no more than one year after the overpayment is identified.
    - It is therefore critical that new legislation be passed to remove this perverse incentive; the new legislation would require the provider to navigate through the informal reconsideration process and include timeliness obligations to ensure HCPF and therefore the state general fund recoups overpayments timely.
    - Further, going straight to appeal deprives both parties of the opportunity to dig into the findings, share perspectives, learn from the dialogue, and dismiss findings given the new shared learnings outside of the appeals process. These benefits are indeed occurring due to the recent improvements made to the exit conferences and most especially the informal reconsideration processes.
    - Further, less findings would occur in the future if the providers leveraged the improved processes because the providers would learn to address the overbilling problems at their root. Because HCPF doesn't audit 100% of claims, it is critical for providers to learn and improve the accuracy of their Medicaid billing process to achieve one of the most important goals of the program – reduce Medicaid overbillings to the benefit of state and federal funds and the sound stewardship of taxpayer dollars. Going straight to an appeal does not accomplish that goal.
- The solution is to pass legislation that requires providers to participate in the informal reconsideration process before submitting a formal appeal. With the newly revamped exit conference and informal reconsideration procedures, many of these findings and resultant disputes can be resolved informally, achieving the goals of the program.

  - We have been collaborating with hospitals on complex audits over the past six months, proving that both sides learn and benefit from informal reconsideration interactions. Greater collaboration between hospital clinicians, HMS clinicians, and HCPF's Chief Medical Officer has also proven hugely beneficial to the providers, resulting in dismissed findings based on shared clinical and case specific perspectives. This process is also helping to advance the operational features of the Medicaid RAC program

- HCPF agreed to make the following changes to the RAC program months ago, based on provider feedback on the RAC program. All of the below are either completed or in process.
  - Introducing of RAC Physician to HCPF Clinical Team
  - Automating Inpatient/Outpatient Re-billing
  - Updating initial hospital care codes audits
  - Catch up on historic audits so that the look back period was reduced (now within 3 years, plus timely filing)
  - Improving Communication and Training
  - Website Enhancements & Navigation- Meeting Recordings and Transparency
  - Appeal Cover Sheet Modification - Providers have templates, forms and information to help define the reason for formal appeal
  - Collaboration to improve the RAC program overall.

- The solution is more effectively improving the Medicaid RAC program is to craft a Medicaid RAC bill that:
  - requires HCPF to address the provider stakeholder findings that help reduce provider administrative burden; note that HCPF worked with the OSA to create about 20 bill provisions to address provider feedback
  - mandates providers to engage in the informal reconsideration process in good faither before they go to appeal
  - gives HCPF authority to require corrective action plans for providers who do not correct systemic RAC audit overbilling findings
  - requires providers to self-audit as required by CMS and turn those findings over to HCPF (including over and underpayments to be properly addressed)

- All of this has been memorialized in the bill created by the Office of the State Auditor (OSA) in collaboration with the Legislative Audit Committee. We ask that the JBC thoroughly review that bill language, which reflects the will of broad provider stakeholdering by the OSA as well as the willingness of HCPF to advance and improve its RAC program in response to this provider stakeholder feedback.

It should be noted, as voiced by Barry Dunn on January 6, based on the areas of provider concern voiced, Barry Dunn focused their audit and findings on 3 of the 31 Medicaid RAC audits in place at the time of the evaluation.

5. **Sen. Amabile - Please provide more information on the independent laboratories. Who are the independent laboratories and what services do they provide? Is there a problem with fraud, waste, and abuse in this service sector?**

RESPONSE

Independent laboratories are not owned or operated by a hospital or physician and offer a variety of services such as blood tests, urine tests, genetic testing, imaging tests, and cardiac testing. Some independent labs provide specialized expertise, advanced technology, and unique tests. Some offer reduced wait times and can be more cost effective for some services. There are independent clinical laboratories, which specialize in analyzing medical tests and samples, as well as independent diagnostic testing centers. As of 1/1/25, HCPF contracts with 558 independent laboratories, which includes both clinical laboratories and diagnostic testing centers.

HMS found that Colorado Medicaid's spending on independent laboratory services far exceeded what other state Medicaid programs pay, indicating that this is a high-risk area for fraud, waste, and abuse in Colorado.

Both the Centers for Medicare and Medicaid Services (CMS) and the federal Office of the Inspector General (OIG) have published warnings about fraud, waste, and abuse, and even outright scams by some independent labs. Colorado's Medicaid Fraud Control Unit (MFCU) also conducts state level investigations. One example is labs encouraging OB/GYNs to order large panels of testing with misleading information about what was actually recommended. Most private insurers will not cover these types of tests. Based on this and related information, and further input from the State Attorney General's Office, HCPF has made several changes to systems and claims monitoring to close potential billing loopholes. Leveraging this guidance and expertise from our own Fraud, Waste, and Abuse Division, HCPF implemented prior

authorization requirements for genetic testing (2020) that helped to reduce improper billing from all types of laboratories. The majority of current lab testing does not require a PAR, but lab PARS for genetic and high-cost oncology or molecular pathology testing make up the majority of required lab PARS. RAC findings before the prior authorizations were implemented will be higher.