Joint Budget Committee Hearing Health Care Policy & Financing

Dec. 21, 2022

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Thank you for your partnership

- Covering 1.7M Coloradans
- That's 1 in every 4 Coloradans
- 43% of births
- 43% of the state's children

- COVID-19 economic downturn increased need for Medicaid
- 37% growth through pandemic, 460,000+ Coloradans, *and we met that need together*
- Medicaid Expansion Adults category grew by 84% (49% of overall growth)

"I wouldn't be able to afford [my daughter's] medications if we didn't live here and Colorado Medicaid didn't make it so simple." Member

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

- Health First Colorado (Colorado's Medicaid Program)
- Child Health Plan *Plus*
- Buy-In Programs
- The Colorado Indigent Care Program
- Long-Term Services and Supports
- Dental Program

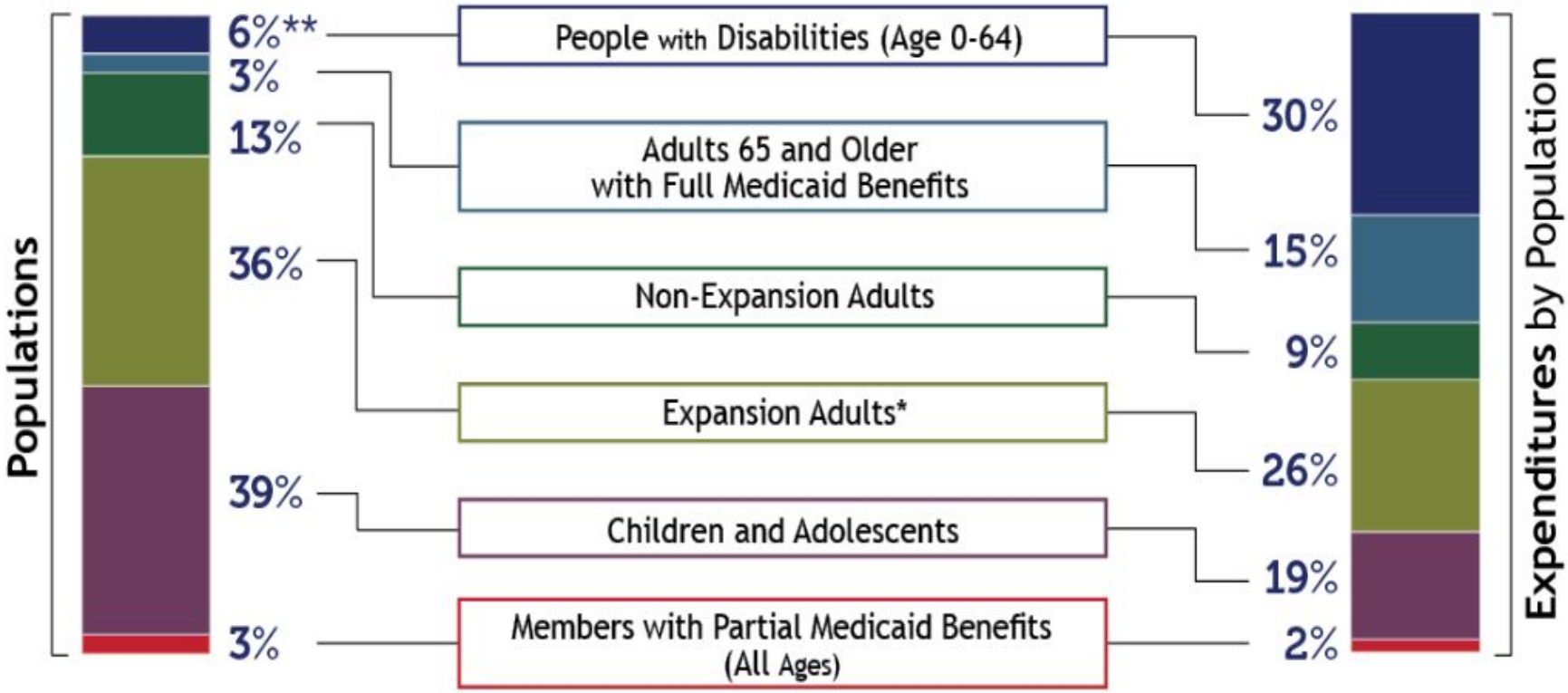
$14.9B Total Funds
$4.43B General Funds

30% of the total state General Fund operating budget

4% allocated to cover administrative expenses like staff and contracted partners

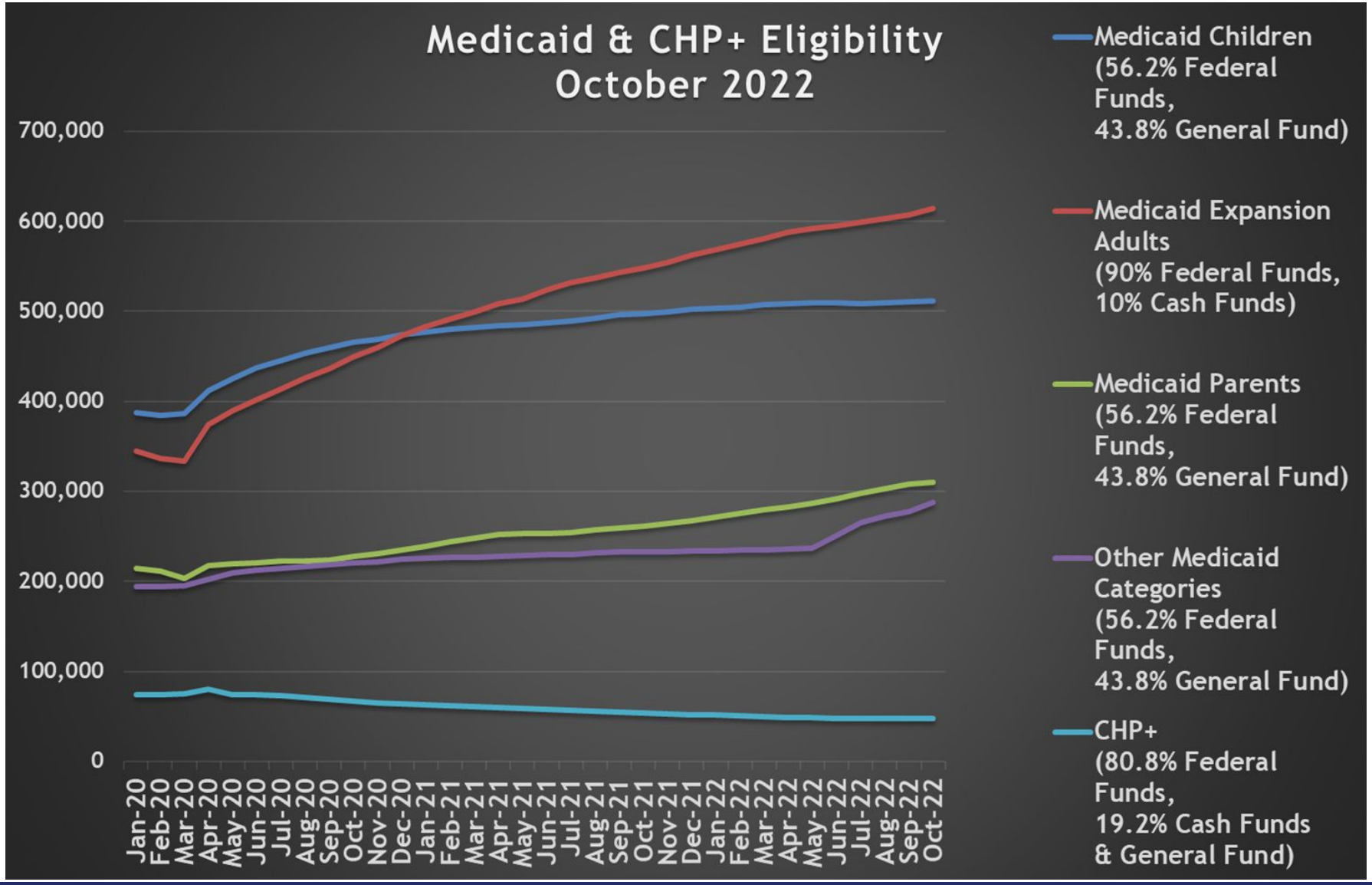
96% of our funding continues to go to providers

Who is covered and what does it cost?



Patient Protection and Affordable Care Act (ACA) Medicaid Expansion. Due to rounding, percentages may not total 100%. *The majority of funding for Expansion Adults is federal dollars, with the state fund source funded by the Healthcare Affordability and Sustainability Fee. **Not all members with disabilities use long-term services and supports.

Past Member Growth. Pending Decline >300k



End of PHE goals, redetermining 1.7M members, est. >300k disenrollment

Goals

1. Member continuity of coverage
2. Member experience, smooth transitions
3. Minimize impact to eligibility workers and state staff

Initiatives and Tactics

- Correspondence clean up
- Contact info refresh
- Educating, targeting
- Automation advances
- C4H partnership
- Educating providers
- And more

Workforce Impact

Free education!

Take advantage of free, short-term health care training with Care Forward Colorado!

In a year or less, become certified in one of these in-demand professions:

- Certified nursing assistant (CNA)
- Emergency medicine
- Phlebotomy
- Medical assisting
- Dental assisting
- Pharmacy technician

Learn more:

https://cccs.edu/new-students/explore-programs/care-forward-colorado/

Take advantage of free education courses to become a child care professional!

Enroll in free Early Childhood Education (ECE) 101 and 103 courses at a local community or four-year college. ECE 101 and 103 are the minimum coursework required to become a child care professional.

Learn more:

coecstimulus.com/faq-free-101-and-103-coursework

Responding to unique provider needs

COVID-19's impact didn't affect providers equally. **Our targeted rate increases** reflect that reality:

Nursing Homes - lower margins, staffing crisis, changing consumer preferences/needs - perfect storm. Need for industry transformation.

Home and Community-Based Services - wage challenges with growing need for direct care workers.

Struggling hospitals: rural, community and our Denver Health safety net.

Provider rate increase approach

Calculation of across-the-board (ATB) provider rate increase

- R-7 equivalent to 3% ATB increase: $70M GF
  - funding for targeted adjustments for providers with critical shortfalls
- Remainder directed to 0.5% ATB, which compares to a 1% average over the last 5 years

FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	Average
1.0%	-1.0%	2.5%	2.0%	0.5%	1.0%

- Co-pay elimination increases provider reimbursements by $8.7M TF ($1.7M GF) and reduces provider admin burden
- MPRRAC increases without balancing decreases = +$8M GF

Importance of Managing Medicaid Medical Trend

- **Goal:** Protect benefits, provider reimbursement rates, eligibility access to Medicaid programs
- **Challenge**: Medical CPI is increasing 50% faster than CPI.
  - CY 2000-2020: CPI 71.3%; Medical CPI 110.1% (KFF)
  - PwC's Health Research Institute (HRI) projects **6.5%** medical cost trend in 2022 and 7% in 2021
  - Medicaid Cost Trends: 2.4% PMPM. 12.9% Paid (member growth of 10.3%)
- Impacting 30% of the state's GF operating budget

Quality, health equity and innovation to manage cost trends

- **Utilization Management**: Right care, right place, right time, right outcome, right price
- **Population Health**: Maternity, Diabetes focus
- **Health Equity**: COVID-19 vaccination, Maternity, Behavioral Health, Prevention
- **Complex Case Management**: High need, high cost members
- **Innovations**: Prescriber Tool, eConsults, Providers of Distinction drive better provider decisions, quality, efficiency
- **Value-Based Payments**: Hospital Transformation Program, Primary Care, Maternity, Prescriber Tool, Behavioral Health, Nursing Home/PACE, Providers of Distinction

Prudent cost controls and innovations battle medical trend and future state budget challenges in order to protect member benefits, provider reimbursements and eligibility access while increasing quality and closing disparities.

Leveraging our solid foundation

- **Expanded network access to care:** added over 23K providers (30%), 739 pharmacists (+32%), 2,578 (+29%) behavioral health
- **Exceeded service standards:** claims paid (<6 days), calls answered (<80 sec)
- **Transformational eligibility automation**: >60% for those eligible, >30% all renewals
- **Implemented system changes to advance policy:** executed 171 internal IT projects with zero defects in MMIS, medical claim system, since Sept.1, 2019
- **Controlled Medicaid cost growth:** 2.4% PMPM
- **Kept Admin Low: <4%** of spend (carriers 13.5%+); FTE <0.43% of spend
- **Protected member benefits, provider reimbursements** through fiscal crisis
- **$1.5B in add'l FMAP (6.2%)** through Dec. returned to the JBC/General Assembly over 12 quarters
- **Stabilized system** with $147M in relief payments to NHs and HCBS providers FYs 2019-21

Leverage Transformational Work

- **ARPA investments**
  - $530M HCBS funding 63 projects, incl $15/hour base wage increase ($15.75 this budget)
  - $10M rural hospitals/clinics affordability and access + $17.4M rural connectivity & access to virtual care (and $12M in HTP assistance fund)
  - $32M to advance integrated behavioral health
- **Nursing home investments & industry transformation**
- **Innovations**: eConsults, Telehealth, Prescriber Tool, Providers of Distinction
- **Advanced value-based payments** to reward quality, equity, affordability
- **Driving health equity** priority initiatives to tackle health disparities
- **Designing ACC 3.0**, our delivery model

$14.9B Total Funds, $4.43B General Funds (30% of state's GF operating budget)

- Increase of $673M TF, $346M GF, most from:
  - $178M GF - utilization growth (1.5M Medicaid/CHP+)
  - $142M GF - provider rate increases
- Discretionary budget requests ($73M):
  - R6 | Supporting PCMP Transition with Value-Based Payments
  - R7 | Provider Rate Adjustments
  - R8 | Cost and Quality Indicators
  - R9 | Advancing Birthing Equity
  - R10 | Children and Youth with Complex and Co-Occurring Needs
  - R11 | Compliance
  - R12 | Behavioral Health Eligibility and Claims Processing Operations
  - R13 | Case Management Redesign
  - R14 | Convert Contractor Resources to FTE
  - R15 | Administrative Technical Request

Budget summary: CO.gov/HCPF/legislator-resource-center

Discretionary budget requests focus on:

Provider rate increases

- 0.5% across-the-board rate increase
- Targeted adjustments for nursing homes
- Increased base wages for home and community-based services workers
- Incentive payment for rural providers
- Eliminating most co-pays paid by members

Health equity

Improving health equity for our members

Quality

Resources to improve quality and ensure compliance

Children, Youth

Supporting children and youth with complex needs

Improve-ments

- BHA claims processing
- Case management

Common Questions for Discussion

COVID-19 Public Health Emergency Questions 1-9

Timing & Federal Updates

Current PHE continues to run through Jan. 11, 2023

We expect this to be extended again

New working dates are:

Feb. 10, 2023 - *next 60 day notice date*

April 11, 2023 - *new expected end date*

Recent Tweet from HHS official on 60 day notice

"The COVID Public Health Emergency remains in effect & HHS will provide a 60-day notice to states before any possible termination or expiration. As we've done previously, we'll continue to lean on the science to determine the length of the PHE. Read FAQs:
https://phe.gov/Preparedness/legal/Pages/phe-qa.aspx

Question 1 & 2: Department's Plan for Public Health Emergency End Renewals

COVID Renewal Unwind Timeline

2023											2024					
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CMS 60 Day Notification 02/12/2023	Ex-Parte runs 03/15/2023 for Feb renewal	PHE Ends (Continuous Coverage Protections End)	CMS Option B - Feb Renewals with term 5/31/2023													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14		
							November-23									
April-23								December-23								
	May-23								January-24							
		June-23								February-24						
			July-23								March-24					
				August-23								April-24				
					September-23								May-24			
						October-23								June-24		
				Appeals												

Renewals during COVID PHE - Continuous Coverage (renewed) regardless if approved or denied

Renewals COVID Unwind - If approved, renewal month reset; If no longer eligible, will not continue to be enrolled

Renewals post COVID Unwind - Return to normal

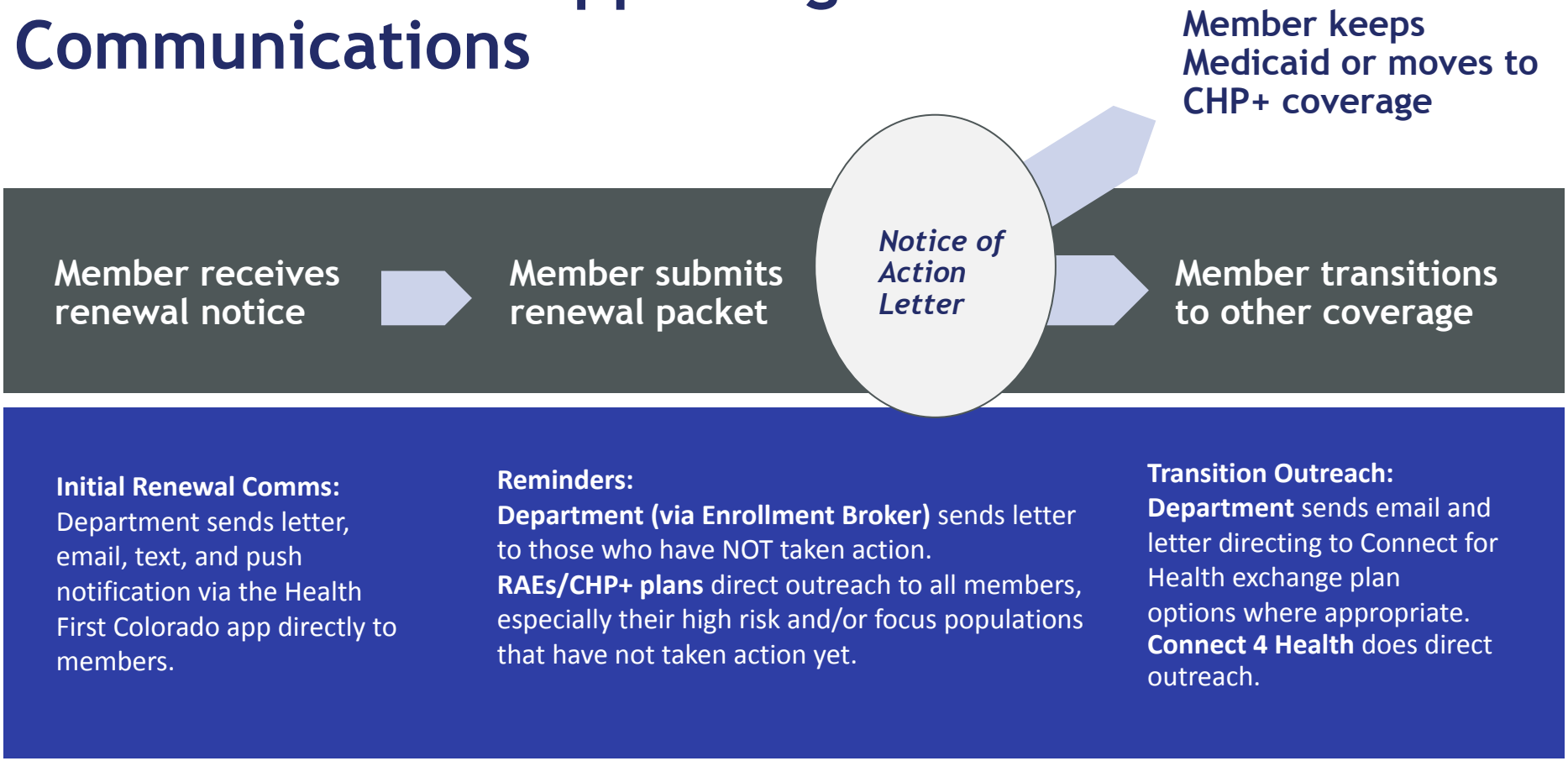
Note: The PHE was extended again on Oct. 14 for another 90 days. The federal government has not indicated an end date for the PHE yet. **This plan is assuming the PHE will end in April 2023 and is subject to change as dates are finalized.**

How We Have Been Preparing: Renewals Strategy

Minimize impact on members through:

- Enhanced ex-parte (use of interfaces and information on file for approval without member engagement)
- Reformatted renewal packet for clarity
  - Special call out on the newly required signature
- Enhanced online member tools (PEAK, electronic signature)
  - Telephonic signature implementation to mitigate paper and expedite processing
- Targeted outreach for members with a call to action
  - Messaging asking to send back a signed renewal packet!

Question 3: Renewal Process Notifications & Supporting Communications



Initial Renewal Comms:
Department sends letter, email, text, and push notification via the Health First Colorado app directly to members.

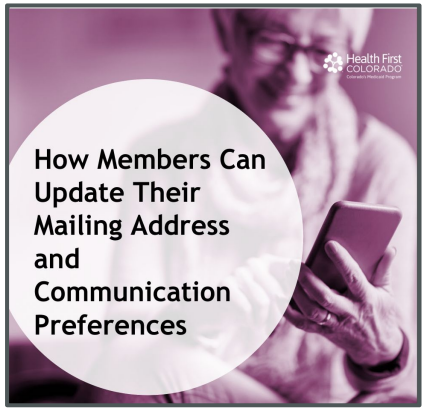
Reminders:
Department (via Enrollment Broker) sends letter to those who have NOT taken action.
RAEs/CHP+ plans direct outreach to all members, especially their high risk and/or focus populations that have not taken action yet.

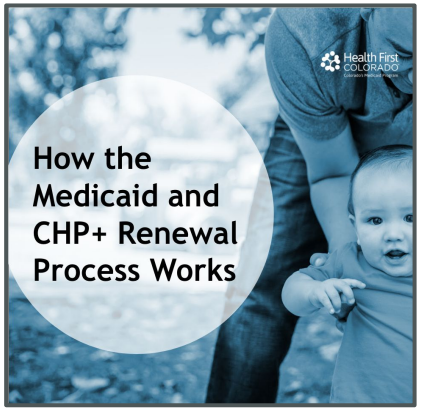
Transition Outreach:
Department sends email and letter directing to Connect for Health exchange plan options where appropriate.
Connect 4 Health does direct outreach.

Ongoing broad outreach: Health First Colorado website, traditional & social media, Health First Colorado app, PEAK, member newsletters, call centers, partner and provider messaging, posters/flyer materials in libraries, homeless shelters, clinics, etc.

Video Series & Toolkits

Accessible for partners & members to understand key actions in the renewal process (English & Spanish)





https://www.youtube.com/playlist?list=PLFlKrQC_PrCGEuVySAlzoUNN23ihtKrD4

Questions 4 - 8: Predicting Who May be Disenrolled & Societal Costs

- Members must be renewed based on **current data at their renewal time**. As member circumstances change, we cannot exactly predict who may no longer qualify until their renewal process is complete.
- Many will still qualify and be automatically renewed or complete the renewal process.
- Others may have employer sponsored coverage or could benefit from a marketplace plan.
  - Colorado Unemployment Rate
    - October 2020: 6.1%
    - October 2022 (most current): 3.6%
  - Colorado Pandemic Job Recovery Rate - 125%
- Connect for Health Colorado partnership

Source: Labor statistics from the Colorado Department of Labor & Employment, “Colorado Employment Situation – October 2022.”

Question 9: Supporting Eligibility Workforce

Budget requests and supplementals to increase workforce

- Combination of new staff, temporary staff, overtime
- Address retention of current staff

Performance management of eligibility sites

- Business process improvement and technical assistance (renewals, backlog)
- County accountability regarding accurate and timely eligibility determinations

Constant collaboration and engagement with eligibility workers

- Small weekly workgroup
- Monthly statewide meetings with county directors and monthly statewide meeting for eligibility workers

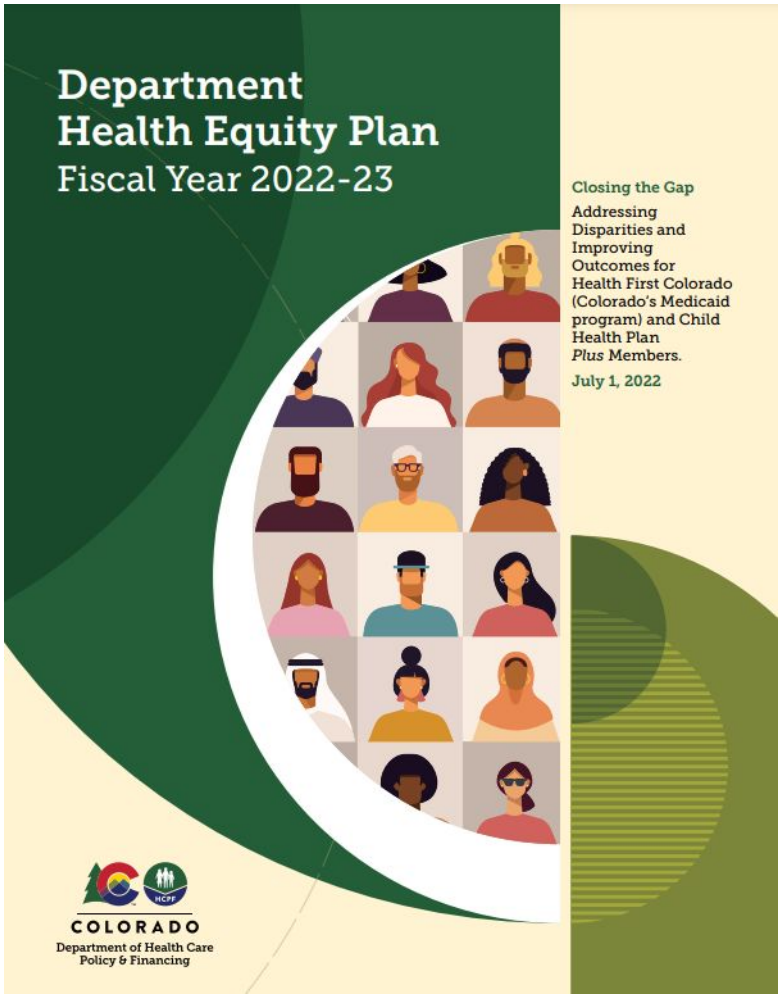
Overflow Processing Center

Consolidated Returned Mail Center

Hospitals
Questions 10-11

R9 Birthing Equity & Doula Services Questions 12-15

Question 12: Doula Benefit Addresses Key Health Equity Priority



- The doula benefit focuses on **reducing disparities, improving health outcomes** and **reducing costs** *for all Medicaid members* with an emphasis on Black, Indigenous, People of Color (BIPOC) birthing people.
- Engagement began with Maternity Advisory Committee & is part of request

Questions 13 & 14: Doula Research & Evidence

Dept. researched implementations in other states to learn from their experiences, and will engage birthworker community to ensure success.

Decreases/Reduces	Increases/Improves
• Cesarean section rates and associated costs • Preterm birth rates • Low birth-weight rates • Rate of birth complications • Rates of perinatal mood and anxiety disorders • ER and hospital visits • Labor duration	• Breastfeeding rates • Adoption of infant safety precautions • Patient satisfaction • APGAR Scores (a test of five measures to evaluate an infant's health at birth)

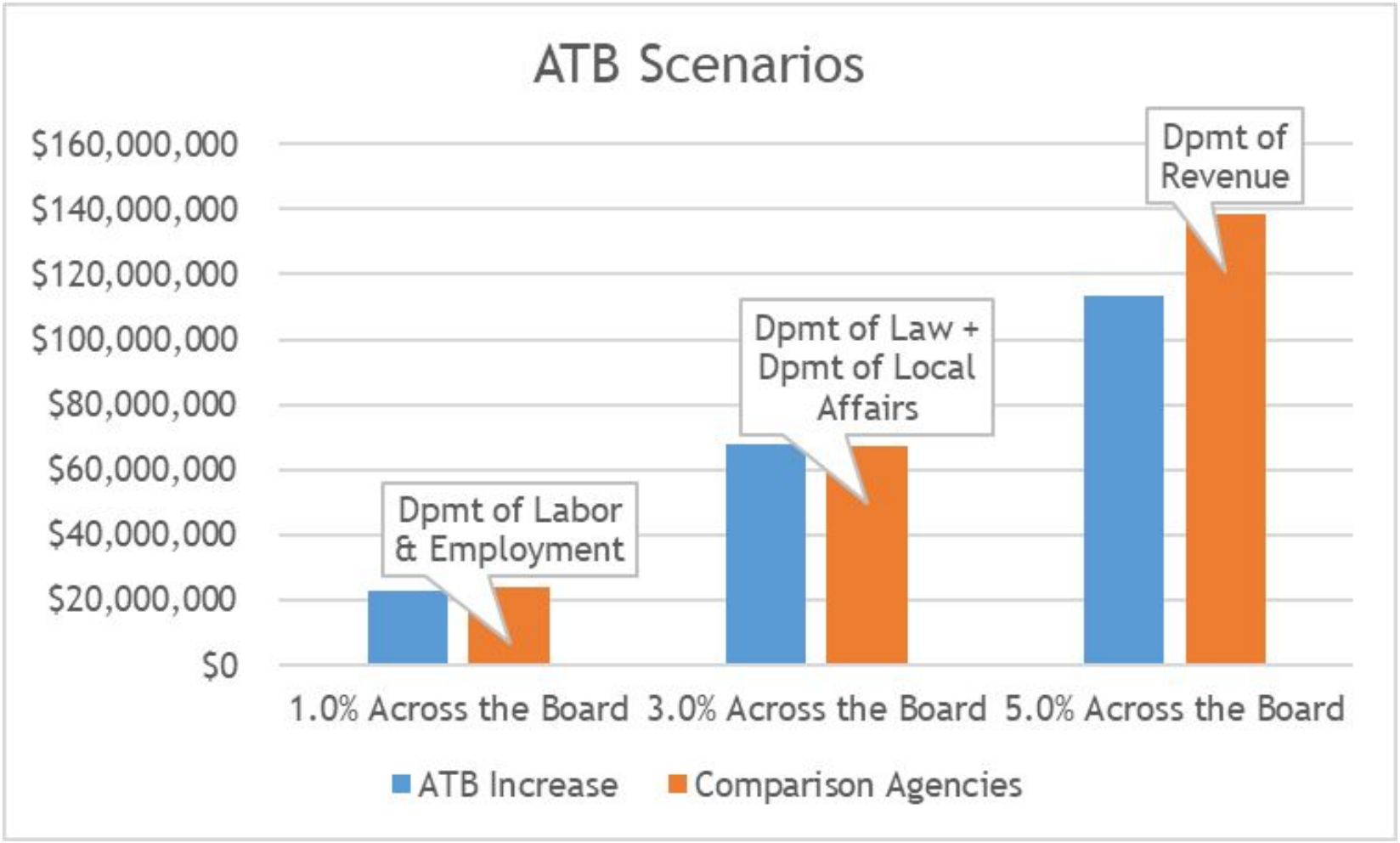
Question 15: Doula Benefit Intersection with Nurse Family Partnership Programs

	NFP	Doula Benefit
Population Served	First-time parent on Medicaid	All pregnant or postpartum Medicaid members
Care Provided	Prenatal through 2 years postpartum nurse visits at the home (frequency varies according to period of pregnancy or child development). Does not include presence at birth to support.	Prenatal, birth support, and postpartum support, usually through the first several weeks. *Note: Colorado model will include stakeholder work to determine how far into postpartum visits may go.* Doula is present at and supports during birth.
Providers of Care	Registered Nurses	Support persons trained specifically in perinatal and postnatal care

R6 Value-Based Payments & R8 Cost & Quality Indicators Questions 16-19

Provider Rates, Participation & Medicaid Provider Rate Review Advisory Committee Questions 20-34

Examples of Magnitude: Across the Board Provider Increases = Entire Agency General Fund Budgets



Question 20: 17% of R7 Request is Across the Board Increase: Other Targeted Rate Increase Focus Areas

Address critical needs
facing the most vulnerable Medicaid providers

- 59% of request to Nursing Home and Home and Community-Based Services providers

Rebalancing rates
based on Medicaid Provider Rate Review Recommendation Report

- 22% of request

Targeted investments
incentive payments for Rural Hospitals to support Health Information Exchange

- 2% of request

Pharmacy Questions 35-37

R14 - Convert Contractor Resources to FTE Questions 38-41

Questions 38-39: Hiring Progress and Confidence

1. 155.6* FTE funded in last 3 FYs
2. 133.2 FTE currently filled
3. 13.5 are in active recruitment

*Some FTEs are short-term ARPA-only ST funded.

Questions 40 - 41: Reasons to Convert Contract to FTE

1. Creates robust and cohesive capacity for stakeholder engagement
2. Greater success in implementing legislative and executive priorities
3. Enhances member engagement in program development
4. Better informs and prepares partners for policy changes

Other Topics - Child Health Plan Plus (CHP+), Co-pays, Recoupments, Audits & Fraud/Waste/Abuse Reporting Questions 42-48

Question 42: CHP+ and Medicaid Differences

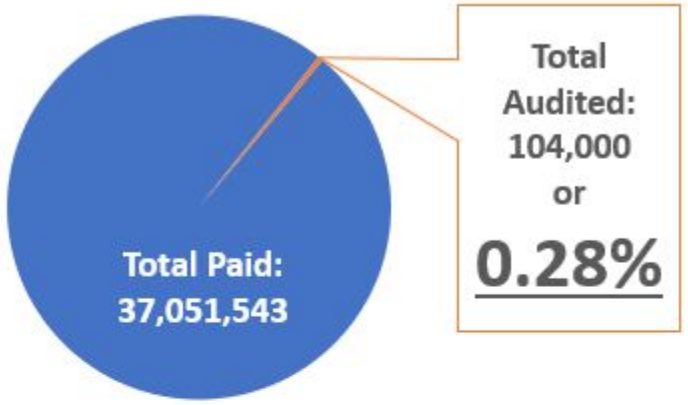
	CHP+	Medicaid
Authority	Title XXI	Title XIX
Federal Matching	65% (PHE Enhanced Federal Medical Assistance Percentage [eFMAP] = 4.34%)	50% (PHE eFMAP = 6.8%)
Eligible Members	Children under 19 and Pregnant People	Children and Adults
Recent Enrollment Numbers	48,200	1.7 million
Federal Poverty Level (FPL)	143%-260%	147% FPL for children 138% FPL for adults under 65 195% FPL for households
Additional Differences	4 Managed Care Organizations with Service Area Overlap (Competition) in Many Counties	Key Performance Indicators and Performance Incentives Regional Service Areas
Payment & Delivery System	Capitated	Capitated and Fee-For-Service
Additional Similarities	Dental Coverage 12-month postpartum expansion Cover All Coloradans (HB 22-1289) look-alike program $0 enrollment fee *1115 Prenatal Waiver	

Question 43: Co-pay Elimination

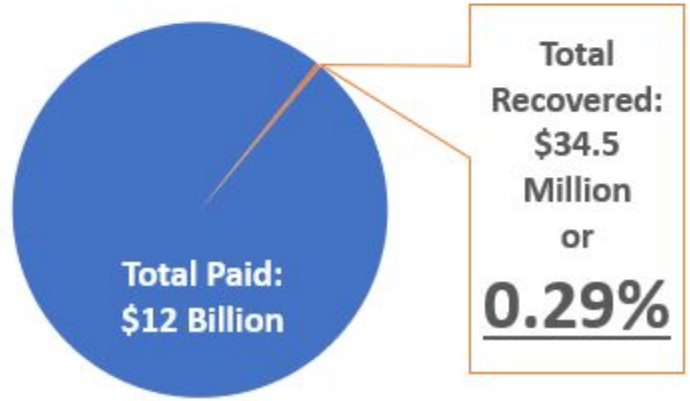
- Reduces barriers to getting care and prescriptions
- Reduces administrative burden
- Only non-urgent use of the ER has a co-pay ($8)
- Elimination essentially a provider rate increase

Questions 44-45: FWA Auditing in FY 2021-22

Claims Paid vs. Claims Audited



Dollars Paid vs. Recovered



- 17.0 FTE and 1 contractor responsible for reviewing all provider, claim types
- Recovery amount up from $13.8 million to $34.5 million
- Types of audits:
  - Post-payment review
  - CMS program requirements
  - OSA/OIG audit recommendations
  - Law enforcement related

Behavioral Health

Dec. 21, 2022

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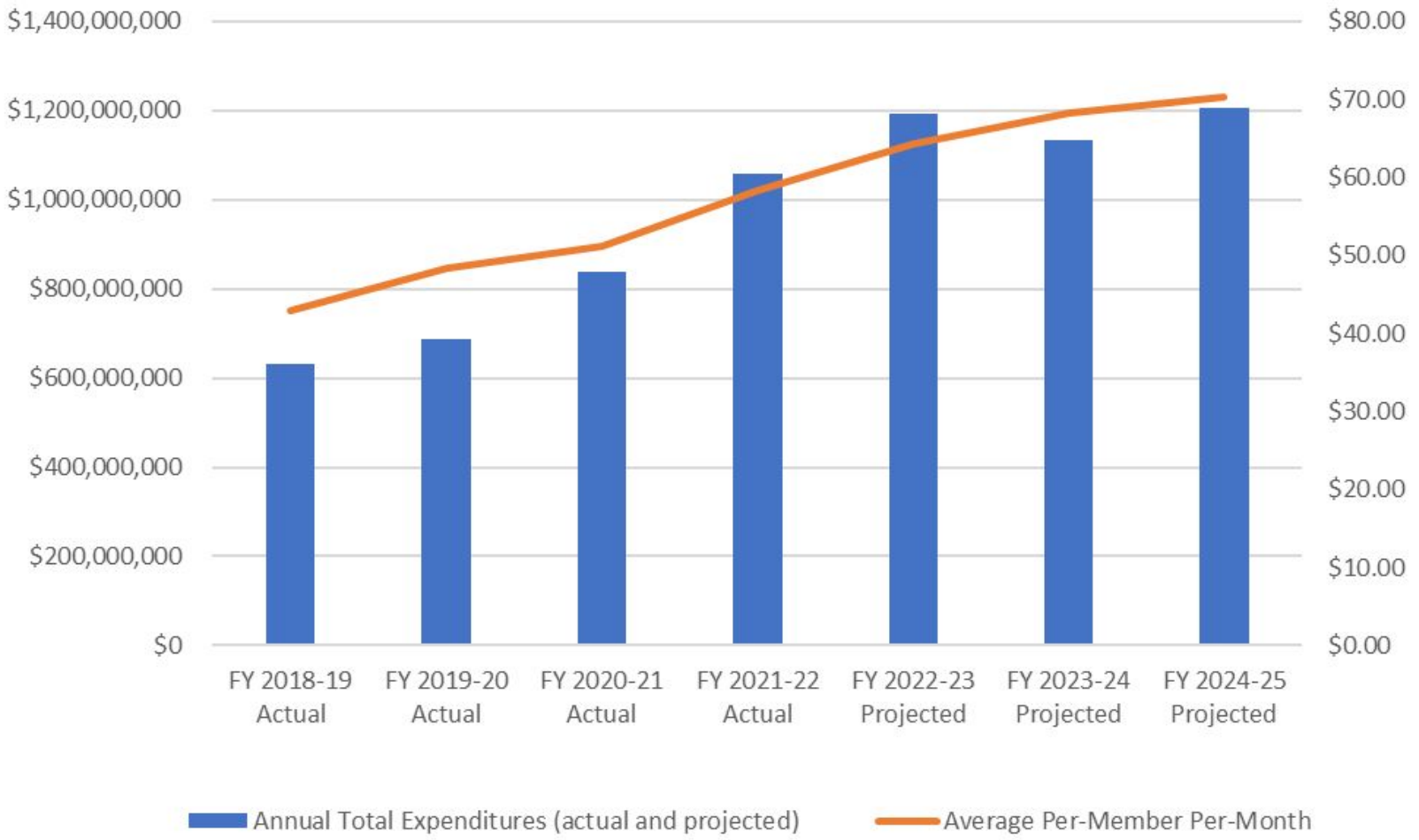
Charlotte Crist, Cost Control & Quality Improvement Office Director

Medicaid Behavioral Health Expenditures 2018-2025



Coverage Across Care Continuum

Prevention, Harm Reduction

- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Overdose reversal (Narcan), Rx and hospital
- Outreach, case management
- Wound care, medical care for SUD-related conditions

Outpatient Treatment and Supports

- Medication-Assisted Treatment (MAT)
- Outpatient; individual, family & group
- Intensive outpatient
- Care coordination and navigation from RAE
- Care management, peer services
- Transportation for appointments (NEMT)

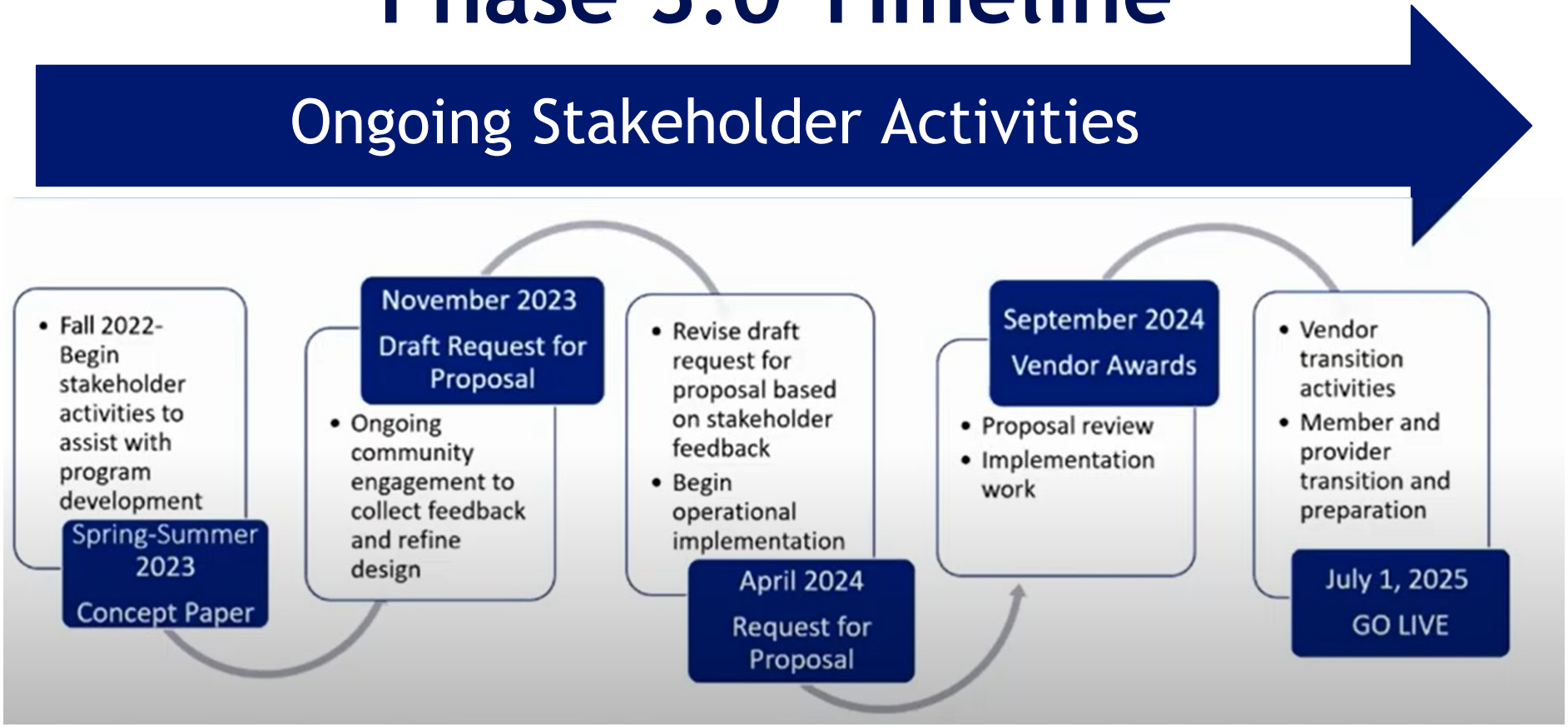
Inpatient and Residential

- Withdrawal management
- Inpatient care
- Residential
- All must follow ASAM Criteria
- Overdose services and MAT in the ER

Behavioral Health Transformation & Investment

- **20+ bills, $550M+ in ARPA stimulus to transform the industry**
  - Redefining the safety net and increasing high-intensity outpatient services
  - More adult beds, youth residential beds, tribal substance use disorder facility
  - Funds to increase integrated care and care coordination technology
  - Mobile crisis response and secure transport
  - Community investments and much more!
- **New Department Office:** Office of Medicaid & CHP+ Innovations and Coverage
- **Medicaid** >$1B (+>$500M since 2018-19). >1,000 behavioral health added last yr (10k+)
- **7 workstreams to improve Community Mental Health Center accountability**

Accountable Care Collaborative Phase 3.0 Timeline



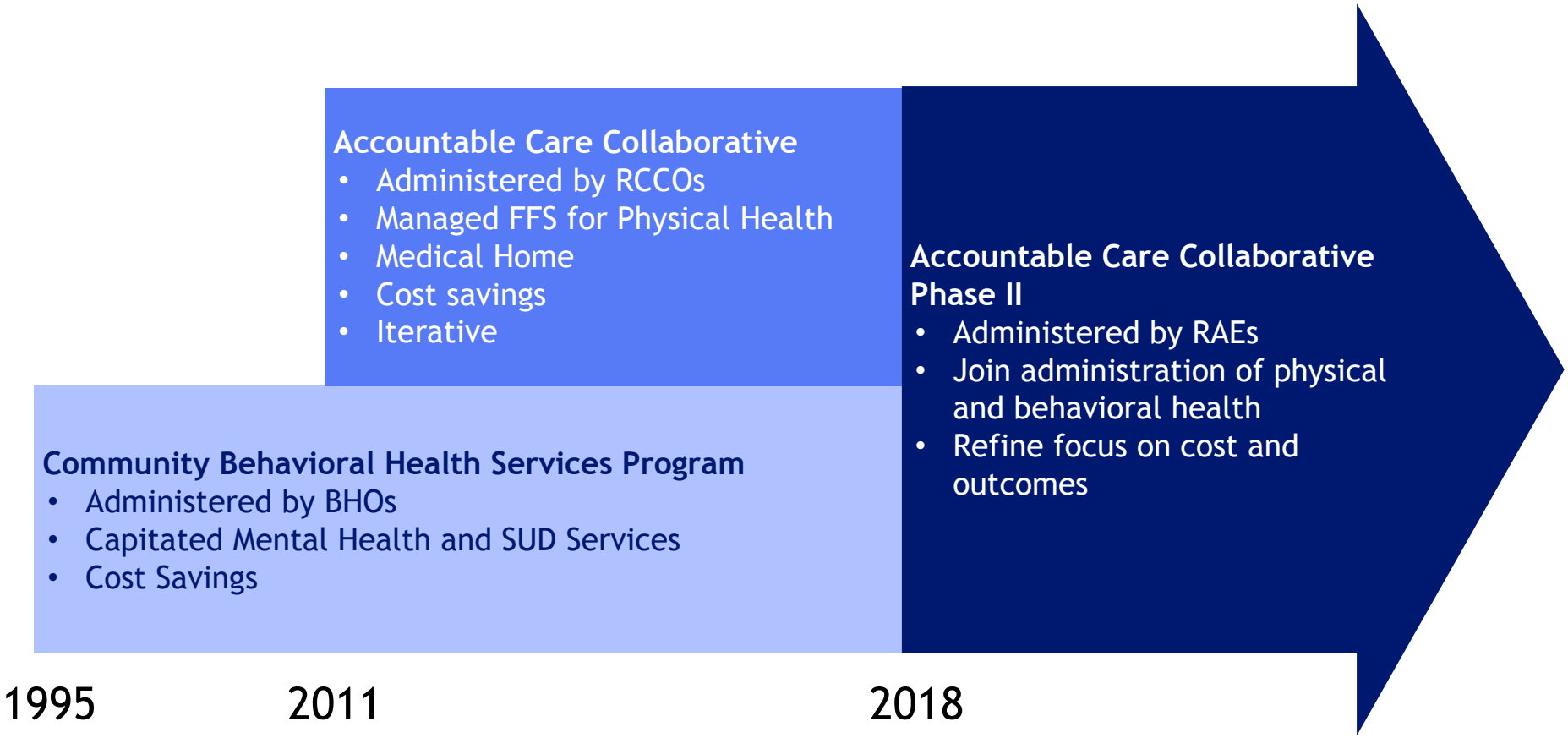
Behavioral Health Delivery System & Provider Network Questions 49-53

Managed Care Across the U.S.

41 states use risk-based managed care contracts to serve at least some of their members.

69% of all Medicaid members receive care under risk-based managed care contracts.

Colorado's Hybrid Managed Care Model



Role of Regional Accountable Entities (RAEs)

- Lead a whole-person health care system for all Medicaid members, including prevention services, care coordination, primary, behavioral health and specialty care to promote members' physical and behavioral health
- Contract with a regional network of Primary Care Medical Providers (PCMPs) to serve as medical home
- Administer capitated behavioral health benefit
- Support providers in coordinating care across disparate providers
- Provide administrative, financial, data and technology, and practice transformation assistance
- Maintain and monitor performance and quality of a diverse network of providers

Join Physical & Behavioral Health

Capitated Behavioral Health Benefit

State Plan/Medical Services

Behavioral Health Assessment

School-Based Mental Health Services

Psychotherapy

Physician Services

Pharmacological Management

Outpatient Day Treatment

Outpatient Hospital

Psychosocial Rehabilitation

Crisis Services

Emergency Services

Inpatient Psychiatric Hospital

State Plan/Medical Services—SUD Specific

Substance Use Disorder Assessment

Alcohol/Drug Screen Counseling

Medication Assisted Treatment

Social Ambulatory Detoxification

Inpatient Withdrawal Management (1115 Waiver)

Residential Withdrawal Management and Treatment (1115 Waiver)

Community-based/Alternative Services

Prevention/Early Intervention

Clubhouses/Drop-in Centers

Vocational Services

Intensive Case Management

Assertive Community Treatment

Residential (Mental Health)

Respite Care

Safety Net Accountability

- **Rewriting the provider standards for all behavioral health providers:** April ‘23
- **Cost Transparency:** ‘22 Behavioral Health Rates Report
- **HCPF leading payment claims and data collection for state-funded behavioral health services**
  - Single process for eligibility and billing starts July ‘23
- **Value-Based Payments (VBPs) for Safety Net Providers**
  - Flexible funds based on patient outcomes: July ‘23
- **Universal Contract and Reducing Administrative Burden**
  - Contract for providers in the public system, clear and aligned role for all parties, connected to VBPs

Behavioral Health Provider Enrollment November 2021 - October 2022

Provider Type	Total Enrolled Providers 11/01/21	Total Enrolled Providers 10/31/22	Total Increase	% Increase
Psychiatric Residential Treatment Facility	36	41	5	13.89%
Community Mental Health Center	251	259	8	3.19%
Licensed Psychologist	1,136	1,254	118	10.39%
Licensed Behavioral Health Clinician	7,680	8,562	882	11.48%
Substance Use Disorders Clinic	410	418	8	1.95%
Total	9,513	10,534	1,021	10.73%

Total Unique Behavioral Health Practitioners by Region

	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
RAE 1	3,293	3,311	3,349	3,360
RAE 2	3,100	3,166	3,291	3,308
RAE 3	6,118	7,040	7,021	6,311
RAE 4	3,097	3,164	3,291	3,307
RAE 5	6,211	6,983	7,021	6,283
RAE 6	3,921	4,113	4,294	4,617
RAE 7	3,921	4,113	4,294	4,617

Behavioral Health Member Engagement

	Member Population	Engagement Rate
RAE1	193,860	21.68%
RAE2	103,100	14.87%
RAE3	353,687	17.37%
RAE4	148,545	17.01%
RAE5	147,639	20.84%
RAE6	191,630	18.86%
RAE7	217,786	17.58%

Overall Accountable Care Collaborative (ACC) Average Performance & National Medicaid HMO Performance

HEDIS Measure	2019		2020		2021	
	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg	ACC Avg	Medicaid MCEs Natl Avg
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [1]	47.64%	14.4%	38.84%	14.1%	46.28%	Data Not available
Follow-up within 7 Days After Hospitalization for Mental Illness [2]	65.43%	36.2%	68.71%	39.4%	52.99%	Data Not available
Follow-up within 7 Days after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence [3]	34.93%	13.3%	36.02%	13.8%	33.27%	Data Not available
Follow-up After a Positive Depression Screen	50.19%	Data Not available	51.94%	Data Not Available	62.8%	Data Not Available

[1] https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/
[2] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[3]https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/

Behavioral Health Provider Rates Questions 54-58

Moving Toward More Equitable and Accountable Payments - HB 22-1268

- **Cost Reports:** changing the way we determine enhanced rates for the safety net, expanding the process beyond CMHCs
- **Universal Contract:** standardizing the processes and policies on payment, claims, data, and priorities for all publicly funded BH providers, reducing burden of multiple expectations
- **Value-Based Payments:** new payment methods for safety net providers based on quality and equity
- **Directed Payments, Valuing BH Provider time:** working with CMS to develop a minimum base rate for providers, called a directed payment, and updating cost value calculations

R10 - Children & Youth with Complex Needs Questions 59-61

Children and Youth with Complex Needs

- Youth with multiple diagnoses and connected to multiple systems (juvenile justice, child welfare etc.) present unique challenge
- Improving the systems
  - Significantly enhance cross-trained staff to serve youth and families - Early Periodic Screening, Diagnostic & Treatment
  - More Colorado-based residential facilities providing the set of programming the youth need
  - Expansion of step-down care from residential facilities, that includes community-based services (wraparound, family and natural supports, in-home treatment)

Crisis Services, Universal Contract & Behavioral Health Administration (BHA) Coordination Questions 62-64

Mobile Crisis Response

Colorado is launching a Mobile Crisis Response (MCR) Medicaid benefit available to all Coloradans regardless of insurance status.

The Department and the BHA are collaborating to design and launch this benefit set to launch in July ‘23.

This service will standardize MCR services, and is designed to de-escalate, stabilize and keep members in community while preventing excess hospitalization and arrest.

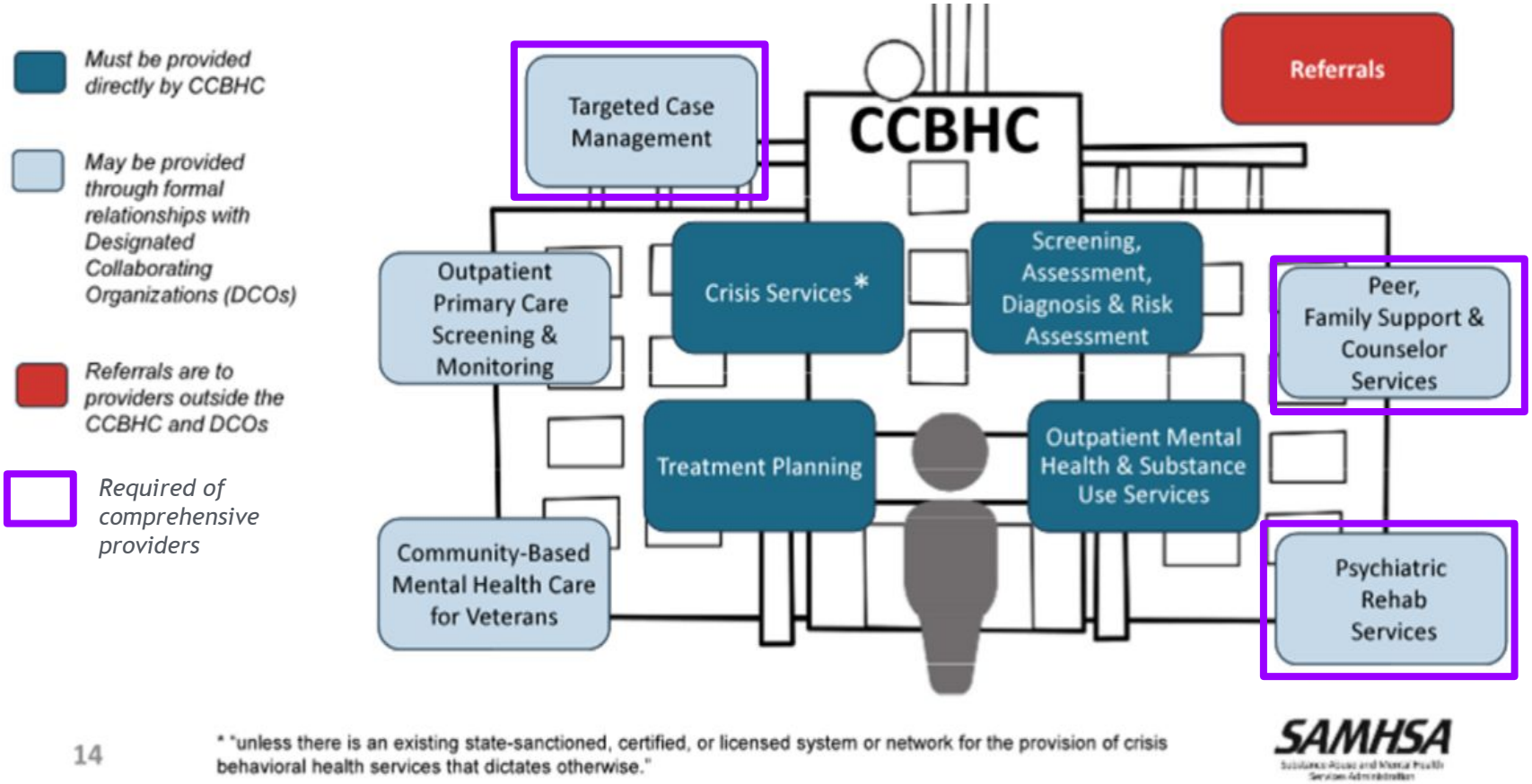
- Funded by ARPA CRSE 9813 planning grant to develop the benefit, and HCBS ARPA 2.02 to administer funds to providers to meet new services standards
- Benefit informed by: BHA rule 2 Colo. Code Regs. § 502-1-21.400.5; Guidance from CMS SHO letter #21-008; ARPA requirements, state and nation best practices
- Enhanced federal match (85/15) for states through 2027

R12 - Behavioral Health Claims System Questions 65-67

Certified Community Behavioral Health Clinics (CCBHC) Grant Questions 68-69

CCBHC Essential Services

9 Key Services of the CCBHC



14

* "unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise."

SAMHSA

Benefits of Prospective Payment Models

- Consistent, predictable, and sustainable funding
- Provider flexibility to meet need of clients
- Cost-based rate
  - Colorado law also requires rate to consider quality, equity, and access for priority populations
- Moving from volume to value
- Administrative Burden changes
  - Providers must still document encounters, but reduce admin time related to rate negotiation and claim submission

Large Activities for Planning Year

- The Department will work with the BHA, providers, advocates, payers, regulators, local community partners, families and members through multiple types of feedback and events, including
  - Surveys
  - In-person and virtual public meetings
  - Targeted interviews
  - What else?
- Will work to include clients to meet grant requirements without unnecessarily duplicating effort, and build on existing pathways for stakeholder feedback where we can.
- Partnership with advocates and members will be key in informing our choices, stakeholder feedback on provider interest in participating, payment models, required metrics, data reporting, and the design of certification will be crucial to moving forward.
- Policy and Fiscal Analysis
  - Crosswalk of state and federal policy
  - Looking at other state successes, challenges
  - Clear financing direction and budget

Office of Community Living

Dec. 21, 2022

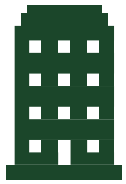
Kim Bimestefer, Executive Director
Bonnie Silva, Office of Community Living Director
Colin Laughlin, Office of Community Living Deputy Director

Long-Term Services and Supports

Community-Based Care

Including Home and Community-Based Services (HCBS), Long-Term Home Health, Private Duty Nursing, or State General Fund Programs

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



Institutional Settings

Nursing Facilities, Intermediate Care Facilities, or Hospital Backup Program

Long-Term Services and Supports System

Direct Services

- At home
- In community
- In facilities

Case Management

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

NOTE: CCBs also provide direct services.

Who Receives Long-Term Services & Supports?

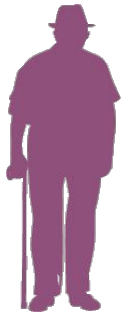
9%

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

45%

Adults
ages 21-64

46%



Older Adults
ages 65 or older

Cross Disability

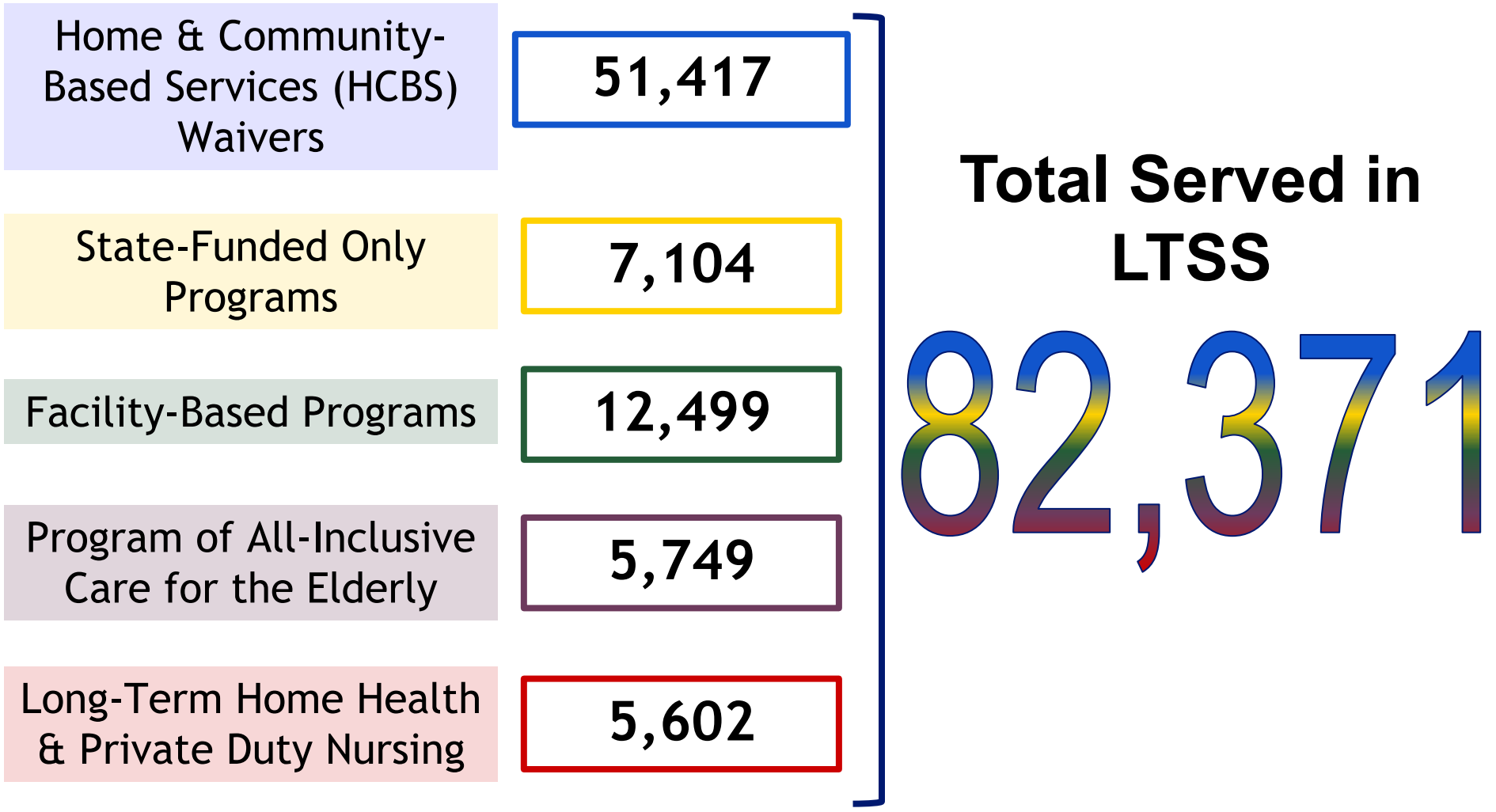
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

85% have a **chronic condition** (compared to 41% of all Medicaid members)

32% have 5 or more chronic conditions

FY 2021-22; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Long-Term Services & Supports Programs



SOURCE: FY 2021-22; based on claims in MMIS.

Community-Based Program Growth

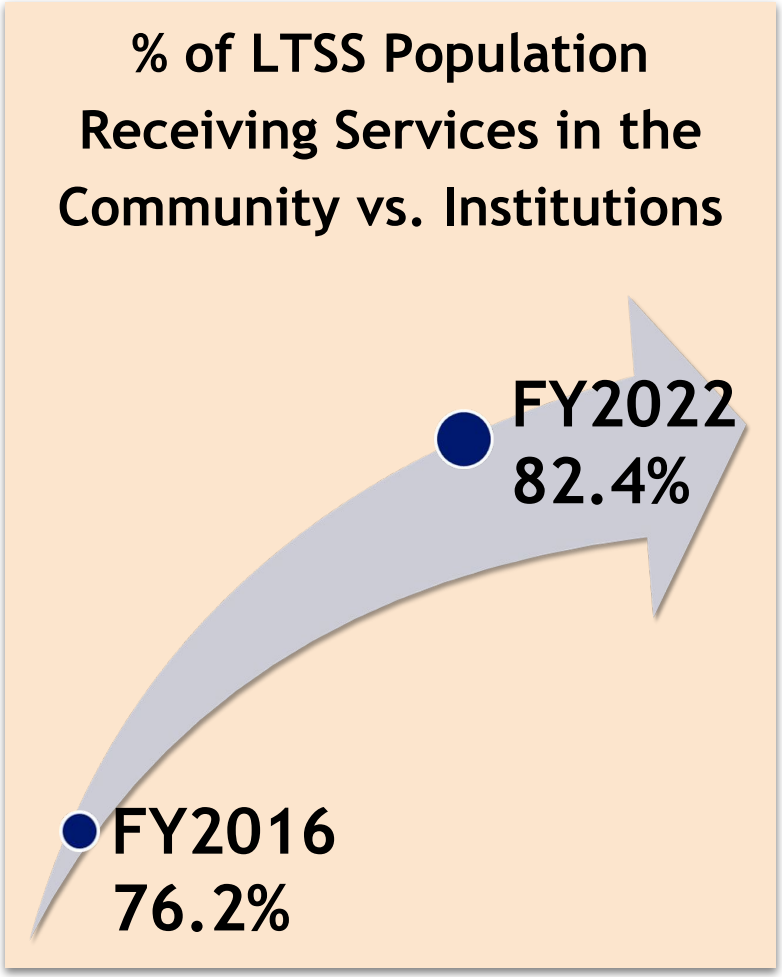
Questions 70-71

Program Growth by HCBS Waiver From FY 2016 - FY 2022

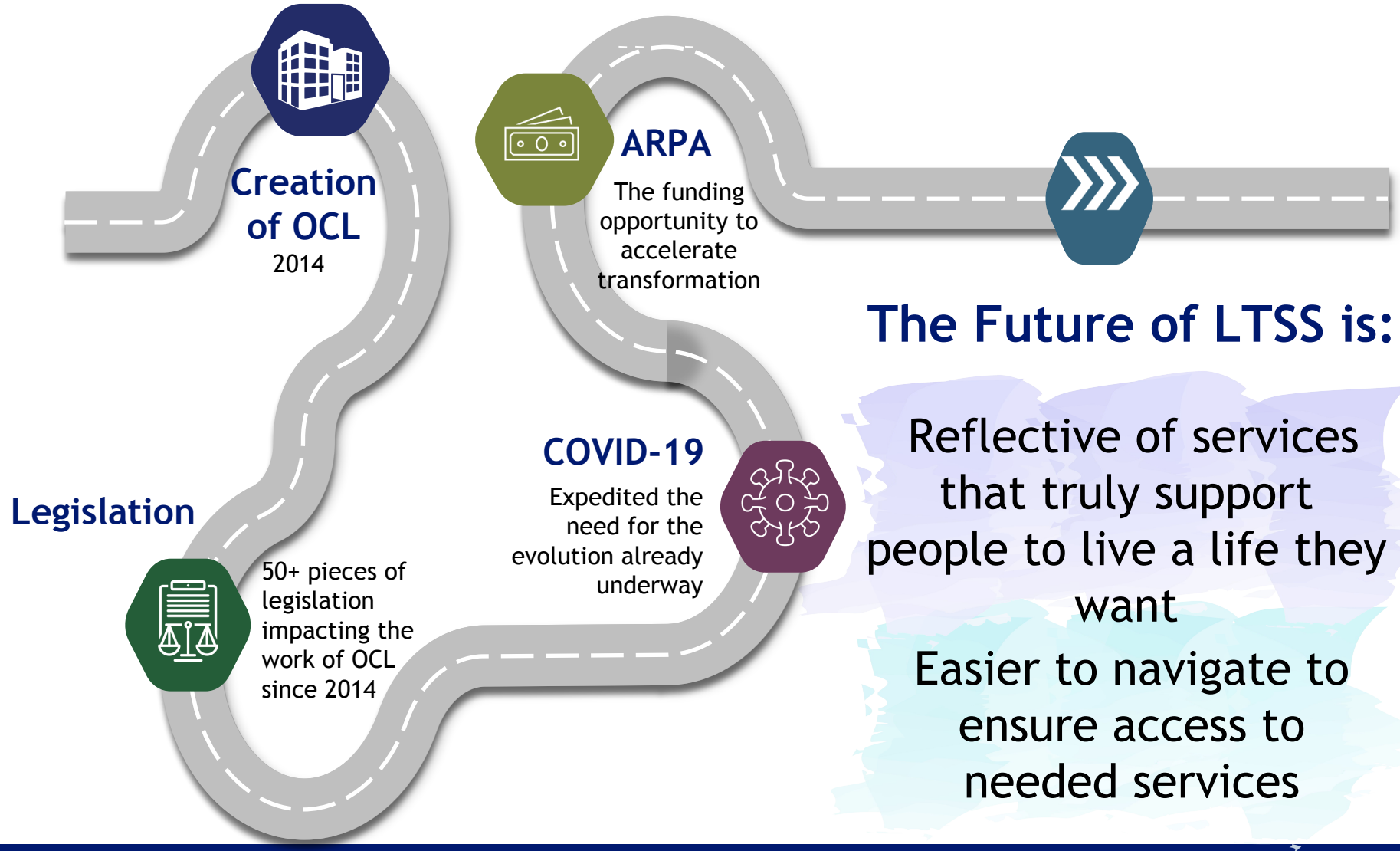
Brain Injury	Children With Life Limiting Illness	Children's Extensive Supports	Children's Habilitation Residential Program	Children's HCBS
+71%	+13%	+67%	+488%	+68%

Community Mental Health Supports	Developmental Disabilities	Elderly, Blind, & Disabled	Spinal Cord Injury	Supported Living Services
+8%	+53%	+14%	+311%	+7%

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



An Evolution of LTSS in CO



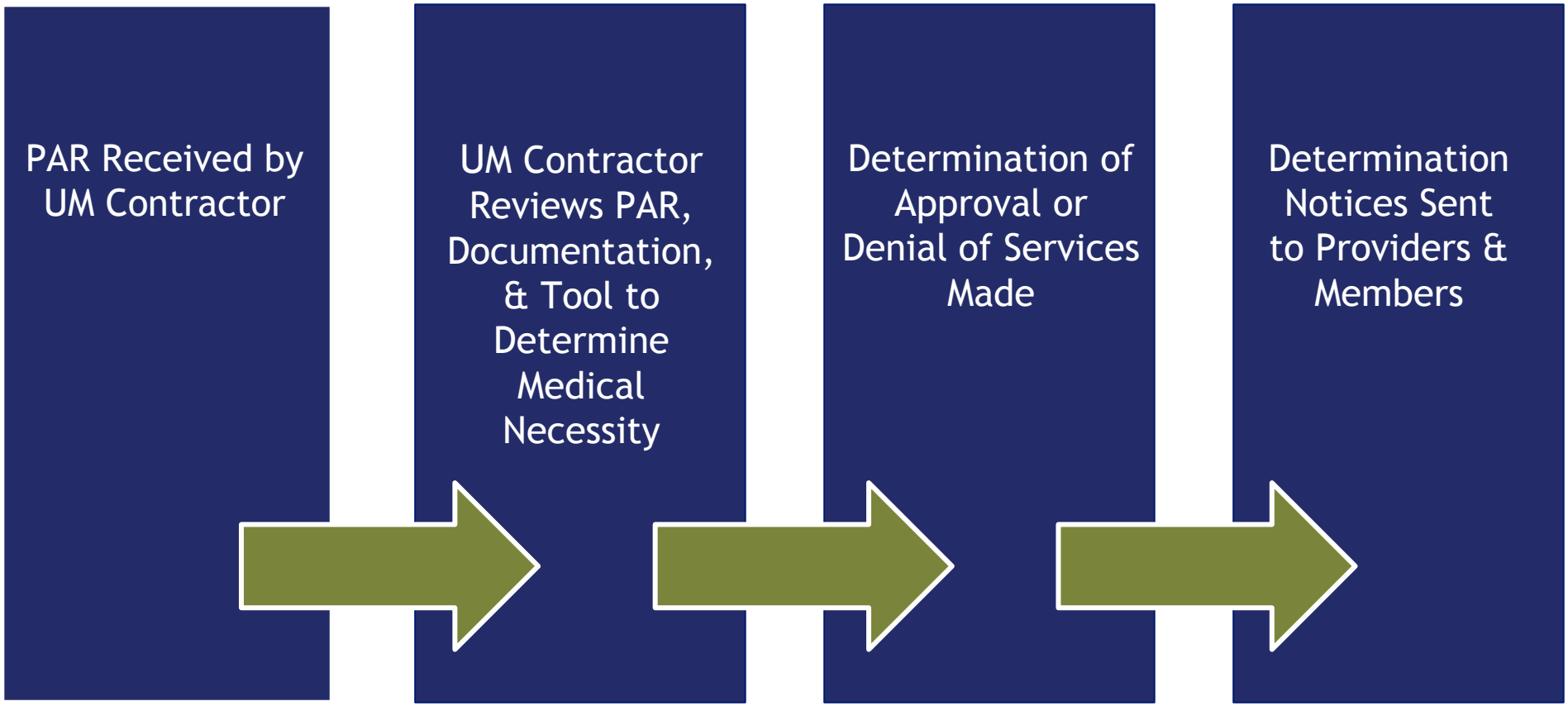
The Future of LTSS is:

Reflective of services that truly support people to live a life they want

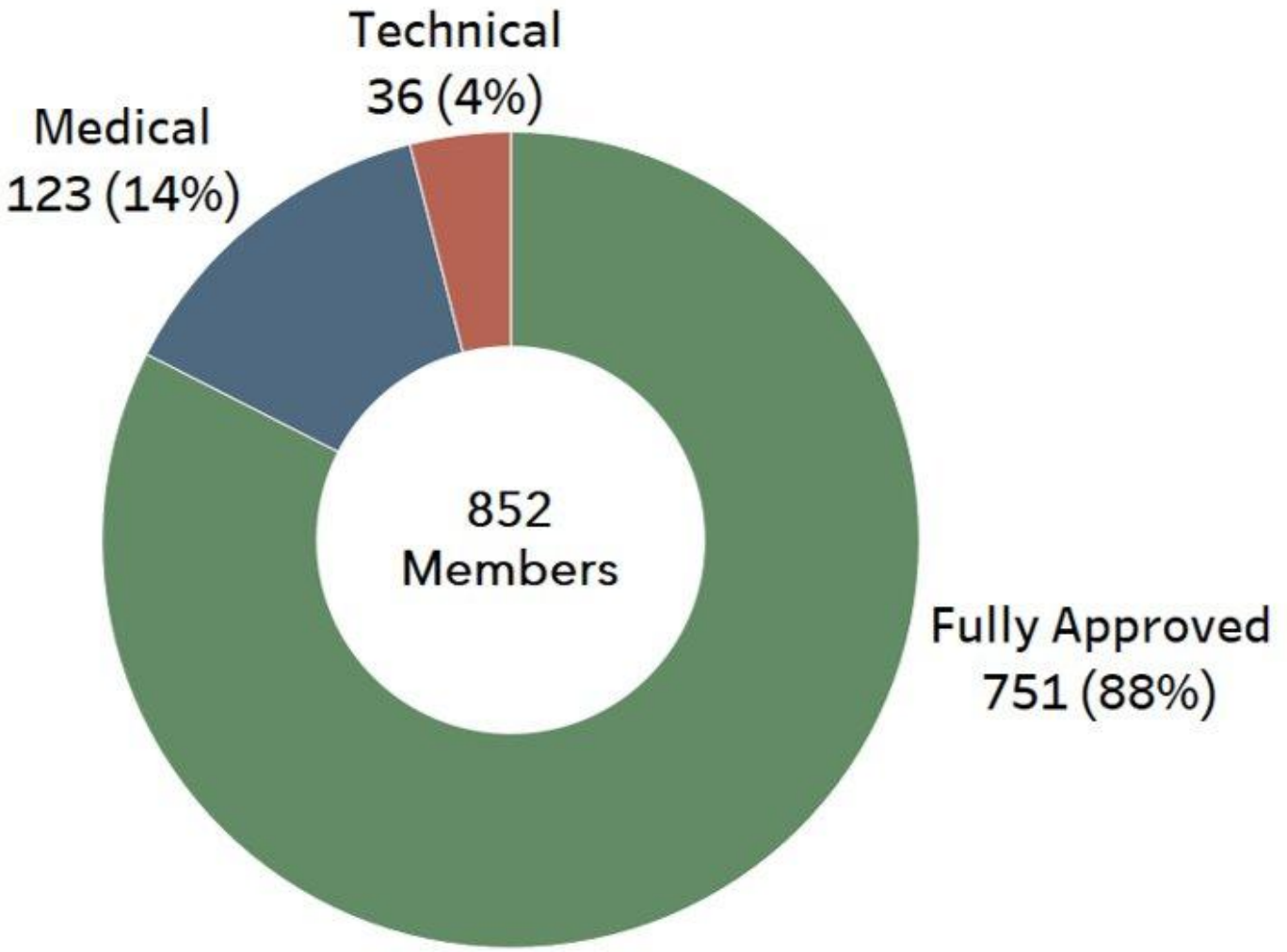
Easier to navigate to ensure access to needed services

Private Duty Nursing (PDN) Questions 72-74

PDN: Utilization Management (UM) and Contractor



PDN Medical & Technical Denials

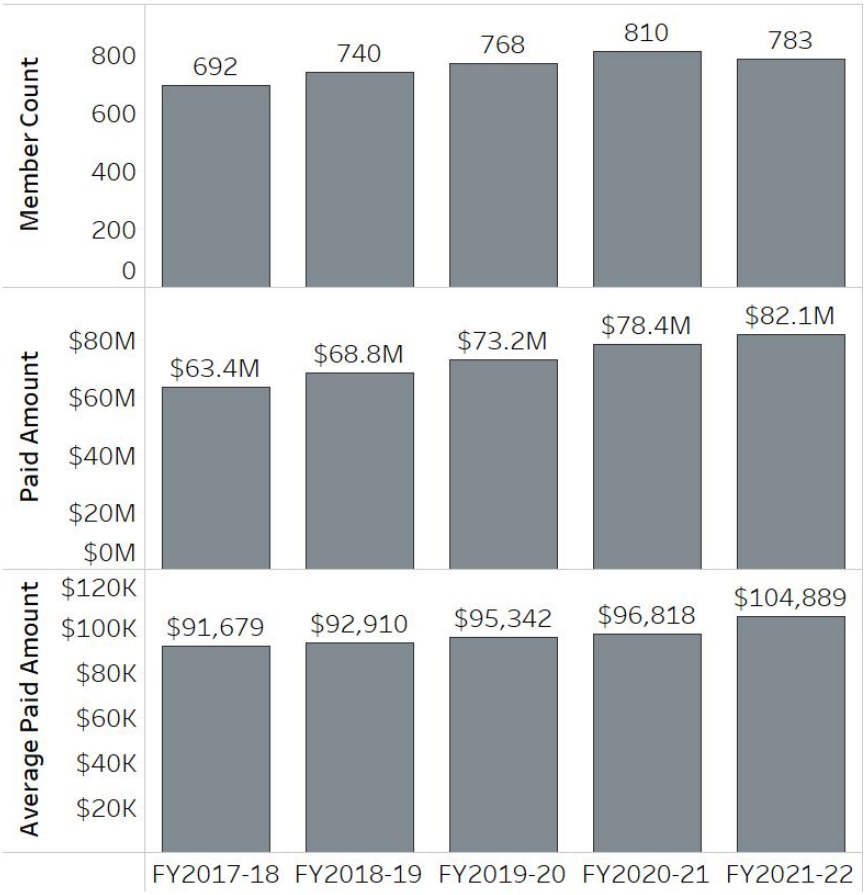


Includes PARs beginning November 2021 through October 2022 under Kepro

PDN Utilization Trends

PDN Adult

PDN Kids



Program for All Inclusive Care for the Elderly (PACE) Question 75

PACE Background

Per-member per-month capitated benefit program that provides comprehensive health care to members over 55 who require assistance with activities of daily living

Main objective is to enable older adults to live in the community as long as possible. A PACE organization is responsible for providing care that meets the needs of each participant across all care settings.

Colorado PACE serves 4,430 Medicaid members through five PACE organizations. PACE services are available in 13 Colorado counties.

InnovAge Enrollment Sanctions

1

May 26, 2021

The Department, with CDPHE & CMS, conducted an audit of all InnovAge Colorado operations

2

Dec. 23, 2021

The Department determined that the seriousness of the deficiencies identified required the suspension of any new enrollments for all of InnovAge Colorado centers

3

Dec. 5, 2022

The Department & CMS began performing an audit to validate improvements to which InnovAge has attested

Participant Direction Questions 76-79

Participant-Directed Programs

Consumer-Directed Attendant Support Services (CDASS)

- Population served: Adults on an approved Medicaid waiver
- Number of members served: 3,665
- Number of attendants: 12,641
- Average attendant wage: $21.56
- Member/AR is the employer
- Member/AR responsible for backup care
- Family members, including spouses, can be hired as attendants

In-Home Support Services (IHSS)

- Population served: Adults and children on an approved Medicaid waiver
- Number of members served: 7,503
- Number of IHSS agencies: 198
- Member/AR chooses an approved IHSS agency for support
- IHSS agency is responsible for backup care, access to a nurse, and independent living core services
- Family members, including spouses, can be hired as attendants

Nursing Facilities Question 80

State & Federal Financial Support

Federal Provider Relief Fund for SNFs	$119,626,046*
State COVID-19 Payments	$43,876,410
HB 22-1247 Payments	$27,001,000
Civil Monetary Penalty Funds to SNFs as grants	$700,000

$191.2 Million

SNF = Skilled Nursing Facility | *Likely higher |Figures through 12/15/2022

1247 Report Recommendations

PLANNING

- Conducted **stakeholder engagement** sessions to gather feedback on potential solutions
- Convened a small group of stakeholders to **evaluate feasibility** of proposed solutions
- **Analyzed cost** report data
- Evaluated factors impacting **sustainability**

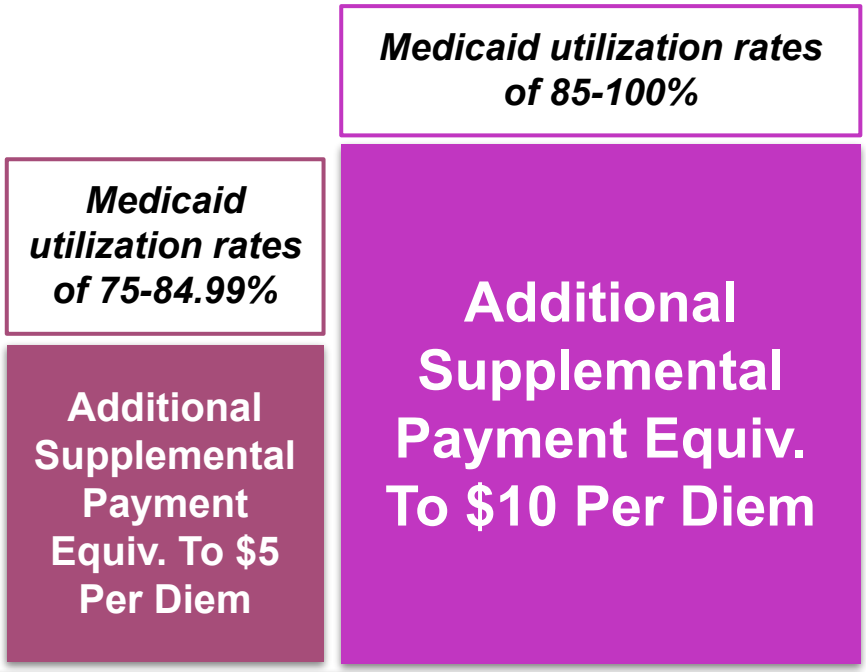
Goal: Stabilize nursing facility solvency while prioritizing quality and innovation

ACTION

- **Improve Stability**- Distribute additional funds to improve stability and retain staff (short-term)
- **Increase Efficiency and Equality**- Address duplicative and inequitable payments (medium-term)
- **Evolve Reimbursement Structure**- Modify reimbursement methodology and incentives (long-term)

R-7: A Thoughtful Approach to NFs

- ❑ Tiered Structure
- ❑ Prioritizes providers who take **Medicaid** and serve more **complex needs**
- ❑ Historic Investments



5.8%
Per Diem Increase Across All Facilities

Case Management Redesign Questions 81-94

How We Got Here

2014
Community Living Advisory Group (CLAG) & CMS

Mandate Issued

Conflict-free Case Management & Streamlined Access into HCBS System

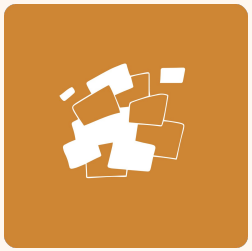
2014 - 2021
- National review of state best practices
- Legislation & rates
- Stakeholder work
- Alignment with CO LTSS Future Vision

Department Planning Process

Implementation

2022 - 2024
Case Management Redesign
- Rule change
- RFP & new contracts
- Transitions

The Future of Case Management



New Structure

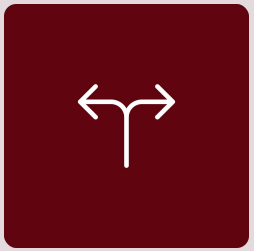
A more person-centered approach with each agency serving people with all disabilities in their geographic area with a rate structure that supports quality

Knowledge

Training for agencies to serve all members in a disability culturally competent manner through a new Learning Management System (LMS) and direct agency support

Accountability

Public-facing score cards and appropriate caseloads to ensure consistent, quality case management



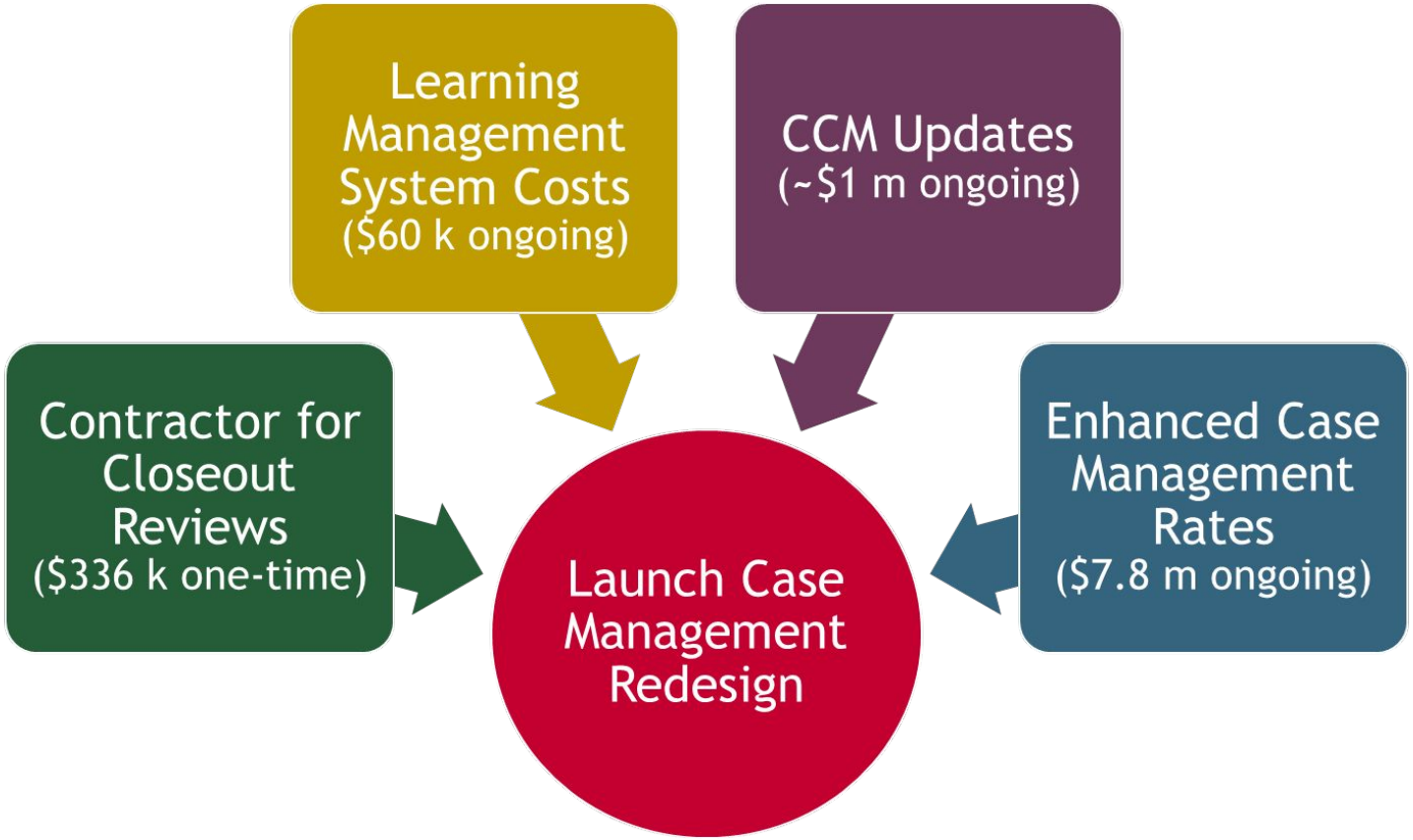
Conflict-Free

Case management and service delivery done by separate entities unless a rural exception is granted; meeting federal requirements and opening doors to additional program expansion and enhancement

Key Outcomes of Case Management Redesign

R-13: Case Management Redesign

Increase allocation by over **$3.6M in FY 23-24** and around **$9M annually ongoing**

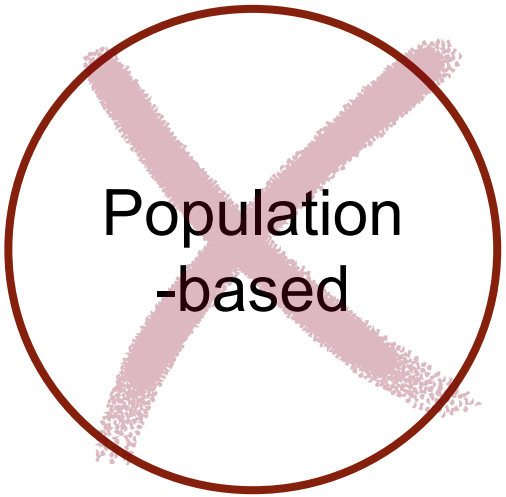


Current vs. New Rate Analysis

FY 2023-24	Forecasted CCB Population	Forecasted SEP Population	Combined CMA Population with Proposed Rate
# of Members	14,976	31,898	46,874
$ Rate	$144.59	$78.84, $86.99, $91.42	$118.04
Total Forecasted Reimbursement	$25,982,900	$31,320,003	**$66,396,241**
	$57,320,903		

Case Management Caseloads

Current System



CCBs: 25 - 85 members per case manager

SEPs: 90-165 members per case manager

- Large variation agency to agency

Future System

CMAs: 65 members per case manager

- Flexibility within agencies
- Based on national best practices, stakeholder feedback
- More balanced

Developmental Disabilities (DD) Waitlist Question 95

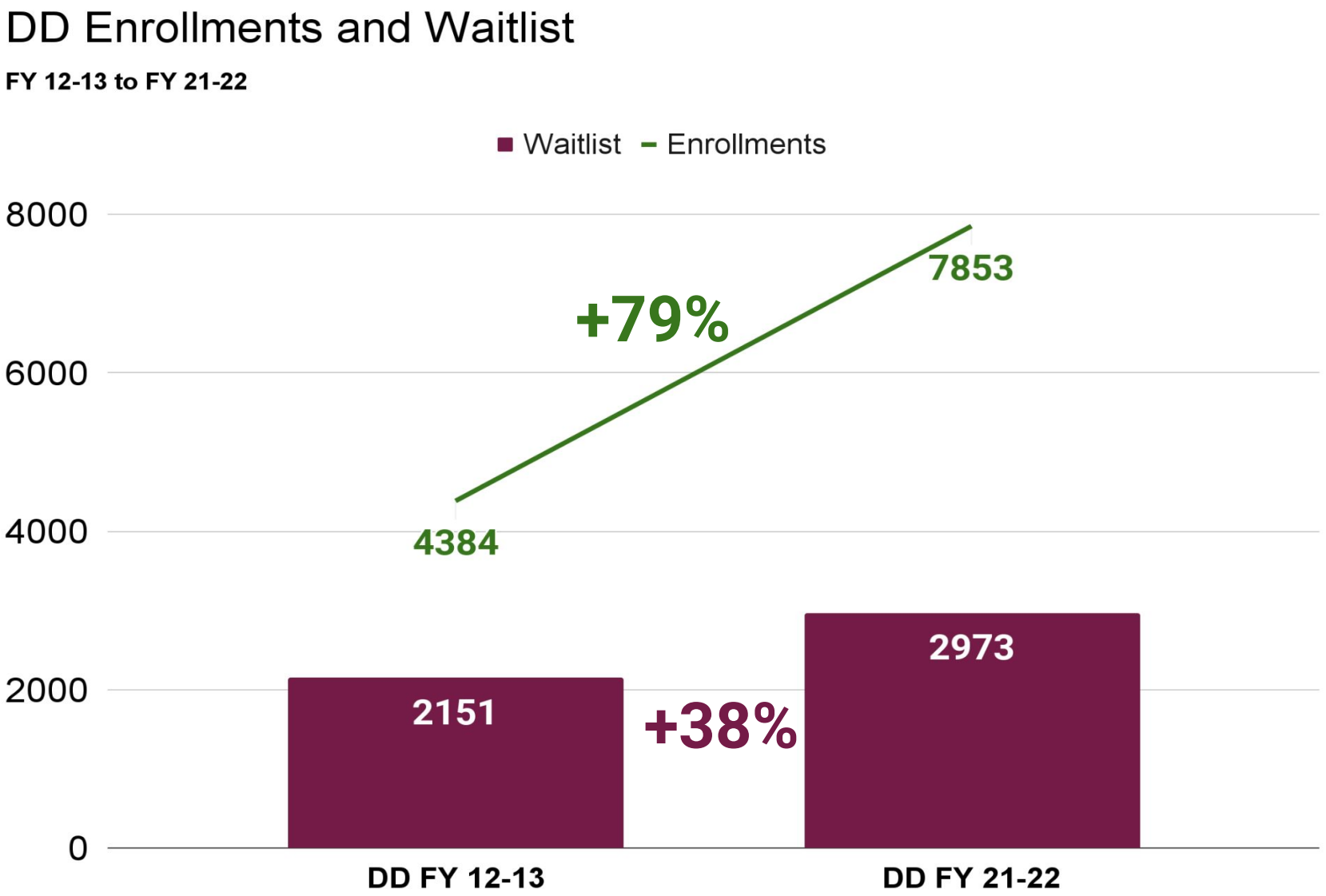
Managing the Waitlist

The Department submitted the **Intellectual and Developmental Disabilities (IDD) Strategic Plan on Nov. 1, 2014** in response to HB 14-1051 and has subsequently submitted an annual update. There was **no corresponding appropriation** for implementation of this strategic plan.

The Department can **authorize enrollments** into the DD waiver three ways:

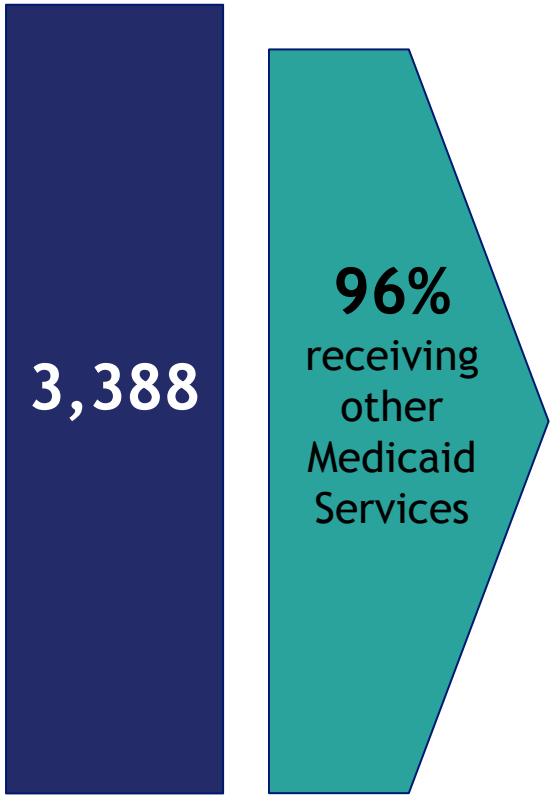
- New enrollments
- Efficient management of the churn
- Reserve capacity enrollments

Waiting List Progress



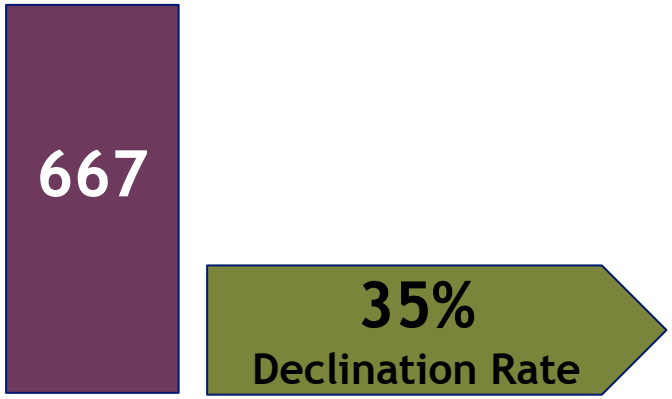
DD = Developmental Disability Waiver

Meeting The Needs of Members



"As Soon As Available" DD Waiting List

Declination Reason: Most individuals reported that it was because they currently receive sufficient services and supports through other Medicaid benefits.



New Enrollments Authorized through SB21-205

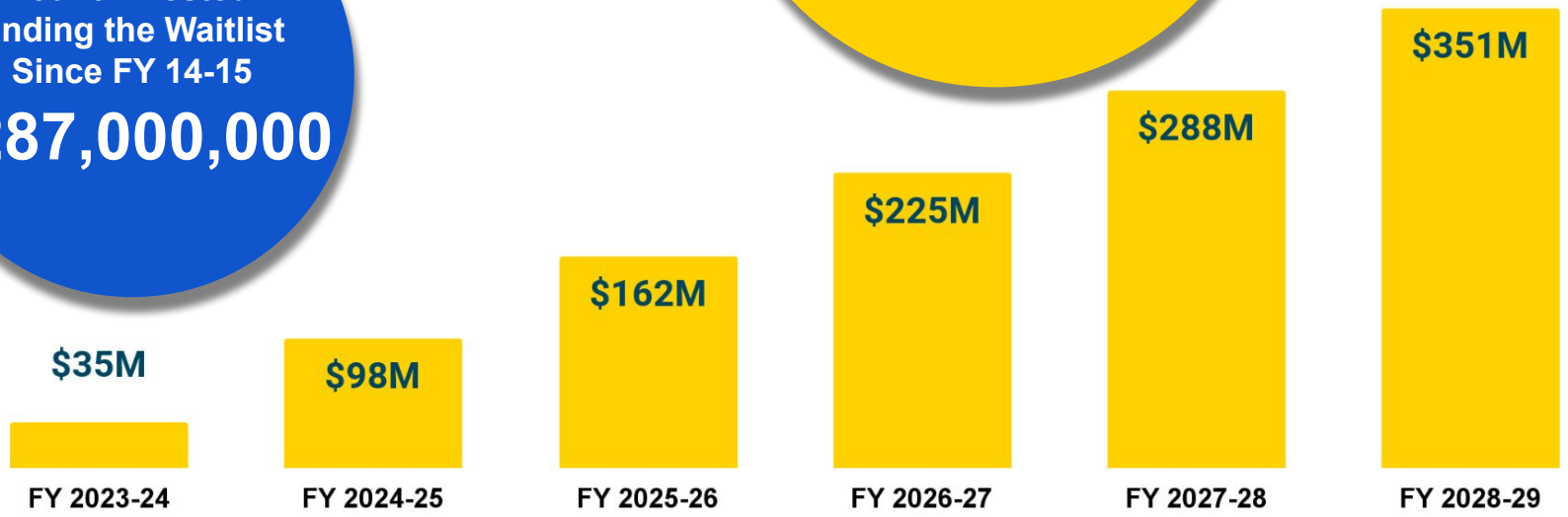
Investment for Enrollment Growth

Amount Invested in Ending the Waitlist Since FY 14-15

$287,000,000

Total cost to end the waitlist by 2030 & ongoing

$378,000,000



Year-Over-Year Investment Path

Thank you!