Department of Health Care Policy and Financing

Funding Request for the FY 2023-24 Budget Cycle

Request Title

R-07 Provider Rate Adjustments

Dept. Approval By: Eri Datys

OSPB Approval By: Megan Davisson

	Supplemental FY 2022-23
	Budget Amendment FY 2023-24
X	**Change Request FY 2023-24**

Summary Information	**Fund**	**FY 2022-23 Initial Appropriation**	**FY 2022-23 Supplemental Request**	**FY 2023-24 Base Request**	**FY 2023-24 Change Request**	**FY 2024-25 Continuation**
	Total	**$11,590,868,492**	**$0**	**$11,599,335,020**	**$192,249,156**	**$209,850,016**
	FTE	0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	$3,383,333,611	$0	$3,461,307,574	$69,830,979	$89,271,077
	CF	$1,316,862,433	$0	$1,247,403,033	$15,324,718	$3,879,353
	RF	$90,013,408	$0	$101,190,328	$0	$0
	FF	$6,800,659,040	$0	$6,789,434,085	$107,093,459	$116,699,586

Line Item Information	Fund	FY 2022-23 Initial Appropriation	FY 2022-23 Supplemental Request	FY 2023-24 Base Request	FY 2023-24 Change Request	FY 2024-25 Continuation
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - County Administration	**Total**	**$123,622,889**	**$0**	**$108,556,866**	**$440,463**	**$480,505**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,061,678	$0	$17,954,713	$52,767	$57,565
	CF	$27,113,119	$0	$24,919,374	$93,555	$102,059
	RF	$0	$0	$0	$0	$0
	FF	$76,448,092	$0	$65,682,779	$294,141	$320,881
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$10,482,357,710**	**$0**	**$10,494,097,233**	**$145,301,590**	**$158,634,491**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,899,250,775	$0	$2,945,642,674	$55,318,312	$63,846,090
	CF	$1,252,446,475	$0	$1,212,977,275	$6,398,557	$3,734,712
	RF	$90,013,408	$0	$101,190,328	$0	$0
	FF	$6,240,647,052	$0	$6,234,286,956	$83,584,721	$91,053,689
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	**Total**	**$12,970,664**	**$0**	**$12,996,494**	**$67,844**	**$74,011**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,881,495	$0	$2,887,233	$15,071	$16,441
	CF	$846,243	$0	$847,928	$4,426	$4,828
	RF	$0	$0	$0	$0	$0
	FF	$9,242,926	$0	$9,261,333	$48,347	$52,742
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	**Total**	**$713,885,548**	**$0**	**$720,480,048**	**$39,763,803**	**$43,378,695**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$333,336,878	$0	$359,107,197	$11,979,517	$21,687,864
	CF	$23,605,897	$0	$1,132,828	$7,902,385	$1,485
	RF	$0	$0	$0	$0	$0
	FF	$356,942,773	$0	$360,240,023	$19,881,901	$21,689,346
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	**Total**	**$80,658,077**	**$0**	**$87,271,330**	**$4,700,613**	**$5,127,941**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$30,977,592	$0	$37,696,396	$1,431,027	$2,534,809
	CF	$9,351,449	$0	$5,939,273	$919,282	$29,164
	RF	$0	$0	$0	$0	$0
	FF	$40,329,036	$0	$43,635,661	$2,350,304	$2,563,968

Line Item Information	Fund	FY 2022-23 Initial Appropriation	FY 2022-23 Supplemental Request	FY 2023-24 Base Request	FY 2023-24 Change Request	FY 2024-25 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	**Total**	**$42,487,893**	**$0**	**$42,672,027**	**$983,058**	**$1,072,427**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,280,542	$0	$21,336,015	$491,531	$536,214
	CF	$963,405	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$21,243,946	$0	$21,336,012	$491,527	$536,213
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	**Total**	**$12,047,333**	**$0**	**$12,314,200**	**$444,030**	**$484,396**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,023,119	$0	$6,157,100	$222,015	$242,198
	CF	$548	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,023,666	$0	$6,157,100	$222,015	$242,198
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management for People with Disabilities	**Total**	**$102,087,659**	**$0**	**$100,196,103**	**$452,367**	**$493,491**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$49,770,813	$0	$49,775,527	$225,351	$245,837
	CF	$2,535,297	$0	$1,586,355	$6,513	$7,105
	RF	$0	$0	$0	$0	$0
	FF	$49,781,549	$0	$48,834,221	$220,503	$240,549
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	**Total**	**$7,825,842**	**$0**	**$7,825,842**	**$36,543**	**$39,865**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,825,842	$0	$7,825,842	$36,543	$39,865
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	**Total**	**$10,337,979**	**$0**	**$10,337,979**	**$47,555**	**$51,878**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$10,337,979	$0	$10,337,979	$47,555	$51,878
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2022-23 Initial Appropriation	FY 2022-23 Supplemental Request	FY 2023-24 Base Request	FY 2023-24 Change Request	FY 2024-25 Continuation
	Total	**$2,519,109**	**$0**	**$2,519,109**	**$10,958**	**$11,954**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,519,109	$0	$2,519,109	$10,958	$11,954
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

	Total	**$67,789**	**$0**	**$67,789**	**$332**	**$362**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventative Dental Hygiene	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$67,789	$0	$67,789	$332	$362
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-7
Request Detail: Provider Rate Adjustments

Summary of Funding Change for FY 2023-24			
		Incremental Change	
	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2024-25 Request
Total Funds	$11,590,868,492	$192,249,156	$209,850,016
FTE	0.0	0.0	0.0
General Fund	$3,383,333,611	$69,830,979	$89,271,077
Cash Funds	$1,316,862,433	$15,324,718	$3,879,353
Reappropriated Funds	$0	$0	$0
Federal Funds	$6,800,659,040	$107,093,459	$116,699,586

Summary of Request

The Department requests $192.2 million in FY 2023-24 and $209.9 million ongoing in FY 2024-25 to provide an across-the-board rate increase of 0.5% and to make various targeted rate adjustments. The most important thing the Department can do to help with the massive workforce shortage is increase reimbursement as the largest payer in the state. The Department's proposed targeted rate adjustments include an increase for nursing facilities, an increase for home and community-based waiver services to reflect a $15.75 per hour base wage for workers statewide and $17.29 per hour in Denver; eliminating copays; and an incentive payment for rural providers. It also includes funding to implement the recommendations determined through the annual rate review process to promote equity in reimbursement for services including adjusting rates for physician services, lab and pathology, dialysis, injections, and eyeglasses and vision services. This request represents an increase of 1.7% from the Department's FY 2022-23 Long Bill total funds appropriation. There would need to be statute changes in order to implement the changes to eliminate copays and increase nursing facility reimbursement.

Requires Legislation	Evidence Level	Impacts Another Department?	Statutory Authority
Yes	3	No	C.R.S. 25.5-4-209 (1)(I)(A)(B) C.R.S. 25.5-6-202

Current Program

Medicaid Provider Rate Review Advisory Committee (MPRRAC)
Colorado's Medicaid program currently provides health care access to about 1.5 million people with a budget of $14 billion. Most providers are paid on a fee-for-service basis, meaning the Department pays for each incurred service based on a set rate. Pursuant to Section 25.5-4-401.5, C.R.S., the Department is required to periodically perform reviews of provider rates under the Colorado Medical Assistance Act. Section 25.5-4-401.5, C.R.S. also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC) to assist in the review of provider reimbursement rates. For the most part, rate increases for providers are subject to annual appropriation by the General Assembly.

Rural Health Providers Supports
The Colorado Regional Health Information Organization (CORHIO) and the Quality Health Network (QHN) were created to help advance data sharing and health information exchange (HIE) capabilities across Colorado. These two organizations provide critical health IT infrastructure and real-time health information to providers. CORHIO manages one of the country's largest health information exchange (HIE) networks and provides advisory services that help health care professionals effectively use technology and improve care delivery.

Funding for the Governor's Office of eHealth Innovation (OeHI) is outlined in the Colorado Health IT Roadmap.[1] This office is funded through resources provided through American Recovery and Reinvestment Act (ARRA), Health Information Technology for Economic and Clinical Health (HITECH) Act, other grant programs, and partnerships with organizations that support Colorado's Health IT infrastructure. Currently, the OeHI and the Department are making one-time investments into rural providers. The goal of OeHI's Rural Connectivity Program is to reduce the rural connectivity gap by facilitating HIE connectivity, providing real-time analytics, and applying technology to practice. This is done by subsidizing fees and providing technical assistance to ensure easy connections, establishing and expanding data connections to make holistic patient and business data available in one place, and using technology to optimize workflows, reduce provider burden, and improve reporting capabilities.

[1] https://oehi.colorado.gov/2021-colorado-health-it-roadmap

Eliminating Copayments
The Department requires copayments on several services including non-emergent outpatient hospital services, physician services, telemedicine services, rural health clinic services, pharmacy, optometry services, podiatry services, durable medical equipment, laboratory and radiology services. The copayment costs that members pay vary based on the services rendered and the income of the member. Federal law prohibits copayment to exceed 5% of a member's household income.

Group Residential Support Services (GRSS) and Non-Medical Transportation (NMT)
The Department manages the Home and Community Based Services waiver for persons with Developmental Disabilities (HCBS-DD) and the HCBS Supported Living Services (SLS) waiver. Both are HCBS waiver programs for people with intellectual and developmental disabilities (IDD). Group Residential Services and Supports (GRSS) and Non-Medical Transportation (NMT) are two services that are offered on these waivers. GRSS are designed to help adult with intellectual and developmental disabilities by providing 24/7 residential services. The GRSS benefit offers training and hands on assistance for self-advocacy, independent living, money management, decision making, and emergency assistance. NMT allows members to gain access to non-medical community services and supports as required by the care plan to prevent institutionalization.

Home and Community Based Waiver Services
Home and Community-Based Service (HCBS) waiver members can receive care in their home or community with services such as personal care, residential care, day habilitation services and behavioral services. These types of services allow individuals to receive essential care and remain in a community setting. The need for Colorado's direct care workforce is anticipated to grow by 40% between 2018 and 2028. There are currently significant shortages in the workforce, and these shortages are anticipated to get worse as demand for direct care services increases. In FY 2021-22, the Department submitted a spending plan to implement initiatives to enhance and expand Home and Community Based services in Colorado over the next three years. This was made possible by Section 9817 of the American Rescue Plan Act (ARPA), which provided enhanced federal funding for one year with the requirement that the state reinvest the enhanced funding back into those services. As part of that plan, the Department increased rates for certain HCBS services with a mandated wage passthrough for providers to pay at least $15 per hour base wage for frontline staff providing direct hands-on care.

Nursing Facilities
Pursuant to rate methodology outlined in section 25.5-6-202, C.R.S the Department is required to annually adjust nursing facility rates based on changes in provider costs. As part of that methodology, nursing facility rates are limited to 3% growth each year, which may not be adequate to keep pace with rising wages. Nursing facilities are also experiencing significant staffing shortages, cost increases, and drops in overall utilization.

Problem or Opportunity

Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieved, and cost-effective services are provided. The Department has an opportunity to address provider rates in a variety of services categories, including rates that may be currently set below reasonable benchmarks. The Department requests to address these areas through a series of provider rate adjustments.

Rate Review Process Recommendations

The Department proposes to implement several key recommendations from the 2022 Medicaid Provider Rate Review Recommendation Report. These recommendations are informed by the results of the 2022 Medicaid Provider Rate Review Analysis Report, the Medicaid Provider Rate Review Advisory Committee's (MPRRAC) recommendations, the Department's rate setting process, and the research of the Department's subject matter experts.

Physician Services

For the following physician services, the Department's recommendation in the Rate Review report is to rebalance rates that were identified to be below 80% of the benchmark and above 100% of the benchmark. This includes the following services: cardiology, cognitive capabilities assessment, ear, nose and throat (ENT) services, gastroenterology, health education, ophthalmology, primary care/evaluation and management (E&M) services, radiology, respiratory, vascular services, women's health and family planning, other physician services. The last remaining physician services category is vaccines and immunizations, the Department's recommendation is to increase rates that were identified to be below 80% of the benchmark up to 80% of the benchmark without a corresponding reduction for rates above 100%. The Department found that the payment rates for of physician services overall ranged from as low as 3.98% of the benchmark to as high as 1058.23% of the benchmark.

Dialysis & Nephrology

The Department found that the average payment rate for dialysis facility-based services was 78.5% of the benchmark. Colorado payment rates varied between 75.4% and 80.2% of Medicare regional rates. The Department also found the average payment rate for dialysis professional services was 61.1% of the benchmark, with Colorado payments varying between 26.9% and 104.0% of Medicare and an average of three other states' Medicaid rates. The Department's recommendation is to increase both facility-based and professional dialysis rates to 80% of the benchmark.

Eyeglasses & Vision

The Department found the average payment rate for eyeglasses and vision services was 57.4% of the benchmark. Colorado payment rates varied between 14.0% and 192.0% of Medicare and an average of six other states' Medicaid rates. The Department's

recommendation is to rebalance rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Laboratory & Pathology

The Department found the average payment rate for laboratory and pathology services was 93.7% of the benchmark. Colorado payment rates varied between 6.9% and 178.3% of Medicare and an average of seven other states' Medicaid rates. The Department's recommendation is to rebalance rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Injections & Miscellaneous J-Codes

The Department found the average payment rate for injections and miscellaneous J-codes was 95.6% of the benchmark. Colorado payment rates varied between 5.0% and 184.9% of Medicare and an average of four other states' Medicaid rates. The Department's recommendation is to rebalance rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Rural Health Provider Payment Increase

About 72% of Colorado's health care providers and hospitals are currently connected to one of Colorado's two recognized Health Information Exchanges (HIEs) – Colorado Regional Health Information Organization (CORHIO) and the Quality Heath Network (QHN). The majority of these health care providers that are not connected to the health IT infrastructure are located in rural communities, and many of these rural providers do not have the financial resources, technical expertise, or capacity to connect to Colorado's health IT infrastructure. OeHI and the Department will make a one-time-only investments in HIT to rural health providers but do not currently have funding to support and maintain those investments. Because this is a one-time only investment, rural health providers will have difficulties maintaining that investment without an incentive payment to continue to participate in the HIE. Health care providers in rural communities are often forced to utilize more outdated infrastructure compared to health care providers in other types of communities.

Eliminating Copayments

Copayments should encourage service utilization that is less costly and of higher value while discouraging service utilization which is more costly and of less value. The Department's current policy maximizes all co-payments irrespective of utilization desirability and is inconsistent with the findings of Medicaid studies of copayment effects on member utilization.[2] For example, studies show that co-payments can lead to delayed care, pill-splitting, and unfilled prescriptions which can result in poor health outcomes and more expensive utilization. A more nuanced policy that eliminates copayments for most services would reduce long-term costs by directing members to seek care in the appropriate settings and not to skip taking necessary prescriptions. The Department's current policy is especially concerning in the context of the COVID Public Health Emergency, which has caused an uneven economic disruption that impacts Medicaid

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

members, and especially members in communities of color, more so than medium and high-wage earners. Copayments increase the risk that members will be forced to choose between seeking necessary medical care and fulfilling living necessities, such as buying food and going to the pharmacy. Copayments are part of the cost-sharing mechanism for reimbursing health providers. If copayments are reduced, the Department will be able to leverage more federal matching funds through higher overall reimbursement to providers.

GRSS and NMT Budget Neutrality Adjustments
Group Residential Service and Supports (GRSS) data illustrates concerns around funding levels. GRSS providers often take on the members with the highest medical and behavioral needs. This requires staffing a registered nurse, acquiring a variety of costly medical equipment, and often having a 2:1 staff to member ratio. Due to workforce pressures, the Department has growing concerns on the ability for provider agencies to successfully render this level of care.

For the HCBS-DD and HCBS-SLS waivers, the Non-Medical Transportation (NMT) service has three different mileage bands, each with different rates. These rates are much lower than the NMT rates for many of the other HCBS waivers such as Elderly, Blind and Disabled (EBD) and can cause issues with consistent and equitable reimbursement of this service to providers.

Nursing Facilities
Nursing Facilities are experiencing staffing shortages, cost increases, and drops in overall utilization. Provider data collected by the Department confirm that costs for food, medical supplies, and particularly staff have increased overall costs. In 2022 the Department received approval to make supplemental payments to nursing facilities to raise all staff wages to $15 per hour, beginning in FY 2022-23. However, there continues to be pressure on wages and competition for these workers. Department data also demonstrates that facilities with higher Medicaid utilization are more likely to be facing financial challenges. This is primarily due to the inability for nursing facilities with a high Medicaid census to share costs with other payors, in part due to the inflexibility of the current Medicaid rate methodology.

Home and Community Based Waiver Services
There are currently significant workforce shortages in the HCBS settings. The rates for HCBS services were increased to reflect a $15 per hour base wage for workers during the 2022 legislative session. However, there continues to be significant pressure on wages for direct care workers, who could make more money working in other industries. This is exacerbated in the City and County of Denver, which recently raised the local minimum wage to $17.29 per hour.

Proposed Solution and Anticipated Outcomes

The Department requests $192,249,156 total funds and $69,830,979 General Fund in FY 2023-24 and $209,850,016 total funds and $89,271,077 General Fund in FY 2024-25 and ongoing to provide an across-the-board provider rate increase of 0.5% and to make various targeted rate adjustments. With rising cost of living due to high inflation, the Department anticipates that providers also are seeing rising costs.[3] The Department proposes to increase rates significantly to account for current economic conditions. The most important thing that the Department can do to help with the massive workforce shortage is increase reimbursement as the largest payer in the state. This will also help to prevent further exacerbating disparities as providers decide whether it makes financial sense to accept Medicaid members.

Across-the Board Rate Adjustment
The department requests to implement an across-the-board (ATB) provider rate increase of 0.5% for most services that are not addressed in the other components of this request. In aggregate, the increases will help address adequacy of payments and support providers who are subject to rising labor, utility, and capital costs, and other inflationary pressure.

MPRRAC Recommendations
Physician Services, Eyeglasses & Vision, Lab & Pathology, Injections & Misc. J-Codes
The Department requests funding to increase rates for certain services that were identified through the rate review process to be out of alignment with specific Medicare benchmarks. Services that were found to be below 80% of their respective Medicare benchmarks will be rebalanced and raised to 80% of that benchmark and services that were found to be higher than 100% of their corresponding Medicare benchmarks will be rebalanced and brought down to 100% of that benchmark. The services recommended for rate rebalancing are physician services, eyeglasses and vision services, laboratory and pathology services, and injections and miscellaneous J-Codes. Overall, this will result in a net increase to expenditure for each of these service categories. For vaccines and immunizations, the Department is requesting to increase rates that are below 80% of the benchmark rate to 80% of the benchmark without a corresponding reduction for those rates above 100% of the benchmark.

The Department is also requesting to align evaluation and management rates that have a family planning modifier with the same service rates paid to other provider types. In some cases, these rates are currently below the corresponding rates for other providers.

Dialysis & Nephrology
The Department requests funding to increase rates for dialysis facility-based and professional services that were below 80% of the Medicare benchmark rate to the 80% level. Overall, this will result in a net increase to expenditure for dialysis and nephrology services.

[3] https://www.bls.gov/news.release/cpi.nr0.htm

Rural Health Provider Payment Increase

The Department requests funding to increase payments for rural providers through an incentive payment for rural providers that participate in OeHI's Rural Connectivity Program. Currently, the Office of eHealth Innovation (OeHI) and the Department will make a one-time only investment into rural providers through OeHI's Rural Connectivity Program. Once the rural providers are participating in the OeHI Program, the Department requests to incentivize those providers to maintain participation. Since the OeHI funding is a one-time investment, providers must find the funding to support their long-term IT investments. Rural providers may drop out of the program overtime if there is not sustainability funding to support their internal IT investments and participation in the program. OeHI will have ongoing operational funding to support the contracted services related to the program, but there is no funding to incentivize providers to maintain their participation. The ability to capture savings and make investments to maintain their participation can be difficult due to their limited revenue sources.

Therefore, the Department proposes to leverage Medicaid funds to incentivize their continued participation in the program by providing increased funding to Rural Health Centers and Critical Access Hospitals enrolled in the program. This request supports three of the Department's six strategic pillars that were established to ensure customer-focused performance management

- Care Access – Improve member access to affordable, high-quality care.
- Member Health – Improve member health outcomes and reduce disparities in care.
- Operational Excellence & Customer Service – Provide excellent service to members, providers, and partners with compliant, efficient, effective person- and family centered practices.

Eliminate Member Copayments

The Department requests to remove copayments for the following services: Primary Care Medical Services, Telemedicine, Rural health clinic, Pharmacy, Optometrist, Podiatrist, Durable Medical Equipment, Laboratory services, and Radiology services. The Department anticipates that by eliminating the copayments for these services, it will shift utilization away from more expensive care such as emergency room services, and more towards less expensive and higher-value services such as primary care, pharmacy, and dental services.[4] The Department also anticipates that removing member copayments will lessen the financial burden that members and families might experience as a result of cost-sharing, such has having to borrow money to pay for care or not being able to afford basic needs like rent and food. Since the removal of member copayments would act as a rate increase for providers and because a large percent of members that pay copayments are in the Medicaid expansion group, the Department anticipates that eliminating member copayments will bring in more federal funding relative to the increase in General Fund expenditure.

[4] https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3164

Legislation would be required to amend section 25.5-4-209(1)(b)(I), C.R.S. to remove the mandate for a Medicaid recipient to pay a portion of the cost for pharmacy and outpatient hospital incurred by the recipient.

GRSS Budget Neutrality Adjustment and NMT Rate Increase
The Department requests funding to increase the rates for GRSS services to more closely align with the adequate and equitable reimbursement of services. GRSS providers take on members with high medical and behavioral needs. Due to these needs, these settings require staffing a registered nurse, that providers acquire expensive medical equipment, and will often need several staff to work with one member. Due to workforce shortages, the Department seeks to ensure provider agencies are able to successfully provide this care and keep members out of more costly Intermediate Care Facilities or Nursing Facilities.

For NMT on the DD and SLS waivers, the Department request funding to increase these rates so that they are in alignment with the NMT service offered on other waivers. This approach will ensure access across all the HCBS waiver programs. The Department requests to use funding from the American Rescue Plan Act Home and Community Based Services (HCBS) spending plan for the state share through October 31, 2023 and use General Fund as the state share ongoing after that.

Increasing the Base Wage for HCBS Direct Care Workers
The Department requests funding to increase the base wage to support direct care workers that provide HCBS services. This increase will be provided through a wage passthrough to ensure that workers receive at least a $15.75 per hour wage for workers in non-Denver Counties and $17.29 for Denver counties. Maintaining these rates will allow the Department to further support the financial stability of workers in the personal care industry in Colorado and ensure that patients have an adequate provider network to meet their needs. The Department requests to use funding from the American Rescue Plan Act HCBS spending plan for the state share through October 31, 2023 and use General Fund as the state share ongoing after that.

Increasing Payments for Nursing Facilities
The Department requests funding to increase the reimbursement rate paid to nursing facilities. This request will allow the Department to further support the financial stability of workers and meet the growing costs of operating in the nursing facility industry in Colorado and ensure that members have an adequate provider network to meet their needs. The Department would implement the increase by allowing the per diem rate for all nursing facilities to grow by 5.86% compared to the FY 2022-23 per diem rates. In addition, nursing facilities with Medicaid utilization rates of 85-100% would receive a supplemental payment equivalent to $10.00 per diem, and nursing facilities with Medicaid utilization of 75-84.99% would receive a supplemental payment equivalent to $5.00 per diem. The Department strongly believes this approach to be in the best interest

of Medicaid members, as data illustrates high Medicaid occupancy facilities are facing the greatest staffing and solvency issues.

Legislation would be required to amend section 25.5-6-202, C.R.S to allow the per diem rate to grow by more than 3% in FY 2023-24. The additional payment for nursing facilities with greater Medicaid utilization would also need to be specified as an allowable supplemental payment. Colorado's nursing facility reimbursement methodology is uniquely outlined in statute and, in most years, requires an annual 3.0% reimbursement rate increase. For many years this methodology worked well for nursing facilities. Unfortunately, the COVID-19 pandemic drastically increased labor costs and the overall complexity of the resident population increased. To support the health, safety, and welfare of Colorado's nursing facility residents the Department seeks removal of the automatic 3% increase to provide for this increase and enhanced flexibility in the future. Accordingly, the Department intends to pursue this legislation as part of its 2023 legislative agenda. The Department looks forward to working with all community partners on next steps.

Evidence-Continuum

Program Objective	Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieve, and that services provided are cost-effective. The objective of increasing provider rates is to increase access to care and to ensure adequate reimbursement of services for providers.		
Outputs being measured	Quality of care, utilization of services, member feedback, and provider feedback.		
Outcomes being measured	Access to services, provider network capacity, adequacy of rates, increased member satisfaction.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Provider network size, evaluation of utilization of services, and provider rates.		
SB21-284 Evidence Category and Evidence Continuum Level	Step 3: Evidence Informed		

Promoting Equitable Outcomes

Historically underserved population or group	Description of existing equity gap(s)	How does the request affect the gaps? (quantify wherever possible).
Uninsured and low-income Medicaid patients and Medicaid patients residing in rural communities.	Rural Coloradans are a population group that experiences significant health disparities caused by geographic isolation, limited access to healthcare specialists, and limited job opportunities.	This request can help rural providers maintain IT investments and thus participation in the OeHI Rural HIE Connectivity program. This program helps providers in remote locations access important medical information of a patient. The result of this is better and faster access to a patient's health information which can help to reduce readmissions, avoid medication errors, improve diagnoses and decrease duplicate testing.

Assumptions and Calculations

Across-the-Board Rate Adjustment
Estimates are based on the Department's FY 2022-23 budget and prior year actuals. Although these rate increases will affect most Medicaid providers, a number of providers will be exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract;
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement;
- Reimbursements to pharmacies are not eligible for the rate increase. Pharmaceutical reimbursement has transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology

is directly tied to a moving price statistic that increases reimbursement as provider costs increase;

- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated;
- Rates for Federally Qualified Health Centers will be ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology;
- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may not be impacted by rate increases depending on the outcome of rate negotiations
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan Plus (CHP+) and regional accountable entities (RAEs)[5] will not receive direct rate increases as part of this change request. Rates are set in accordance with federal regulation and actuarial standards, which do not generally permit general provider rate increases. The department notes, however, that RAE and CHP+ rates generally increase in response to provider cost, and rates for Medicaid managed care organizations will increase indirectly based on increases applied to fee-for-service rates; and

Services receiving targeted rate increases will not be eligible for the additional across the-board rate increase.

Physician Services, Lab & Pathology, Injections & Misc. J-Codes

The Department compared rates for physician services, laboratory and pathology services, as well as injections and miscellaneous J-Codes to their appropriate and corresponding benchmark rates and estimated the Department's reimbursement rates compared to the benchmarks as a percentage. For these services, rates that were below 80.00% of the benchmark will be brought up to 80.00% of the benchmark. Similarly, rates that are above 100.00% of the benchmark will be brought down to 100.00% of the benchmark. The Department estimated the cost by calculating the difference between the current rates and the proposed rates at either 80% or 100% of the benchmark and multiplied that difference by the annual utilization.

Dialysis & Nephrology

The Department compared rates for dialysis facility-based and dialysis professional services to appropriate benchmark rates and estimated the Department's reimbursement rates compared to the benchmark as a percentage. For dialysis services below 80.00% of the benchmark, rates will be brought up to 80.00% of the benchmark. The Department

[5] The Department assumes an across-the-board increase would still apply to the administrative per member per month payment for care coordination.

estimated the cost by calculating the difference between the current rates and the proposed rates at either 80% or 100% of the benchmark and multiplied that difference by annual utilization.

Rural Health Providers Payment Increase
The estimated payment increase for Rural Health Providers will be based on the estimated number of Critical Access Hospitals (CAHs) and Rural Health Centers (RHCs) and the annual increase in expenditure for each of these types of providers. Qualifying rural providers are those that invest in technology upgrades to connect CORHIO and QHN and participate in the OeHIs Rural Health Connectivity Program. The Department assumes that the payment increases for Rural Health Providers will be funded as an administrative payment, however the Department plans to discuss receiving an enhanced federal match with CMS and would adjust that through the normal budget cycle.

Eliminating Copayments
The estimated impact of eliminating member copayments is based on the average number of copayments paid in FY 2018-19 across several services, multiplied by the proposed change in the copayment amount.

GRSS Budget Neutrality Adjustment and NMT Rate Increase
The Department calculated the incremental impact of increasing the GRSS rates by comparing total GRSS expenditure for FY 2020-21 to the proposed annual GRSS expenditure after making the necessary adjustments to the GRSS to align with the state budget. This impact was adjusted to assume a start date of July 1, 2023 where this rate adjustment will be funded using American Rescue Plan Act (ARPA) funds through October 31, 2023.

The impact of adjusting NMT rates on the DD and SLS waivers was calculated by comparing total annual transportation expenditure to the new estimate in transportation expenditure that would occur after raising rates for the NMT service to align with NMT on other waivers.

Increasing the Base Wage for HCBS Direct Care Workers
The Department estimated Home- and Community-Based rate increase by projecting expenditure by services receiving the proposed rate increase and calculating the increase in payments based on the variable percentage increase by service.

Increasing Payments for Nursing Facilities
The Department estimated an increase of $18.37 as the average increase on a per diem basis to help offset the growth in costs incurred by nursing facilities. This increase is based on a tiered rate increase for nursing facilities based on the percentage of Medicaid clients the facilities serve.

Table 1.1
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$440,463	0.0	$52,767	$93,555	$0	$294,141	66.78%	Table 3.1 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$145,301,590	0.0	$55,318,312	$6,398,557	$0	$83,584,721	N/A	Table 3.1 Row G + Corresponding rows in Summary by Initiative Table 2.1
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$67,844	0.0	$15,071	$4,426	$0	$48,347	N/A	Table 3.1 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$39,763,803	0.0	$11,979,517	$7,902,385	$0	$19,881,901	50.00%	Table 3.1 Row K
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$4,700,613	0.0	$1,431,027	$919,282	$0	$2,350,304	50.00%	Table 3.1 Row M
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	$983,058	0.0	$491,531	$0	$0	$491,527	50.00%	Table 3.1 Row O
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$444,030	0.0	$222,015	$0	$0	$222,015	50.00%	Table 3.1 Row Q
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$452,367	0.0	$225,351	$6,513	$0	$220,503	48.74%	Table 3.1 Row S
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	$36,543	0.0	$36,543	$0	$0	$0	0.00%	Table 3.1 Row Y
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	$47,555	0.0	$47,555	$0	$0	$0	0.00%	Table 3.1 Row U
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	$10,958	0.0	$10,958	$0	$0	$0	0.00%	Table 3.1 Row W
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	$332	0.0	$332	$0	$0	$0	0.00%	Table 3.1 Row AA
M	**Total Request**	**$192,249,156**	**0.0**	**$69,830,979**	**$15,324,718**	**$0**	**$107,093,459**	**N/A**	**Sum of Rows A thru L**

Table 1.2
Summary by Line Item
FY 2024-25

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$480,505	0.0	$57,565	$102,059	$0	$320,881	66.78%	Table 3.2 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$158,634,491	0.0	$63,846,090	$3,734,712	$0	$91,053,689	N/A	Table 3.2 Row G + Corresponding Rows in Summary by Initiative Table 2.2
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$74,011	0.0	$16,441	$4,828	$0	$52,742	N/A	Table 3.2 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$43,378,695	0.0	$21,687,864	$1,485	$0	$21,689,346	50.00%	Table 3.2 Row K
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$5,127,941	0.0	$2,534,809	$29,164	$0	$2,563,968	50.00%	Table 3.2 Row M
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	$1,072,427	0.0	$536,214	$0	$0	$536,213	50.00%	Table 3.2 Row O
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$484,396	0.0	$242,198	$0	$0	$242,198	50.00%	Table 3.2 Row Q
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$493,491	0.0	$245,837	$7,105	$0	$240,549	48.74%	Table 3.2 Row S
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	$39,865	0.0	$39,865	$0	$0	$0	0.00%	Table 3.2 Row Y
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	$51,878	0.0	$51,878	$0	$0	$0	0.00%	Table 3.2 Row U
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	$11,954	0.0	$11,954	$0	$0	$0	0.00%	Table 3.2 Row W
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	$362	0.0	$362	$0	$0	$0	0.00%	Table 3.2 Row AA
M	**Total Request**	**$209,850,016**	**0.0**	**$89,271,077**	**$3,879,353**	**$0**	**$116,699,586**	**N/A**	**Sum of Rows A thru L**

Table 1.3
Summary by Line Item
FY 2025-26

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$480,505	0.0	$57,565	$102,059	$0	$320,881	66.78%	Table 3.2 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$158,634,491	0.0	$63,846,090	$3,734,712	$0	$91,053,689	N/A	Table 3.2 Row G + Corresponding Rows in Summary by Initiative Table 2.2
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$74,011	0.0	$16,441	$4,828	$0	$52,742	N/A	Table 3.2 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$43,378,695	0.0	$21,687,864	$1,485	$0	$21,689,346	50.00%	Table 3.2 Row K
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$5,127,941	0.0	$2,534,809	$29,164	$0	$2,563,968	50.00%	Table 3.2 Row M
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	$1,072,427	0.0	$536,214	$0	$0	$536,213	50.00%	Table 3.2 Row O
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$484,396	0.0	$242,198	$0	$0	$242,198	50.00%	Table 3.2 Row Q
0	0	$0	0.0	$0	$0	$0	$0	0.00%	Table 3.2 Row CC
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$493,491	0.0	$245,837	$7,105	$0	$240,549	48.74%	Table 3.2 Row S
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	$39,865	0.0	$39,865	$0	$0	$0	0.00%	Table 3.2 Row Y
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	$51,878	0.0	$51,878	$0	$0	$0	0.00%	Table 3.2 Row U
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	$11,954	0.0	$11,954	$0	$0	$0	0.00%	Table 3.2 Row W
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	$362	0.0	$362	$0	$0	$0	0.00%	Table 3.2 Row AA
M	**Total Request**	**$209,850,016**	**0.0**	**$89,271,077**	**$3,879,353**	**$0**	**$116,699,586**	**N/A**	**Sum of Rows A thru L**

Table 2.1
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
	Across the Board Rate Adjustment								
A	Across the Board Rate Increase of 0.5%	$24,200,145	0.0	$8,630,708	$1,135,953	$0	$14,433,484	NA	Table 3.1 Row DD
Targeted Rate Adjustments									
	MPRRAC Recommendations								
B	Physician Services	$19,311,361	0.0	$5,907,439	$799,446	$0	$12,604,476	65%	Table 4.1 Row N * (11/12)
C	Dialysis & Nephrology	$427,077	0.0	$92,379	$26,460	$0	$308,238	72%	Table 4.1 Row Q * (11/12)
D	Laboratory & Pathology	$2,453,573	0.0	$542,448	$138,613	$0	$1,772,513	72%	Table 4.1 Row R * (11/12)
E	Eyeglasses and Vision	$19,167,764	0.0	$5,863,512	$793,502	$0	$12,510,750	65%	Table 4.1 Row S * (11/12)
F	Injections & Miscellaneous J-Codes	$86,238	0.0	$26,381	$3,571	$0	$56,286	65%	Table 4.1 Row T * (11/12)
G	**Total Funding For MPRRAC Recommendations**	**$41,446,013**	**0.0**	**$12,432,159**	**$1,761,592**	**$0**	**$27,252,263**		**Sum of Row B through Row F**
	Other Provider Rate Adjustments								
H	Rural Hospital Technology Payment	$4,220,000	0.0	$2,110,000	$0	$0	$2,110,000	50.00%	Table 5.1 Row D + Table 5.2 Row D
I	Eliminating Members Copays	$8,659,604	0.0	$1,697,022	$526,557		$6,436,025	74.32%	Table 6.1 Row E
J	GRSS and NMT Rate Adjustments DD	$15,802,052	0.0	$5,293,686	$2,607,339	$0	$7,901,027	50.00%	Table 7.1 Row C * (DD Expenditure/ Total
K	GRSS and NMT Rate Adjustments SLS	$1,785,095	0.0	$598,006	$294,541	$0	$892,548	50.00%	Table 7.1 Row C * (SLS Expenditure/ Total
L	Nursing Facility Rate Increase	$39,182,927	0.0	$19,591,463	$0	$0	$19,591,464	50.00%	Table 8.1 Row G
M	Denver Min Wage and Increase for Base Wage for HCBS Workers	$56,953,319	0.0	$19,477,936	$8,998,735	$0	$28,476,648	50.00%	Table 9.1 * (11/12)
N	**Total Funding For Provider Rate Adjustments**	**$126,602,997**	**0.0**	**$48,768,113**	**$12,427,172**	**$0**	**$65,407,712**		**Sum of Row H through Row M**
O	**Total Request**	**$192,249,156**	**0.0**	**$69,830,979**	**$15,324,718**	**$0**	**$107,093,459**	**50.00%**	**(Row A) + (Row G) + (Row N)**

Table 2.2
Summary by Initiative
FY 2024-25

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Across the Board Rate Adjustment									
A	Across the Board Rate Increase of 0.5%	$26,400,158	0.0	$9,415,317	$1,239,222	$0	$15,745,619	NA	Table 3.1, Adjusted for full year impact
Targeted Rate Adjustments									
	MPRRAC Recommendations								
B	Physician Services	$21,066,939	0.0	$6,444,479	$872,123	$0	$13,750,337	65%	Table 4.1 Row N
C	Dialysis & Nephrology	$465,902	0.0	$100,777	$28,865	$0	$336,260	72%	Table 4.1 Row Q
D	Laboratory & Pathology	$2,676,626	0.0	$591,762	$151,214	$0	$1,933,650	72%	Table 4.1 Row R
E	Eyeglasses and Vision	$20,910,288	0.0	$6,396,558	$865,639	$0	$13,648,091	65%	Table 4.1 Row S
F	Injections & Miscellaneous J-Codes	$94,078	0.0	$28,779	$3,896	$0	$61,403	65%	Table 4.1 Row T
G	**Total Funding For MPRRAC Recommendations**	**$45,213,833**	**0.0**	**$13,562,355**	**$1,921,737**	**$0**	**$29,729,741**		**Sum (Row B) through (Row E)**
	Other Provider Rate Adjustments								
H	Rural Hospital Technology Payment	$4,220,000	0.0	$2,110,000	$0	$0	$2,110,000	50.00%	Table 5.1 Row D + Table 5.2 Row D
I	Eliminating Members Copays	$8,659,604	0.0	$1,697,022	$526,557	$0	$6,436,025	74.32%	Table 6.1 Row E
J	GRSS and NMT Rate Adjustments DD	$17,238,601	0.0	$8,619,301	$0	$0	$8,619,300	50.00%	Table 7.1 Row C * (DD Expenditure/ Total Expenditure)
K	GRSS and NMT Rate Adjustments SLS	$1,947,377	0.0	$973,689	$0	$0	$973,688	50.00%	Table 7.1 Row C * (SLS Expenditure/ Total Expenditure)
L	Nursing Facility Rate Increase	$44,039,550	0.0	$22,019,775	$0	$0	$22,019,775	50.00%	Table 8.1 Row G
M	Denver Min Wage and Increase for Base Wage for HCBS Workers	$62,130,893	0.0	$30,873,618	$191,837	$0	$31,065,438	50.00%	Table 9.1
N	**Total Funding For Provider Rate Adjustments**	**$138,236,025**	**0.0**	**$66,293,405**	**$718,394**	**$0**	**$71,224,226**		**Sum of Row H through Row M**
O	**Total Request**	**$209,850,016**	**0.0**	**$89,271,077**	**$3,879,353**	**$0**	**$116,699,586**		**(Row A) + (Row G) + (Row N)**

Table 2.3
Summary by Initiative
FY 2025-26

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Across the Board Rate Adjustment									
A	Across the Board Rate Increase of 0.5%	$26,400,158	0.0	$9,415,317	$1,239,222	$0	$15,745,619	NA	Table 3.2 Row DD
Targeted Rate Adjustments									
	MPRRAC Recommendations								
B	Physician Services	$21,066,939	0.0	$7,316,602	$0	$0	$13,750,337	65.27%	Table 4.1 Row N
C	Dialysis & Nephrology	$465,902	0.0	$129,642	$0	$0	$336,260	72.17%	Table 4.1 Row Q
D	Laboratory & Pathology	$2,676,626	0.0	$742,976	$0	$0	$1,933,650	72.24%	Table 4.1 Row R
E	Eyeglasses and Vision	$20,910,288	0.0	$7,262,197	$0	$0	$13,648,091	65.27%	Table. 4.1 Row S
F	Injections & Miscellaneous J-Codes	$94,078	0.0	$32,675	$0	$0	$61,403	65.27%	Table 4.1 Row T
G	**Total Funding For MPRRAC Recommendations**	**$45,213,833**	**$0**	**$15,484,092**	**$0**	**$0**	**$29,729,741**		**Sum (Row B) through (Row E)**
	Other Provider Rate Adjustments								
H	Rural Hospital Technology Payment	$4,220,000	0.0	$2,110,000	$0	$0	$2,110,000	50.00%	Table 5.1 Row D + Table 5.2 Row D
I	Eliminating Members Copays	$8,659,604	0.0	$1,697,022	$526,557	$0	$6,436,025	74.32%	Table 6.1 Row E
J	GRSS and NMT Rate Adjustments DD		0.0	$8,619,301	$0	$0	$8,619,300	50.00%	Table 7.1 Row C * (DD Expenditure/ Total Expenditure)
K	GRSS and NMT Rate Adjustments SLS	$1,947,377	0.0	$973,689	$0	$0	$973,688	50.00%	Table 7.1 Row C * (SLS Expenditure/ Total Expenditure)
L	Nursing Facility Rate Increase	$44,039,550	0.0	$22,019,775	$0	$0	$22,019,775	50.00%	Table 8.1 Row G
M	Denver Min Wage and Increase for Base Wage for HCBS Workers	$62,130,893	0.0	$30,873,618	$191,837	$0	$31,065,438	50.00%	Table 9.1
N	**Total Funding For Provider Rate Adjustments**	**$120,997,424**	**0.0**	**$66,293,405**	**$718,394**	**$0**	**$71,224,226**		**Sum of Row H through Row M**
O	**Total Request**	**$209,850,016**	**0.0**	**$91,192,814**	**$1,957,616**	**$0**	**$116,699,586**		**(Row A) + (Row G) + (Row N)**

Table 3.1: FY 2023-24 - Amounts Eligible for 0.50% Rate Change by Funding Source (November Forecasted Budget)

Row	Long Bill Group	Total Funds		General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(1) Executive Director's Office						
A	(D) Eligibility Determination and Clients	$88,092,552			$21,423,565	$0	$66,668,987
B	**Impact of 0.50% Rate Change**	**$440,463**		**$52,767**	**$93,554**	**$0**	**$294,141**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $7,438; Local Funds: $12,433							
	(2) Medical Services Premiums	**Total Funds**		**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
C	Acute Care	$2,774,838,578		$790,139,388	$168,879,643	$0	$1,815,819,547
D	Community Based Long Term Care	$1,339,779,514		$655,796,567	$9,818,831	$0	$674,164,116
E	Service Management	$239,528,627		$70,774,398	$21,974,710	$0	$146,779,519
F	**Total Medical Services Premiums**	**$4,354,146,719**		**$1,516,710,353**	**$200,673,184**	**$0**	**$2,636,763,182**
G	**Impact of 0.50% Rate Change**	**$21,770,734**		**$7,583,551**	**$1,003,366**	**$0**	**$13,183,817**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $913,464; Breast and Cervical Cancer Prevention and Treatment Fund: $3,224; Adult Dental Cash Fund: $86,679							
	(3) Behavioral Health Community Programs	**Total Funds**		**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
H	Behavioral Health Fee-for-Service	$13,568,608		$3,014,331	$885,255	$0	$9,669,022
I	**Impact of 0.50% Rate Change**	**$67,844**		**$15,071**	**$4,426**	**$0**	**$48,347**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $4,426							
Row	**(4) Office of Community Living**	**Total Funds**		**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
	(4) Office of Community Living						
J	Adult Comprehensive Services	$157,644,647		$78,550,306	$272,018	$0	$78,822,323
K	**Impact of 0.50% Rate Change**	**$788,223**		**$392,751**	**$1,360**	**$0**	**$394,112**
L	Adult Supported Living Services	$70,394,226		$29,850,227	$5,346,886	$0	$35,197,113
M	**Impact of 0.50% Rate Change**	**$351,971**		**$149,251**	**$26,734**	**$0**	**$175,986**
N	Children's Extensive Support Services	$35,481,201		$17,740,601	$0	$0	$17,740,600
O	**Impact of 0.50% Rate Change**	**$177,406**		**$88,703**	**$0**	**$0**	**$88,703**
P	Children's Habitation/Rehabilitation Program	$11,149,704		$5,574,852	$0	$0	$5,574,852
Q	**Impact of 0.50% Rate Change**	**$55,749**		**$27,874**	**$0**	**$0**	**$27,875**
R	Case Management	$90,473,482		$45,070,248	$1,302,610	$0	$44,100,624
S	**Impact of 0.50% Rate Change**	**$452,367**		**$225,351**	**$6,513**	**$0**	**$220,503**
T	State Supported Living Services	$9,511,028		$9,511,028	$0	$0	$0
U	**Impact of 0.50% Rate Change**	**$47,555**		**$47,555**	**$0**	**$0**	**$0**
V	State Supported Living Services Case Management	$2,191,580		$2,191,580	$0	$0	$0
W	**Impact of 0.50% Rate Change**	**$10,958**		**$10,958**	**$0**	**$0**	**$0**
X	Family Support Services	$7,308,510		$7,308,510	$0	$0	$0
Y	**Impact of 0.50% Rate Change**	**$36,543**		**$36,543**	**$0**	**$0**	**$0**
Z	Preventive Dental Hygiene	$66,460		$66,460	$0	$0	$0
AA	**Impact of 0.50% Rate Change**	**$332**		**$332**	**$0**	**$0**	**$0**
BB	Eligibility Determination and Waitlist Management	$0		$0	$0	$0	$0
CC	**Impact of 0.50% Rate Change**	**$0**		**$0**	**$0**	**$0**	**$0**
DD	**Total Impact**	**$24,200,145**	**$0**	**$8,630,707**	**$1,135,953**	**$0**	**$14,433,484**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $34,607							

Table 4.1 Repricing Services to 80-100% of Benchmark						
Row	**Service**	**Lower Bound**	**Upper Bound**	**Current Cost**	**Projected Cost**	**Difference**
Physician Services						
A	Cardiology	80%	100%	$16,065,292	$15,695,785	($369,507)
B	Cognitive Capabilities Assessment	80%	100%	$7,390,369	$4,674,734	($2,715,635)
C	Earn, Nose, and Throat	80%	100%	$19,610,893	$20,854,913	$1,244,020
D	Gastroenterology	80%	100%	$162,160	$206,695	$44,535
E	Health Education	80%	100%	$687,240	$915,585	$228,345
F	Ophthalmology	80%	100%	$26,152,155	$27,364,043	$1,211,888
G	Primary Care/Evaluation and Management	80%	100%	$361,644,914	$370,066,768	$8,421,853
H	Radiology	80%	100%	$58,816,577	$57,068,001	($1,748,577)
I	Respiratory	80%	100%	$914,336	$883,053	($31,283)
J	Vaccines and Immunizations	80%	N/A	$14,203,812	$14,232,602	$28,790
K	Vascular	80%	100%	$3,904,163	$2,926,114	($978,049)
L	Women's Health and Family Planning	80%	100%	$188,679,084	$194,271,874	$5,592,790
M	Other Physician Services	80%	100%	$371,158,303	$381,296,072	$10,137,769
N	**Total Physician Services**			**$1,069,389,298**	**$1,090,456,240**	**$21,066,939**
Dialysis and Nephrology						
O	Facility-Based Payments	80%	100%	$8,444,228	$8,609,671	$165,443
P	Professional Procedure Codes (Non Facility)	80%	100%	$910,930	$1,211,389	$300,459
Q	**Total Dialysis and Nephrology**			**$9,355,158**	**$9,821,060**	**$465,902**
Laboratory & Pathology						
R	**Total Laboratory & Pathology**	80%	100%	**$75,238,081**	**$77,914,707**	**$2,676,626**
Eyeglasses and Vision						
S	**Total Eyeglasses and Vision**	80%	100%	**$51,457,214**	**$72,367,502**	**$20,910,288**
Injections and Miscellaneous J-Codes						
T	**Total Injections and Misc. J-Codes**	80%	100%	**$1,250,195**	**$1,344,273**	**$94,078**
U	**Grand Total**			**$1,206,689,947**	**$1,251,903,782**	**$45,213,833**

Table 5.1 - Rural Health Clinic Rate Increase					
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Notes/Calculations**
A	Estimated Number of Rural Health Clinics	51	51	51	Department List of RHC Providers
B	Estimated Annual Increase in Expenditure per Rural Health Clinic	$20,000	$20,000	$20,000	Based on Arizona's RHC payments
C	Adjustments for Timing of Payments	100.00%	100%	100%	Projected Implementation July 1, 2024
D	**Total Proposed Increase**	**$1,020,000**	**$1,020,000**	**$1,020,000**	**Row A * Row B * Row C**

Table 5.2 - Critical Access Hospital Rate Increase					
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Notes/Calculations**
A	Estimated Number of Critical Access Hospitals	32	32	32	Department List of CAH Providers
B	Estimated Annual Increase in Expenditure per Hospital	$100,000	$100,000	$100,000	Based on Arizona's CAH payments
C	Adjustments for Timing of Payments	100.00%	100%	100%	Projected Implementation July 1, 2024
D	**Total Proposed Increase**	**$3,200,000**	**$3,200,000**	**$3,200,000**	**Row A * Row B * Row C**

Table 6.1 - Estimated Impact of Changing Co-Pays to Proposed Levels											
Row	**Item**	**Pharmacy**	**Physician Services[2]**	**Federally Qualified Health Centers**	**Rural Health Centers**	**Inpatient Services**	**Outpatient Services[3]**	**Non-Emergent Use of Emergency Depar tment**	**Durable Medical Equipment**	**Lab and X-Ray**	**Total**
A	Number of Co-Pays in FY 2018-19	2,264,303	799,343	175,270	30,708	4,457	159,055	11,218	146,438	39,222	3,630,014
B	Average Health First Colorado Co-Pays as of FY 2018-19	$2.96	$1.71	$1.99	$1.98	$27.05	$4.00	$6.00	$1.00	$1.00	-
C	Proposed Co-Pays	$0.00	$0.00	$0.00	$0.00	$25.00	$4.00	$8.00	$0.00	$0.00	-
D	Proposed Change in Medicaid Contributions to Co-Pays	-$2.96	-$1.71	-$1.99	-$1.98	-$2.05	$0.00	$2.00	-$1.00	-$1.00	-
E	**Estimated Decrease in Co-pay Revenue due to Proposed Change**	**$6,709,287**	**$1,369,010**	**$349,073**	**$60,699**	**$9,137**	**$0**	**($22,436)**	**$145,750**	**$39,084**	**$8,659,604**
F	General Fund[3]	$1,314,819	$268,285	$68,408	$11,895	$1,790	$0	($4,397)	$28,563	$7,659	$1,697,022
G	Cash Funds[3]	$407,965	$83,244	$21,226	$3,691	$556	$0	($1,364)	$8,862	$2,377	$526,557
H	Federal Funds[3]	$4,986,503	$1,017,481	$259,439	$45,113	$6,791	$0	($16,675)	$108,325	$29,048	$6,436,025

Footnotes:

(1) The Department assumes a uniform co-pay increase for clients of all Federal Poverty Levels (FPLs), including those above 100% FPL. The federal maximum co-pay for individuals with FPLs in the range of 100% - 150% is 10% of the cost of the service and 20% of the cost of service for individuals above 150% FPL. The Department assumes implementing this co-pay maximum based on 10% or 20% of the cost of service would result in an indeterminate fiscal impact based on the implications of 42 CFR 447.52 (g) "Income Related Charges." This regulation states the Department must ensure that lower income individuals are charged less than individuals with higher income if the Department establishes different cost sharing charges. In instances where 10% or 20% of the cost of service is less than the co-pay for individuals with FPLs less than 100% FPL, the Department assumes it must require clients to pay the lesser co-pay, regardless of FPL. For this reason, the Department assumes total co-pays may go up or down under a co-pay maximum that is based on a percentage of the cost of the service.

(2) Physician services include optometry and podiatry services.

(3) Outpatient services include urgent care centers/facilities and emergency services.

(4) Federal regulations allow co-pays up to $8 for non-emergent services delivered at the emergency department, including ambulatory services.

Table 7.1 - GRSS and NMT Rate Adjustments					
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Notes/Calculations**
A	Total Annual GRSS Expenditure	$3,237,354	$3,531,658	$3,531,658	Table 7.2 Row D
B	Total Transportation Expenditure	$14,349,793	$15,654,320	$15,654,320	Table 7.3 Row E
C	**Total Incremental Rate Increase**	**$17,587,147**	**$19,185,978**	**$19,185,978**	**Row A + Row B**

Table 7.2 - GRSS Budget Neutrality Adjustment					
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Notes/Calculations**
A	Total Annual GRSS Expenditure	$51,863,295	$51,863,295	$51,863,295	FY 2020-21 Expenditure
B	Total Incremental Rate Increase	$3,531,658	$3,531,658	$3,531,658	Incremental Rate Adjustment using variable Budget Neutrality Factor
C	Adjustments for Timing of Payments	92%	100%	100%	Assuming One Month Pay Lag
D	**Total Adjusted Increase in GRSS Expenditure**	**$3,237,354**	**$3,531,658**	**$3,531,658**	**Row C * Row D**

Table 7.3 - Transportation Budget Neutrality Adjustment					
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Notes/Calculations**
A	Total Annual Transportation Expenditure	$32,040,751	$32,040,751	$32,040,751	Projected Expenditure for under Current Rates
B	Proposed Annual Transportation Expenditure	$47,695,071	$47,695,071	$47,695,071	Projected Expenditure using LTSS Rates
C	Total Incremental Rate Increase	$15,654,320	$15,654,320	$15,654,320	Row B - Row A
D	Adjustments for Timing of Payments	92%	100%	100%	Assuming One Month Pay Lag
E	**Total Adjusted Increase in Transportation Expenditure**	**$14,349,793**	**$15,654,320**	**$15,654,320**	**Row C * Row D**

Table 8.1 Nursing Facility Rate Increases				
Row	**Item**	**FY 2023-24**	**FY 2024-25**	**Notes**
B	Previous Year Reimbursement Rate	$208.64	$214.90	FY23 and FY24 Rates, respectively.
C	Adjust to align with NF Costs	$18.37	$18.37	Per diem cost NFs aren't currently being reimbursed for
D	FY 2023-24 Medicaid Reimbursement Rate	$227.01	$233.27	Row B + Row C
E	Total FY 2023-24 Expenditure	$779,183,036	$856,853,843	FY 2023-24 Total Patient days * (Row D)
F	Previously Estimated FY 2023-24 Expenditure	$740,000,109	$812,814,293	FY 2023-24 R-1 Estimate
G	**Total Estimated Impact of Rate Increase**	**$39,182,927**	**$44,039,550**	**Row E - Row F**

Table 9.1 Home and Community Based Wage Passthrough Rate Increase					
Service	County Type	Waiver	Expenditure[1]	Wage Pass Through	
				Percent Increase[2]	Estimated Increase[3]
Adult Day Services	Frontier	SCI, EBD, CMHS, BI	$66,157	5.2%	$6,833
Adult Day Services	Rural	SCI, EBD, CMHS, BI	$359,556	5.2%	$37,134
Adult Day Services	Urban	SCI, EBD, CMHS, BI	$9,497,359	5.2%	$980,874
Adult Day Services	Urban - Denver	SCI, EBD, CMHS, BI	$5,610,038	15.7%	$1,764,477
Alternative Care Facility	Frontier	CES, CHRP	$1,293,347	3.5%	$90,889
Alternative Care Facility	Rural	CES, CHRP	$3,786,776	3.5%	$266,114
Alternative Care Facility	Urban	CES, CHRP	$27,808,514	3.5%	$1,954,228
Alternative Care Facility	Urban - Denver	CES, CHRP	$5,934,968	10.7%	$1,273,474
Consumer Directed Attendant Support Services (CDASS)	Frontier	SCI, EBD, CMHS, BI, SLS	$4,410,973	3.5%	$312,295
Consumer Directed Attendant Support Services (CDASS)	Rural	SCI, EBD, CMHS, BI, SLS	$13,190,407	3.5%	$933,875
Consumer Directed Attendant Support Services (CDASS)	Urban	SCI, EBD, CMHS, BI, SLS	$58,424,500	3.5%	$4,136,427
Day Habilitation	Frontier	SLS, DD	$596,409	3.9%	$46,159
Day Habilitation	Rural	SLS, DD	$3,775,651	3.9%	$292,213
Day Habilitation	Urban	SLS, DD	$44,829,794	3.9%	$3,469,563
Day Habilitation	Urban - Denver	SLS, DD	$5,181,296	11.0%	$1,144,026
Homemaker - Denver	Urban - Denver	SCI, CES, EBD, CMHS, BI, SLS	$4,376,357	5.2%	$455,130
Homemaker - Outside Denver	Frontier	SCI, CES, EBD, CMHS, BI, SLS	$742,922	3.1%	$46,677
Homemaker - Outside Denver	Rural	SCI, CES, EBD, CMHS, BI, SLS	$2,458,344	3.1%	$154,455
Homemaker - Outside Denver	Urban	SCI, CES, EBD, CMHS, BI, SLS	$15,378,022	3.1%	$966,185
In-Home Support Services - Denver	Urban - Denver	SCI, CHCBS, EBD	$32,045,331	5.1%	$3,246,956
In-Home Support Services - Outside Denver	Frontier	SCI, CHCBS, EBD	$2,754,493	2.7%	$148,586
In-Home Support Services - Outside Denver	Rural	SCI, CHCBS, EBD	$11,225,198	2.7%	$605,522
In-Home Support Services - Outside Denver	Urban	SCI, CHCBS, EBD	$134,790,327	2.7%	$7,271,012
Mentorship	Frontier	SLS	$88,545	1.8%	$3,252
Mentorship	Rural	SLS	$169,420	1.8%	$6,223
Mentorship	Urban	SLS	$8,119,223	1.8%	$298,216
Mentorship	Urban - Denver	SLS	$627,393	4.7%	$59,517
Non Medical Transportation	Frontier	SCI, EBD, CMHS, BI, SLS, DD	$204,278	8.4%	$34,164
Non Medical Transportation	Rural	SCI, EBD, CMHS, BI, SLS, DD	$1,026,783	8.4%	$171,720
Non Medical Transportation	Urban	SCI, EBD, CMHS, BI, SLS, DD	$10,133,772	8.4%	$1,694,783
Non Medical Transportation	Urban - Denver	SCI, EBD, CMHS, BI, SLS, DD	$3,204,273	19.4%	$1,245,076
Personal Care - Denver	Urban - Denver	EBD, SCI, BI, CMHS, SLS	$33,504,207	5.4%	$3,603,707
Personal Care - Outside Denver	Frontier	EBD, SCI, BI, CMHS, SLS	$3,076,099	3.1%	$187,798
Personal Care - Outside Denver	Rural	EBD, SCI, BI, CMHS, SLS	$2,638,776	3.1%	$161,099
Personal Care - Outside Denver	Urban	EBD, SCI, BI, CMHS, SLS	$53,259,311	3.1%	$3,251,519
Prevocational Services	Rural	SLS, DD	$447	4.8%	$43
Prevocational Services	Urban	SLS, DD	$541,836	4.8%	$51,595
Prevocational Services	Urban - Denver	SLS, DD	$12,815	13.9%	$3,553
Residential Habilitation - Denver	Urban - Denver	DD, CHRP	$19,705,972	10.1%	$3,998,664
Residential Habilitation - Outside Denver	Frontier	DD, CHRP	$3,835,625	3.6%	$275,016
Residential Habilitation - Outside Denver	Rural	DD, CHRP	$18,481,177	3.6%	$1,325,110
Residential Habilitation - Outside Denver	Urban	DD, CHRP	$194,198,848	3.6%	$13,924,160
Respite Care	Frontier	CES, SCI, EBD, CMHS, BI, SLS, CHRP, CLLI	$137,117	3.3%	$8,922
Respite Care	Rural	CES, SCI, EBD, CMHS, BI, SLS, CHRP, CLLI	$237,578	3.3%	$15,459
Respite Care	Urban	CES, SCI, EBD, CMHS, BI, SLS, CHRP, CLLI	$10,377,057	3.3%	$675,224
Respite Care	Urban	CES, SCI, EBD, CMHS, BI, SLS, CHRP, CLLI	$718,959	14.7%	$211,893
Supported Employment	Frontier	SLS, DD	$149,215	2.4%	$7,292
Supported Employment	Rural	SLS, DD	$788,827	2.4%	$38,552
Supported Employment	Urban	SLS, DD	$11,071,758	2.4%	$541,102
Supported Employment	Urban - Denver	SLS, DD	$1,860,783	5.4%	$201,776
Supported Living Programs	Frontier	BI	$62,038	1.7%	$2,110
Supported Living Programs	Rural	BI	$129,695	1.7%	$4,411
Supported Living Programs	Urban	BI	$13,061,352	1.7%	$444,263
Supported Living Programs	Urban - Denver	BI	$732,539	5.3%	$78,016
Transitional Living Program	Urban	BI	$0	3.6%	$0
Transitional Living Program	Urban - Denver	BI	$11,211	11.0%	$2,463
Total			**$780,703,668**		**$62,129,802**

[1]Actual Expenditure from January 1, 2022 through June 2022 by category of service

[2]The Department estimated increases in rates based on increasing wages in Denver county to $17.29 and wages in Non-Denver Counties to $15.75.

[3]Total Projected Increase based on estimated percentage increase in rates and the 6 month actual expenditure by Category of Service annualized.